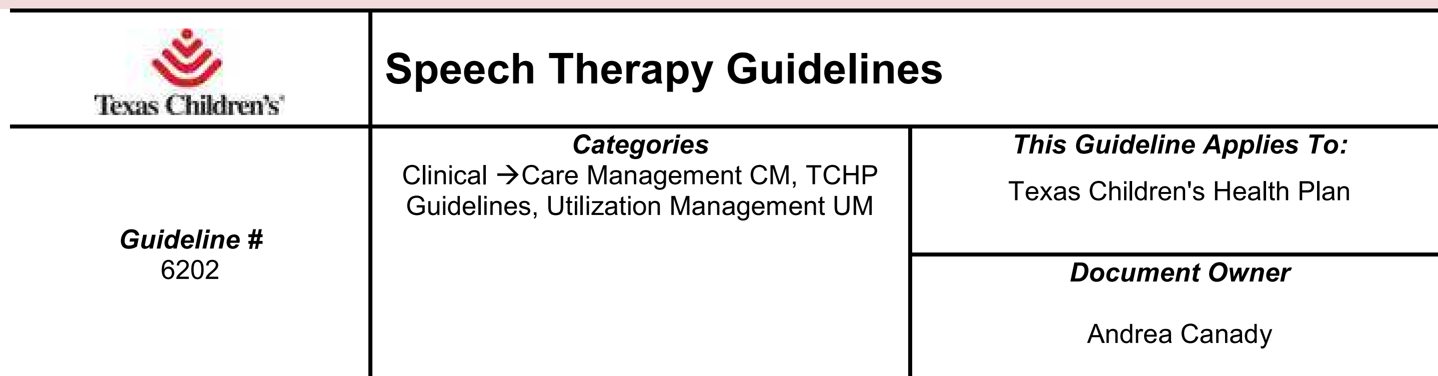

GUIDELINE

Texas Children's	Speech Therapy Guidelines	
Guideline # 6202	***Categories*** Clinical →Care Management CM, TCHP Guidelines, Utilization Management UM	***This Guideline Applies To:*** Texas Children's Health Plan ***Document Owner*** Andrea Canady

GUIDELINE STATEMENT:

Texas Children's Health Plan (TCHP) performs authorization of all speech therapy evaluations and treatment.

DEFINITIONS:

- **Standardized tests** are tests that are used to determine the presence or absence of deficits; any diagnostic tool or procedure that has a standardized administration and scoring process and compares results to an appropriate normative sample.
- **Criterion-referenced tests** are tests that measure an individual's performance against a set of predetermined criteria or performance standards (e.g., descriptions of what an individual is expected to know or be able to do at a specific stage of development or level of education). Criterion-referenced procedures can also be developed informally to address specific questions (e.g., understanding of wh- questions,) and to assess response to intervention (RTI).
- **Co-treatment** is defined as two different therapy disciplines that are performed on the same member at the same time by a licensed therapist for each therapy discipline. The co-treatment must be rendered in accordance with the Executive Council of Physical Therapy, Occupational Therapy Examiners or the State Board of Examiners for Speech-Language Pathologists and Audiologists.
- Acute therapy: Services for the medically necessary short term treatment of an acute medical condition or an acute exacerbation of a chronic medical condition. Treatments are expected to significantly improve, restore or develop functions diminished or lost as a result of a recent (occurring within the past 90 days of the provider's evaluation of the condition) trauma, illness, injury, disease, surgery, or change in medical condition, in a reasonable and generally predictable period of time (60 days), based on the prescribing provider's and therapist's assessment of the client's restorative potential.
- **Guardian may be defined as the parent, primary caregiver or legal representative for a member.**

GUIDELINES

1. ECI services do not require prior authorization and must comply with policy stipulated in the Texas Medicaid Provider Procedure Manual Children's Services Handbook..

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2. All requests for prior authorization for speech therapy evaluations and treatment are received via online submission, fax, phone or mail by the Utilization Management Department and processed during normal business hours.

3. School-based Services

3.1. Members who are eligible for Speech Therapy through the public school system (SHARS), may only receive additional therapy if medical necessity criteria are met as outlined in this guideline.

3.1.1. Services provided to a member on school premises are only permitted when delivered before or after school hours.

4. Speech Therapists in the Comprehensive Care Program are eligible to provide telehealth services as written in the current Texas Medicaid Provider Procedures Manual - Telecommunication Services Handbook.

5. Acute Therapy Services

5.1. Requests for acute speech therapy services will require documentation from the prescribing provider that a visit for the acute injury or acute exacerbation of the medical condition requiring therapy has occurred within the last 90 days.

5.1.1. Acute speech therapy authorization will not require evidence of current Texas Health Steps well checkup for therapy treatment requests of 60 days or less.

