SUPERIOR HEALTH PLAN

Specific policy administered by National Imaging Associates, Inc. (NIA)

National Imaging Associates, Inc.	
Clinical guidelines **OUTPATIENT HABILITATIVE AND REHABILITATIVE SPEECH THERAPY**	**Original Date: November 2015**
Physical Medicine – Clinical Decision Making	**Last Revised Date: February 2024**
Guideline Number: NIA_CG_602	**Implementation Date: July 2024**

*** Refers to health plan specific language[12]**

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General Information

It is an expectation that all patients receive care/services from a licensed clinician. All appropriate supporting documentation, including recent pertinent office visit notes, laboratory data, and results of any special testing is provided. If applicable: All prior relevant imaging results and the reason that alternative imaging cannot be performed must be included in the documentation submitted.

Statement

Habilitative/Rehabilitative speech therapy should meet the definitions below, be provided in a clinic, an office, at home, or in an outpatient setting and be ordered by either a primary care practitioner or specialist.

Purpose

This guideline describes the documentation requirements of appropriate Habilitative/Rehabilitative Speech Therapy.

All recommendations in this guideline reflect practices that are evidence-based and/or supported by broadly accepted clinical specialty standards.

Scope

This guideline applies to all physical medicine practitioners, including Speech-Language Pathologists (SLP) and Speech-Language Pathology Assistants (SLP-A).
National Imaging Associates will review all requests resulting in adverse determinations for Medicaid members for coverage under federal Early and Periodic Screening, Diagnostic and Treatment (EPSDT) guidelines.[1, 2]

Requirements

The following criteria must be addressed to justify the medical necessity of the prescribed treatment.

Documentation

Progress notes or updated plans of care that cover the patient's specific progress towards their goals with review by the primary care practitioner or other non-physician (NPP) will be required every 60-90 days or per state guidelines.

Documentation should include: [3]

- Written referral from primary care practitioner or other non-physician practitioner (NPP) as required by state guidelines.
- Patient's current level of function and any conditions that are impacting his/her ability to benefit from skilled intervention
- Objective measures of the patient's overall functional progress relative to each treatment goal as well as a comparison to the previous progress report
- Skilled treatment techniques that are being utilized in therapy as well as the patient's response to therapy
- If appropriate, documentation should provide a rationale for lack of progress or response to treatment
- Treatment goals that follow a hierarchy of complexity to achieve the target skills for a functional goal
- Re-evaluation or annual testing (for habilitative therapy) using formal standardized assessment tools and formal assessment of progress must be performed to support progress, ongoing delays, and medical necessity for continued services.
    - An explanation of any significant changes in the plan of care and clinical rationale for why the ongoing skills of a SLP are medically necessary
- When skilled services are also being provided by other community service agencies and/or school systems the notes must show:
    - Applicable coordination of services with those agencies
    - When services are not available

Evaluation

- Speech therapy initial evaluation and re-evaluations must include age-appropriate standardized tests, documenting a developmental delay or condition: [4, 3]
- To establish a developmental delay, all of the criteria must be met:[12]
    - Tests used must be norm-referenced, standardized, and specific to the therapy provided.
    - Retesting with norm-referenced standardized test tools for re-evaluations must occur yearly and may occur every 180 days. Tests must be age appropriate for the child being tested and providers must use the same testing instrument as used in the initial evaluation. If reuse of the initial testing instrument is not appropriate, i.e. due to change in member status or restricted age range of the testing tool, provider should explain the reason for the change.
    - Eligibility for therapy will be based upon a score that falls 1.5 standard deviations (SD) or more below the mean (at or below 10^{th} percentile) in at least one subtest area of composite score on a norm-referenced, standardized test. Raw scores must be reported along with score reflecting SD from mean.
    - When the member's test score is less than 1.5 SD below the mean, a criterion-

