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A WellCare Company

POLICY AND PROCEDURE MANUAL

Policy Title: Speech Therapy		Policy Number: G.05
Primary Department: Medical Management		NCQA Standard: N/A URAC Standard: N/A
Affiliated Department(s): N/A		
Last Revision Date: 09/30/2019 Revision Dates: 09/30/2019 Effective Date: 09/26/2018	Next Review Date: 09/2021 Review/Revision Dates: 09/26/2018; 09/30/2019; 09/2020	
Applicable Lines of Business: ☐MeridianCare ☒MeridianHealth ☐MeridianComplete ☒MeridianChoice		
Applicable States: ☐All ☒MI ☒IL ☐OH ☐_______ ☐________		
Applicable Programs: ☒All ☐Other ________________________		
Policy is to be published: Internally Only ☐ Internally & Externally ☒		

Procedure:

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.

Procedure:

Criteria for Coverage:

1. Utilization Management Care Coordinators can approve up to 24 therapy visits
2. Following the initial 24 visits nurse reviewers can approve an additional 12 therapy visits if the member is making documented progress towards goals per this policy
3. Any requests for therapy beyond 36 visits need to be reviewed by a medical director

All OON requests require a Prior Authorization.

Speech Therapy:

1. Speech therapy must relate to a medical diagnosis, and is limited to services for:
    a. Articulation
    b. Language
    c. Rhythm
    d. Swallowing
    e. Training in the use of an speech-generating device
    f. Training in the use of an oral-pharyngeal prosthesis
    g. Voice
2. Therapy must be reasonable, medically necessary and expected to result in an improvement and/or elimination of the stated problem within a reasonable amount of time (i.e., when treatment is due to a recent change in medical or functional status affecting speech, and the beneficiary would experience a reduction in medical or functional status without therapy).
3. The skills of an ST are required for training or monitoring of maintenance programs being carried out by family and/or caregivers, or continued follow-up for the fit and function of orthotic or prosthetic devices. PA is not required for these types of service for up to four times per 12-month period in the outpatient setting.
    a. The ST request must include the following:
        i. Service summary, including a description of the skilled services being provided (to include the treating ST'S analysis of the rate of progress, and justification for any change in the treatment plan).
            1. Documentation must relate to the period immediately prior to that time period for which PA is being requested
        ii. A comprehensive description of the maintenance/activity plan.
        iii. A statement of the beneficiary's response to treatment, including factors that have affected progress during this interim.
        iv. A statement detailing coordination of services with other therapies (medical and educational) if appropriate.
        v. The anticipated discharge plan.
        vi. The anticipated frequency and duration of continued maintenance/monitoring

Specific Diagnosis:

General Information Required for Continued Therapy (applies ST requests beyond 36 visits):

Requests to continue active therapy must be supported by the following:

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 affected progress during this interim.
5. Statement detailing coordination of services with other therapies (e.g., medical and educational) if appropriate.
6. A copy of the prescription must be provided with each request. The prescription must be hand-signed by the referring provider and dated within 30 days prior to initiation of the continued service.
7. A discharge plan.
    a. This must include:
        i. Dates of service (i.e., initial and discharge dates);
        ii. Description of services provided;
        iii. Functional status related to treatment areas/goals at discharge;
        iv. Analysis of the effectiveness of the therapy program, including reasons for goals not met or changes in the treatment plan necessitated by changes in medical status;
        v. Description or copy of follow-up or maintenance program put into place, if appropriate;
        vi. Identification of adaptive equipment provided (e.g., walker) and its current utilization, if appropriate; **and**
        vii. Recommendations/referral to other services, if appropriate

Services to School-aged Beneficiaries:
1. Meridian expects educational ST to be provided by the school system and it is not a covered benefit.
    a. Example of education speech includes, but is not limited to:
        i. 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

Absolute Contraindications :
The following therapy services are excluded from coverage:
1. The type of therapy does not require the skills of a therapist in an outpatient hospital setting or free standing clinic
2. Therapy which is long-term in patients with cerebral palsy for adults 21 or older
3. Work hardening/conditioning programs, including vocational rehabilitation programs
4. Strength training and exercise programs