5.1.1.1. Therapy services for greater than 60 days will require evidence that the member is current in their Texas Health Steps Checkup via

5.1.2. Documentation of ordering provider attestation

5.1.3. Copy of the current Texas Health Steps Checkup

5.1.4. If evidence that the member is current in their Texas Health Steps Checkup was not submitted, therapy requests may be approved for a maximum of 90 days with medical director approval.

5.1.5. After two 60 day authorized periods, any continued requests for therapy services must be considered under the chronic therapy sections of this guideline.

5.1.6. Out-of-Network acute speech therapy services will also need to comply with TCHP Out of Network Services Guidelines

6. Chronic Therapy Services

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7. Initial chronic therapy evaluations

7.1. Initial chronic therapy evaluations do not require prior authorization when provided by an in-network provider however the therapy provider is responsible for maintaining the following documentation in the member record, which must be made available when requested:

7.1.1. A signed and dated prescribing provider's order for the evaluation

7.1.2. Clinical documentation that identifies and supports the medical need for the therapy evaluation

7.2. Out of Network chronic therapy evaluations require submission of:

7.2.1. Signed physician order requesting a therapy evaluation, dated within 30 days prior to the therapy evaluation date

7.2.1.1. Clear documentation of the medical necessity of the requested evaluation – this may include:

7.2.1.1.1. Copy of a physician/physician extender visit note that identifies a need for evaluation OR

7.2.1.1.1.1. For children with chronic underlying medical condition associated with developmental delay (Autism, Autism Spectrum Disorder, Pervasive Developmental Disorder, Down Syndrome, Cerebral Palsy, etc.) the visit note identifying the need for services should be dated within the last 12 months. A note from a subspecialist will be accepted.

7.2.1.1.1.2. For undiagnosed conditions, developmental delays or isolated speech/communication/language disorders the visit note identifying the reason for evaluation must be the most recent age-appropriate well child exam including results of the age-appropriate developmental screening tool required by THSteps (PEDS or ASQ) periodicity schedule conducted at the well child visit. The well child exam must be current per the THSteps periodicity schedule. If the most recent well child exam did not identify the delay, a provider may submit a subsequent visit that identifies the need for speech therapy.

7.2.1.1.2. Letter of Medical Necessity signed by the ordering physician that identifies the medical need of the therapy evaluation

8. To request prior authorization for chronic speech therapy treatment, the following documentation must be provided:

8.1. Initial Treatment

8.1.1. Order or prior authorization form signed by the referring provider that is dated within 60 days of submission and specifies the frequency and duration of the requested service

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8.1.1.1. Frequency and dates of service requested cannot exceed those listed on the provider order and the evaluation plan of care

8.1.2. Evaluation report and Plan of Care dated within 60 days of submission signed by the ordering physician that includes:

8.1.2.1. Documentation of the diagnosis and reason for referral

8.1.2.2. Documentation of the date of onset Date of Onset of the member's Condition Requiring Therapy or Exacerbation as Applicable - If the date of onset is congenital, providers should state onset date at birth.

8.1.2.3. Brief statement of the member's medical history and any prior therapy treatment. Providers may reference information provided by the member or member's family and identify it as such.

8.1.2.4. Documentation of member's primary language and any other languages spoken at home.

8.1.2.5. Documentation of the language that therapy will be conducted in

8.1.2.6. A description of the member's current level of functioning or impairment, to include current **norm-referenced standardized assessment scores.

8.1.2.6.1. Developmental age should be adjusted for children born before 37 weeks gestation (based on a 40-week term). The developmental age must be measured against the adjusted age rather than chronological age until the child is 24 months of age. The age adjustment should not exceed 16 weeks.

8.1.2.6.2. For monolingual members, testing should be conducted in their dominant language.

8.1.2.6.3. For bilingual/multilingual members –

8.1.2.6.3.1. Members should receive culturally and linguistically adapted **norm-referenced standardized testing when possible in all languages the child is exposed to if available to compare potential deficits and include them in the documentation.

- The therapist will provide all scores and the highest score of the multiple languages will determine whether the child qualifies for therapeutic intervention and which is the dominant language that will be used for the child's therapy.

8.1.2.6.3.2. In addition, criterion-referenced assessment tools can be used to identify and evaluate a member's strengths and weaknesses.

8.1.2.7. A clear diagnosis and reasonable prognosis;

8.1.2.8. A statement of the prescribed treatment modalities and their recommended frequency and duration

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8.1.2.8.1. Treatment plans and plans of care developed must include not only the initial frequency (high, moderate or low) but the expected changes of frequency throughout the duration period requested based on the member's anticipated therapy treatment needs

8.1.2.9. Short and long-term treatment goals which are specific to the member's diagnosed condition or impairment

8.1.2.10. List any adaptive equipment or assistive devices that contribute toward member function. If the member does not have adaptive equipment or assistive devices, indicate that this element is not applicable.