referenced test along with informed evidenced-based clinical opinion must be included to support the medical necessity of services and will be sent to physician review to determine medical necessity.
    - If a child cannot complete norm-referenced standardized assessments, then a functional description of the child's abilities and deficits must be included. Measurable functional short- and long-term goals will be considered along with test results. Documentation of the reason a standardized test could not be used must be included in the evaluation.
    - Test information must be linked to difficulty with or inability to perform everyday tasks [5, 6]
- Specific developmental delay criteria requirements for speech diagnoses are as follows:[12]
    - Language—at least one norm-referenced, standardized test with good reliability and validity, a score that falls 1.5 SD or more below the mean, and clinical documentation of an informal assessment that supports the delay
    - Articulation—at least one norm referenced, standardized test with good reliability and validity, a score that falls 1.5 SD or more below the mean, and clinical documentation of an informal assessment that supports the delay
    - Apraxia—at least one norm-referenced, standardized test with good reliability and validity, a score that falls 1.5 SD or more below the mean, and clinical documentation of an informal assessment that supports the delay
    - Fluency—at least one norm-referenced, standardized test with good reliability, a score that falls 1.5 SD or more below the mean, and clinical documentation of an informal assessment that supports the delay
    - Voice—an evaluation from a qualified specialist is required for eligibility and based on medical referral
    - Oral Motor/Swallowing/Feeding—an in-depth, functional profile of oral motor structures and function and any impact to feeding development
    - Additional speech therapy visits or sessions may be considered for moderate speech language, articulation, voice and dysphagia developmental delays when documentation submitted supports medical necessity as delineated in the frequency criteria in this guideline.
- Evaluation for habilitative therapy should include:
    - A reasonable expectation that the services will bring about a significant improvement within a reasonable time frame, regardless of whether the individual has a coexisting disorder
    - Evidence that ongoing treatment is appropriate; note: ongoing treatment is not appropriate when patient function is steady and treatment no longer yields measurable and significant functional progress
- Evaluation for rehabilitative therapy should include:
    - The specific impact or exacerbation of injury on the patient's ability to perform

in their everyday environment must be supported by appropriates tests and measures in addition to clinical observations

- Functional skills
    - The initial plan of care must document baseline impairments as they relate to functional communication and feeding/swallowing with specific goals developed that are measurable, sustainable and time-specific

Treatment Goals

- Treatment goals must be:
    - Realistic, measurable, and promote attainment of developmental milestones and functional communication abilities appropriate to the member's age and circumstances.[7, 4]
    - Include the type, amount, duration, and frequency of therapy services.
        - These must be consistent with accepted standards of practice and correspond with the patient's medical and skilled therapy needs and level of disability.
    - Individualized and measurable in order to identify the functional levels related to appropriate maintenance or maximum therapeutic benefit, targeted to identified deficits, and promote the attainment of:
        - Age-appropriate developmental milestones
        - Functional skills appropriate to the patient's age and circumstances.
- Although identified as component parts of participation, underlying factors, performance skills, patient factors or the environment should not be the targeted outcome of long-term goals.
- For sustained positive benefits from therapeutic interventions, activities can be practiced in the child's environment and reinforced by the parents or other caregivers.
- Services must be considered reasonable, effective, and of such a complex nature that they require the technical knowledge and clinical decision-making skill of a therapist or can be safely and effectively conducted by non-skilled personnel without the supervision of qualified professionals.

Frequency and Duration

- Frequency is not for the convenience of the member or the responsible adult.[12]
- When therapy is initiated, the therapist must provide education and training of the member and responsible caregivers, by developing and instructing them in a home treatment program to promote effective carryover of the therapy program and management of safety issues.[12]
- Frequency and duration of skilled services must also be in accordance with the following:
    - Intense frequencies (3x/week or more) will require additional documentation and testing supporting a medical need to achieve an identified new skill or

recover function with specific, achievable goals within the requested intensive period. Details on why a higher frequency is more beneficial than a moderate or low frequency must be included. More intensive frequencies may be necessary in the acute phase, however, progressive decline in frequency is expected within a reasonable time frame.

- Therapy provided three times a week may be considered for 2 or more of these exceptional situations:[12]
  - The member has a medical condition that is rapidly changing.
  - The member has a potential for rapid progress (e.g., excellent prognosis for skill acquisition) or rapid decline or loss of functional skill (e.g., serious illness, recent surgery).
  - The member's therapy plan and home program require frequent modification by the licensed therapist.
- On a case-by-case basis, a high frequency requested for a short-term period (4 weeks or less) which does not meet the above criteria may be considered with all of the following documentation:[12]
  - Letter of medical need from the prescribing provider documenting the member's rehabilitation potential for achieving the goals identified.
  - Therapy summary documenting all of the following:
    - Purpose of the high frequency requested (e.g., close to achieving a milestone)
    - Identification of the functional skill which will be achieved with high frequency therapy
    - Specific measurable goals related to the high frequency requested and the expected date the goal will be achieved.

