*Evolent	
Clinical guidelines **OUTPATIENT HABILITATIVE AND REHABILITATIVE SPEECH THERAPY**	**Original Date: November 2015**
Physical Medicine – Clinical Decision Making	**Last Revised Date: December 2023**
Guideline Number: Evolent_CG_602	**Implementation Date: July 2024**

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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 must be 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 practitioner (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

- Establishing a delay or deficit

  Formal testing [4, 3]
    - Age-appropriate, norm-referenced, standardized, and specific to the therapy provided
    - Different tests use different scoring methods and risk categories; any selected test must be interpreted in accordance with its scoring method.
    - Test scores and interpretation should establish the presence of a significant delay
    - While standardized testing is preferred, scores alone may not be used as the sole criteria for determining a patient's medical need for skilled intervention; test information must be linked to difficulty with or inability to perform everyday tasks [5, 6].
    - In the absence of standardized testing or when test scores show skills within normal ranges, the documentation must include detailed clinical observations and objective data to document the degree and severity of the condition to support the medical need for skilled services; a caregiver interview/questionnaire can also support the request.
    - Any time standardized testing cannot be completed, the documentation must clearly state the reason formal testing could not be done.
- 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 appropriate 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 patient'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 functional 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, client factors and/or the environment should not be the targeted outcome of long-term goals.
- 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.
- For sustained positive benefits from therapeutic interventions, activities can be practiced in the child's environment and reinforced by the parents or other caregivers.

Frequency and Duration

- All requested frequencies must be supported by skilled treatment interventions regardless of level of severity of delay.
- Intense frequencies (i.e., 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.

    - Higher frequencies may be considered when delays are classified as severe (as indicated by corresponding testing guidelines used in the evaluation) [4].
    - More intensive frequencies may be necessary in the acute phase, however, progressive decline in frequency is expected within a reasonable time frame [4].
- Moderate frequency (i.e., 2x/week) should be consistent with moderate delays as established in the general guidelines of formal assessments used in the evaluation.
    - This frequency may be used for ongoing care when documentation supports this frequency as being clinically effective toward achieving the functional goals in the treatment plan within a reasonable time frame.
- Low frequency (i.e., 1x/week or less) may be considered when testing guidelines indicate mild delays or when a higher frequency has not been clinically effective, and a similar outcome is likely with less treatment per week.
- Additional factors may be considered on a case-by-case basis.
- If the patient is not progressing, documentation of a revised treatment plan is necessary.
- Maintenance level of therapy services may be considered when a member requires skilled therapy for ongoing periodic assessments and consultations and the member and the responsible adult have a continuing need for education, or a periodic adjustment of the home program is needed to meet the member's needs.
    - It is expected that there be evidence of the development of age-appropriate home regimen to facilitate carry-over of target skills and strategies and education of patient, family, and caregiver in home practice exercises, self-monitoring as well as indication of compliance for maximum benefit of therapy.
    - Goals in the plan of care must be updated to reflect that care is focused on maintaining the current level of functioning and preventing regression, rather than progressing or improving function.
    - 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.

Discontinuation of Treatment

- A specific discharge plan, with the expected treatment frequency and duration is included in the plan of care [7]. The discharge plan must indicate the plan to wean services once the patient 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 conducted 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 patient 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.

***** A weaning process of one or two months should be implemented.

Other Considerations

- When a patient's language background differs from the rendering therapist and a clinician with 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 patient, family, and caregiver.
    - Therapies for picky eaters who can eat and swallow normally, are 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 and feeding/swallowing 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

References

[1] Centers for Medicare and Medicaid Services, "EPSDT - A Guide for States: Coverage in the Medicaid Benefit for Children and Adolescents," Medicaid CHIP Program, 2014.

[2] Centers for Medicare and Medicaid Services, "Early and Periodic Screening, Diagnostic, and Treatment," June 2022. [Online]. Available: https://www.medicaid.gov/medicaid/benefits/early-and-periodic-screening-diagnostic-and-treatment/index.html. [Accessed August 2023].

[3] P. H. Lipkin and M. M. Macias, "Promoting optimal development: Identifying infants and young children with developmental disorders through developmental surveillance and screening," *Pediatrics,* vol. 145, no. 1, 2020.

[4] A. Houtrow and N. Murphy, "Prescribing physical, occupational, and speech therapy services for children with disabilities," *Pediatrics,* vol. 143, no. 4, 2019.

[5] American Speech-Language-Hearing Association, "Admission/Discharge Criteria in Speech-Language Pathology," 2023. [Online]. [Accessed https://www.asha.org/policy/gl2004-00046/#sec1.3 August 2023].

[6] R. G. Voigt, "Clinical judgment and child development, revisited," *Pediatrics,* vol. 149, no. 3, 2022.

[7] American Speech-Language-Hearing Association, "Scope of practice in speech-language pathology," 2016. [Online]. Available: https://www.asha.org/policy/SP2016-00343/#Domains. [Accessed August 2023].

[8] American Speech-Language-Hearing Association, "Bilingual Service Delivery," 2023. [Online]. Available: https://www.asha.org/practice-portal/professional-issues/bilingual-service-delivery/#collapse_1. [Accessed August 2023].

[9] American Speech-Language-Hearing Association, "Voice Disorders (Practice Portal)," [Online]. Available: www.asha.org/Practice-Portal/Clinical-Topics/Voice-Disorders/. [Accessed 28 November 2023].

[10] B. Guitar and E. G. Conture, Eds., The child who stutters: To the pediatrician, Fourth ed., Memphis: Stuttering Foundation of America, 2006.

[11] A. Alhaidary, "Treatment of speech sound disorders in children: Nonspeech oral exercises," *International Journal of Pediatrics and Adolescent Medicine,* vol. 8, pp. 1-4, 2021.

Reviewed / Approved by Clinical Guideline Committee

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