Clinical Policy: Speech Therapy

Reference Number: IL.CP.MP.526
Last Review Date: 06/22

Coding Implications
Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description

Speech Therapy (ST)	Involves speech-language pathology, which includes human communication behaviors and disorders as well as swallowing or other upper aerodigestive functions and disorders. The overall objective of speech-language pathology services is to optimize individuals' ability to communicate and/or swallow in natural environments, and thus improve their quality of life. Therapy is considered medically necessary and a covered service if it can be reasonably expected to result in a meaningful improvement in the member's ability to perform functional day-to-day activities that are significant in the member's life roles within 90 days of initiation of the Speech therapy.
Rehabilitative Services	Health care services that help you keep, get back, or improve skills and functioning for daily living that have been lost or impaired because member became ill, hurt, or disabled.
Habilitative Services	Service that help a person keep, learn or improve skills and functioning for daily living. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings. Includes teaching a beneficiary how to perform a task (i.e., daily living skill) for the first time without compensatory techniques or processes. For example, teaching a child normal dressing techniques or teaching cooking skills to an adult who has not performed meal preparation tasks previously.

Policy/Criteria

I. It is the policy of MeridianHealth affiliated with Centene Corporation® that speech therapy is **medically necessary** for the following indications:

1. For therapy services that include medically necessary evaluations and treatment by a licensed therapist when:
    a. Services are required because an illness, disability or infirmity limits functional performance AND
    b. Therapy services will improve functional skills performance.
2. Services that include, but are not limited to, activities of daily living, when therapy services will increase independence and/or decrease the need for other support services.
3. Services must be provided in accordance with a definite plan of care established by the therapist, for the purpose of attaining maximum reduction of a physical disability and

restoration of the client to an acceptable functional level.

Services to School-aged Beneficiaries:

1. Meridian Health affiliated with Centene Corporation expects educational ST to be provided by the school system and it is not covered a covered benefit.
    a. Example of education speech includes, but is not limited to: Enhancing vocabulary, improving sentence structure, improving reading, increasing attention span, and identifying colors and numbers (Educational Speech therapy)
2. Only medically necessary ST will be covered when provided in the outpatient setting.
    a. Coordination between all providers must be continuous to ensure a smooth transition between sources.
    b. A copy of member's IEP should be submitted with initial requests
3. Summer months:
    a. When ST is provided to school-aged children during the summer months in order to maintain the therapy services provided in school, this is considered a continuation of therapy services when there is no change in beneficiary diagnosis or function.
    b. Prior Authorization is required before initiating a continuation of therapy.
    c. Coordination of therapy between providers is required if the school-aged beneficiary receives medically necessary therapy services in both a school setting (part of an Individualized Education Plan (IEP) and in an outpatient setting. Providers are to maintain documentation of coordination in the beneficiary's file.

General Information Required:

<u>Request to continue active therapy must be supported by the following:</u>

1. Treatment summary of previous therapy period, including measurable progress on each short-and long-term goal. This must include the treating provider's analysis of the therapy provided during the previous month, rate of progress, and justification for any change in the treatment plan. Do not send daily treatment notes.
2. Progress summary related to the identified treatment goals, reporting progress toward those goals, as well as revised goals for the requested period of therapy.
3. Documentation related to the period no more than 30 days prior to that time period for which prior approval is being requested.
4. Statement of the beneficiary's response to treatment, including factors that have affect progress during this interim.
5. Statement detailing coordination of services with other therapies (i.e., medical and educational) if appropriate.
    A. Copy of the prescription must be provided with each request. The prescription must be signed by the referring provider and dated within 30 days prior to initiation of the continued service.
6. A discharge plan.

Absolute Contraindications:

The following therapy services are not a covered benefit:

1. Services for which medical necessity is not clearly established are not covered by the Department's Medical Programs. Refer to 89 III. Adm. Code 140.6 for a general list of non-covered services.
    a. The objective of the Department's Medical Programs is to enable eligible participants to obtain necessary medical care. "Necessary medical care" is that which is generally recognized as standard medical care required because of disease, disability, infirmity, or impairment.
2. Therapy is for the purpose of attaining reduction of a physical disability and/or restoration of the individual to an acceptable functional level.
3. Services provided for the general good and welfare of participants, such as fitness exercises and activities to provide diversion or general motivation, and maintenance therapy to maintain the current level of function, are not covered.
4. Treatment related to recreational/sports/leisure goals that do not demonstrate medical necessity is not coved.
5. Therapy services should not replace a home exercise program (HEP) that can be demonstrated and implemented by the participant and/or family.

There are no pre-authorization requirements needed for members 21 year of age or older for up to 24 visits per therapy type. All ST visits performed by a non-contracted provider will still require a prior authorization and must be a Medicaid covered benefit.

Coding Implications

This clinical policy references Current Procedural Terminology (CPT®). CPT® is a registered trademark of the American Medical Association. All CPT codes and descriptions are copyrighted 2019, American Medical Association. All rights reserved. CPT codes and CPT descriptions are from the current manuals and those included herein are not intended to be all-inclusive and are included for informational purposes only. Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

CPT®* Codes	Description
N/A	

ICD-10-CM Diagnosis Codes that Support Coverage Criteria

+ Indicates a code(s) requiring an additional character

ICD-10-CM Code	Description
N/A	

Reviews, Revisions, and Approvals	Revision Date	Approval Date
Original approval date		09/26/18
Annual Review	09/2021	09/2021
Annual Review		06/22

References

1. Illinois DHFS. Handbook for Practitioners of Therapy Services. Chapter 200 Section J-203.4 Version Date: July 1, 2016.

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. "Health Plan" means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan's affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

This clinical policy is the property of the Health Plan. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members and their representatives agree to be bound by such terms and conditions by providing services to members and/or submitting claims for payment for such services.

Note: For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

Note: For Medicare members, to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs, LCDs, and Medicare Coverage Articles should be reviewed prior to applying the criteria set forth in this clinical policy. Refer to the CMS website at http://www.cms.gov for additional information.