- Moderate frequency (2x/week) Therapy provided two times a week may be considered when documentation shows one or more of the following:[12]
  - The member is making very good functional progress toward goals
  - The member is in a critical period to gain new skills or restore function or is at risk of regression.
  - The licensed therapist needs to adjust the member's therapy plan and home program weekly or more often than weekly based on the member's progress and medical needs.
  - The member has complex needs requiring ongoing education of the responsible adult.
- Low frequency (at or less than 1x/week)[12]
  - Therapy provided one time per week or every other week may be considered when the documentation shows one or more of the following[3]:
    - The member is making progress toward the member's goals, but the progress has slowed, or documentation shows the member is at risk of deterioration due to the member's development or medical condition.
    - The licensed therapist is required to adjust the member's therapy plan

and home program weekly to every other week based on the member's progress.
        - Every other week therapy is supported for members whose medical condition is stable, they are making progress, and it is anticipated the member will not regress with every other week therapy.
        - As the member's medical need for therapy decreases, it is expected that the therapy frequency will decrease as well.
    - Frequencies less than every other week may be appropriate for those children who cannot yet tolerate more frequent therapy sessions. They may also have needs that are addressed on a periodic basic as part of comprehensive management in a specialty clinic. Occasional consultation may be appropriate to ensure gains continue, to address emerging concerns, or to help order equipment and train in its use.
- All requested frequencies must be supported by skilled treatment interventions regardless of level of severity of delay.
- Additional factors may be considered on a case-by-case basis.
- There must be evidence as to whether the services are considered reasonable, effective, and of such a complex nature that they require the technical knowledge and clinical decision-making skill of a therapist or whether they can be safely and effectively carried out by non-skilled personnel without the supervision of qualified professionals.
    - In determining whether a service requires the skill of a licensed physical and occupational therapist or speech language pathologist, consideration must be given to the inherent complexity of the service, the condition of the member, the accepted standards of medical and therapy practice guidelines, with consideration of the following:[12]
    - If the service could be performed by the average nonmedical person, the absence of a competent person (such as a family member or medical assistant) to perform it does not cause it to be a skilled therapy service.[12]
    - If the nature of a service is such that it can be safely and effectively performed by the average nonmedical person without direct supervision of a licensed therapist, the services cannot be regarded as skilled therapy.[12]
    - Treatment that requires the technical knowledge and clinical decision-making expertise to meet the skilled service needs of the individual. This includes analyzing medical/behavioral data and selecting appropriate evaluation tools/protocols to determine communication/swallowing diagnosis and prognosis.
- In the case of maintenance programs, clear documentation of the skilled interventions rendered and objective details of how these interventions are preventing deterioration or making the condition more tolerable must be provided. The notes must also clearly demonstrate that the specialized judgment, knowledge, and skills of a qualified therapist (as opposed to a non-skilled individual) are required for the safe and effective performance of services in a maintenance program.

    - This frequency level (e.g., every other week, monthly, every 3 months) is used when the therapy plan changes very slowly, the home program is at a level that may be managed by the member or the responsible adult/caregiver, or the therapy plan requires infrequent updates by the skilled therapist.[12]
        - Documentation must show that the habilitative/rehabilitative plan of care has ended, and a new plan of care established for maintenance[12]
- A maintenance level of therapy services may be considered when a member requires skilled therapy for ongoing periodic assessments and consultations and the member meets one of the following criteria:[12]
    - Progress has slowed or stopped, but documentation supports that ongoing skilled therapy is required to maintain the progress made or prevent deterioration.
    - The submitted documentation shows that the member may be making limited progress toward goals or that goal attainment is extremely slow.
    - Factors are identified that inhibit the member's ability to achieve established goals (e.g., the member cannot participate in therapy sessions due to behavior issues or issues with anxiety).
    - Documentation shows the member and the responsible adult have a continuing need for education, a periodic adjustment of the home program, or regular modification of equipment to meet the member's needs.
    - Clear documentation of the skilled interventions rendered and objective details of how these interventions are preventing deterioration or making the condition more tolerable must be provided. The notes must also clearly demonstrate that the specialized judgment, knowledge, and skills of a qualified therapist (as opposed to a non-skilled individual) are required for the safe and effective performance of services in a maintenance program.
- If the member is not progressing, then documentation of a revised treatment plan is necessary. Discontinuation of therapy may be considered in one or more of the following situations:
- Member no longer demonstrates functional impairment or has achieved goals set forth in the treatment plan or plan of care[12]
    - Member has returned to baseline function
- Member can continue therapy with a home treatment program and deficits no longer require a skilled therapy intervention and, for members who are 20 years of age and younger only, maintain status[12]
    - Member has adapted to impairment with assistive equipment or devices
    - Member is able to perform ADLs with minimal to no assistance from caregiver
- Member has achieved maximum functional benefit from therapy in progress or will no longer benefit from additional therapy[12]
- Member is unable to participate in the treatment plan or plan of care due to medical, psychological, or social complications; and responsible adult has had instruction on the

home treatment program and the skills of a therapist are not needed to provide or supervise the service[12]
    - Testing shows member no longer has a developmental delay
    - Plateau in response to therapy/lack of progress towards therapy goals
- Non-compliance due to poor attendance and with member or responsible adult, non-compliance with therapy and home treatment program[12]
- Member has achieved the maximum therapeutic value of a treatment plan, no additional functional improvement is apparent or expected to occur, and the provision of services for a condition cease to be of therapeutic value.[12]