Speech Therapy is not covered for the following:
1. For educational, vocational, social/emotional, or recreational purposes
2. If services are required to be provided by another public agency (e.g., PIHP/CMHSP provider,
3. SBS)
   When intended to improve communication skills beyond premorbid levels (e.g., beyond the functional communication status prior to the onset of a new diagnosis or change in medical status).
4. If it requires PA but is rendered before PA is approved
5. If it is habilitative
    - **Note:** Federal EPSDT (Early and Periodic Screening, Diagnosis, and Treatment) regulations require coverage of medically necessary treatment for children under 21 years of age, including medically necessary habilitative therapy services

6. If it is designed to facilitate the normal progression of development without compensatory techniques or processes
7. If continuation is maintenance in nature
8. If provided to meet developmental milestones

<u>Illinois Outpatient Speech Therapy**</u>**

Procedure:
Criteria for Coverage:
<u>Speech and Language Therapy requests</u>

1. Covered therapy services include medically necessary evaluations and treatment by a licensed therapist when:
   a. Services are required because an illness, disability or infirmity limits functional performance <u>AND</u>
   b. Therapy services will improve functional skills performance.
2. Covered services 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.

<u>Services to School-aged Beneficiaries</u>:

1. MHP expects educational ST to be provided by the school system and it is not covered a covered benefit.
   i. 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:
Requests to continue active therapy must be supported by the following:

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 affected progress during this interim.
5. Statement detailing coordination of services with other therapies (e.g., medical and educational) if appropriate.
6. 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.
7. 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 Ill. 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 covered.
5. Therapy services should not replace a home exercise program (HEP) that can be demonstrated and implemented by the participant and/or family.

Line of Business Applicability:
This policy applies to Michigan Medicaid, Illinois Medicaid, and Individual plans.

For **Medicaid/Medicaid Expansion Plan** members, this policy will apply. Coverage is based on medical necessity criteria being met and the codes being submitted and considered for review being included on either the Michigan Medicaid Fee Schedule (located at: http://www.michigan.gov/mdch/0,1607,7-132-2945_42542_42543_42546_42551-159815--,00.html), or the Illinois Medicaid Fee Schedule (located at: http://www.illinois.gov/hfs/MedicalProviders/MedicaidReimbursement/Pages/default.aspx). If there is a discrepancy between this policy and either the Michigan Medicaid Provider Manual (located at: http://www.michigan.gov/mdch/0,1607,7-132-2945_5100-87572--,00.html), or the Illinois Medicaid Provider Manual (located at: http://www.illinois.gov/hfs/MedicalProviders/Handbooks/Pages/default.aspx) the applicable Medicaid Provider Manual will govern.

For **Individual** members, consult the individual insurance policy. If there is a discrepancy between this policy and the individual insurance policy document, the guidelines in the individual insurance policy will govern.

State specific special instructions:

None: ☐

ALL: Covered Items and Limits: All services must be provided under the written order of a Medical Doctor (MD), Doctor of Osteopathic Medicine (DO), or other qualified health professional as defined by law according to a written treatment plan established by that provider.

MI:

IL: Medicaid:

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.

Individual: Only Cover 30 visits per year for each of physical/occupational, speech, and cardiopulmonary therapy.

- Member may receive 30 visits of physical therapy and 30 visits of speech therapy, but not 30 visits of both physical and occupational therapy as they are under the same visit limit.
- We cover certain Habilitative and certain short-term Rehabilitative services. Refer to COC for coverage details.

- You may receive 30 visits of physical therapy and 30 visits of speech therapy, but not 30 visits of both physical and occupational therapy as they are subject to the same visit limit.
- This limit is applied separately from the 30 visit limit on rehabilitative services.

References:

1. Michigan Department of Health and Human Services. MDHHS Medicaid Provider Manual, Version date: July 1, 2020. Outpatient therapy.
2. Illinois DHFS. Handbook for Practitioners of Therapy Services. Section J-203.5. Version Date: July 1, 2016.
3. Meridian Choice: Certificate of Coverage. Effective January 2020. Page 45-47. https://corp.mhplan.com/ContentDocuments/default.aspx?x=EEN86ffs7BVb6BVEwBUcHm4qTxThpECLYGVdHDTNGE64oLyWn7QA++5tg2JfvSU7NXFKDwEBdz9ScirweniO7A

State Letters/Bulletins			
CMS National/Local Coverage Determination (NCD/LCD)			
Medicare Managed Care Manual:			
Medicaid CFR:			
State Administrative Codes:			
Contract Requirements:			
Related Policies:			
Related Desk Level Procedures/ Job Aids/Template Letters:			
Related Algorithms/Flowcharts/ Attachments			