Discontinuation of Treatment

- A specific discharge plan, with the expected treatment frequency and duration, must be included in the plan of care. [7] The discharge plan must indicate the plan to wean services once the member has attained their goals.[5] Discharge may also be warranted if:
    - No measurable functional improvement has been demonstrated.
        - Behaviors that interfere with the ability to progress with therapy qualify under the American Speech-Language-Hearing Association (ASHA) discharge criteria guidelines.
    - Program can be carried out by caregivers or other non-skilled personnel.
    - Maximum therapeutic value of a treatment plan has been achieved.
    - No additional functional improvement is apparent or expected to occur.
    - Provision of services for a condition cease to be of therapeutic value.
- If the member shows signs of regression in function, the need for skilled speech therapy can be re- evaluated at that time.
    - Periodic episodes of care may be needed over a lifetime to address specific needs or changes in condition resulting in functional decline.

Other Considerations

- When a patient's language background differs from the rendering therapist and a clinician who has native or near-native proficiency in the target language is not available, use of an interpreter is appropriate and should be documented accordingly.
    - If an interpreter is not present this should be documented along with evidence of a communication disorder and a treatment plan that supports linguistically appropriate services without the use of an interpreter.
- If a patient is substantially exposed to more than one language, the assessment must evaluate both languages and contain appropriate tests and measures to clearly denote the presence that a communication disorder is present as opposed to normal linguistic variations related to second language learning.[8]
- Swallowing disorders (dysphagia) and feeding disorders will need documentation of an

oral, pharyngeal, and/or esophageal phase disorder, food intolerance or aversion.[4, 5, 7]
    - There must be evidence of ongoing progress and a consistent home regimen to facilitate carry-over of target feeding skills, strategies and education of member, family, and caregiver.
    - Therapies for picky eaters who can eat and swallow normally meeting growth and developmental milestones, eat at least one food from all major food groups (protein, grains, fruits, etc.) and more than 20 different foods are not medically necessary.
- Treatment that includes goals for reading/literacy must also have a primary diagnosis of a speech or language disorder.
    - Documentation must support that the deficits in reading/literacy are affecting functional activities of daily living and are not the primary focus of treatment. They must show how the services for reading/literacy are of such a complex nature that they require the skills of a speech language pathologist.
- Treatment for voice disorders will need evidence of an instrumental assessment completed by an ENT or SLP to rule out a medical cause or structural deficit.[9]
- Treatment for fluency disorders will need evidence that stuttering is a medical condition and is no longer developmental in nature.[10]
- Treatment incorporating nonspeech oral motor exercises (NSOMEs) must be evidence based and paired with functional articulation and/or feeding/swallowing tasks.[11]

Background

Definitions

Habilitative Speech Therapy
Treatment provided by a state-regulated speech therapist to help a person attain, maintain, or prevent deterioration of a skill or function never learned or acquired. Treatment may also be appropriate in a child with a progressive disorder when it has the potential to prevent the loss of a functional skill or enhance the adaptation to such functional loss.

Rehabilitative Speech Therapy
Treatment provided by a state-regulated speech therapist designed to help a person recover from an acute injury or exacerbation of a chronic condition that has resulted in a decline in functional performance.

Functional Skills
They are considered necessary communication activities of daily life.

POLICY HISTORY

Date	Summary
December 2023	• Required test score cut-offs removed, replaced with requirement that any testing method be interpreted in accordance with its scoring method • Distinction made between high frequency and intense frequency of treatments. • Additional guidance on treatment for fluency disorders and nonspeech oral exercises added
December 2022	• Updated indications – revised criteria for standardized testing • Revised language for maintenance programs • Revised language for patients with a language background different than rendering therapist and for patients exposed to more than one language • Clarified formal testing section and added references to support accepted measures for a significant delay • Updated references
December 2021	• Added “General Information” statement • Added “resulting in adverse determinations” to EPSDT statement • Reworded for clarity indication regarding bilingual members (members whose language background differs from rendering therapist) • Added criteria stating that treatment including goals for reading/literacy must have primary diagnosis of speech or language disorder with documentation support showing how services for reading/literacy require skills of a speech language pathologist

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Reviewed/Approved by NIA Clinical Guideline Committee

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