8.1.2.11. Prescribed home exercise program including the guardian's expected involvement in the member's treatment.

8.1.2.12. Plan for collaboration with ECI, Head Start, or SHARS when applicable

8.1.3. Results of objective hearing screen performed within the last 6 months for members birth through 3 years of age or within the last 12 months for members 3 years and older. Preferred screening is by pure tone audiometry or OAE in screening mode (65/55 dB)

8.1.3.1. Members who are unable to cooperate with objective hearing screen or who fail the objective hearing screen should be referred for Audiology evaluation. This information should be clearly identified in the authorization request if applicable.

8.1.3.2. Members who fail Audiology evaluation should be referred for medical management. This information should be clearly identified in the authorization request if applicable.

8.1.3.3. For children with chronic underlying medical condition associated with developmental delay (Autism, Autism Spectrum Disorder, Pervasive Developmental Disorder, Down Syndrome, Cerebral Palsy, etc.), the request for hearing screen may be waived if the initial evaluation request is due to a change in provider, a referral after service interruption or if there is a medical barrier to obtaining a hearing screen.

8.1.3.4. *No hearing screen or audiology referral is required for speech therapy related to dysphagia.*

8.1.3.5. If there is a documented barrier to obtain hearing screen results or Audiology consult note at the start of treatment, initial treatment will only be approved for 3 months. Extension of the initial treatment may only be granted with results of the hearing screen or Audiology consult.

8.1.4. Evidence that the member is current in their Texas Health Steps Checkup via:

8.1.4.1. Documentation of ordering provider attestation

8.1.4.2. Copy of the current Texas Health Steps Checkup

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8.2. Formal Re-evaluations (should be performed every 180 days or if required sooner due to changes in the member's status). Re-evaluations do not require authorization for payment when rendered in-network. The following documentation is required to request a re-evaluation by an out-of-network provider:

8.2.1. Signed physician order dated within 30 days for re-evaluation.

8.2.2. Requests for re-evaluation should be submitted no sooner than 30 days prior to the expiration of the current treatment authorization period.

8.3. Ongoing treatment requests will require the following documentation:

8.3.1. A complete request must be received no earlier than 30 days before the current authorization period expires.

8.3.2. Order or prior authorization form signed by the referring provider that is dated within 60 days of submission and specifies the frequency and duration of the requested service

8.3.2.1. Frequency and dates of service requested cannot exceed those listed on the provider order and the re-evaluation plan of care

8.3.3. Evidence that the member is current in their Texas Health Steps Checkup via:

8.3.3.1. Documentation of ordering provider attestation

8.3.3.2. Copy of the current Texas Health Steps Checkup

8.3.4. Evaluation report and Plan of Care dated within 60 days of submission signed by the ordering physician that includes:

8.3.4.1. Documentation of the diagnosis and reason for referral

8.3.4.2. Documentation of the date of onset Date of Onset of the member's Condition Requiring Therapy or Exacerbation as Applicable - If the date of onset is congenital, providers should state onset date at birth.

8.3.4.3. Brief statement of the member's medical history and any prior therapy treatment. Providers may reference information provided by the member or member's family and identify it as such.

8.3.4.4. Objective documentation of compliance: BOTH guardian/member attendance to therapy sessions AND guardian/member's participation in prescribed home exercise program.

8.3.4.5. Documentation of member's primary language and any other languages spoken at home.

8.3.4.6. Documentation of the language that therapy is conducted in

8.3.4.7. A description of the member's current level of functioning or impairment, to include current **norm-referenced standardized assessment scores

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8.3.4.7.1. The same **norm-referenced standardized tests must be utilized for re-evaluation as were used to evaluate the member initially unless these are no longer appropriate for the member's age.

8.3.4.7.2. Re-evaluations should document comparison to prior **norm-referenced standardized test scores.

8.3.4.7.3. Developmental age should be adjusted for children born before 37 weeks gestation (based on a 40-week term). The developmental age must be measured against the adjusted age rather than chronological age until the child is 24 months of age. The age adjustment should not exceed 16 weeks.

8.3.4.7.4. For monolingual members, testing should be conducted in their dominant language.

8.3.4.7.5. For bilingual/multilingual members –

8.3.4.7.5.1. Criterion-referenced assessment tools can be used in addition to norm-referenced testing to identify and evaluate a member's strengths and weaknesses.

8.3.4.7.5.2. Testing for all re-evaluations should only be conducted in the language used in therapy.

8.3.4.8. A clear diagnosis and reasonable prognosis including assessment of the member's capability for continued measurable progress;

8.3.4.9. A statement of the prescribed treatment modalities and their recommended frequency / duration;

8.3.4.10. Treatment plans and plans of care developed must include not only the initial frequency (high, moderate or low) but the expected changes of frequency throughout the duration period requested based on the member's anticipated therapy treatment needs

8.3.4.11. Short and long-term functional treatment goals which are specific to the member's diagnosed condition or impairment including objective demonstration of the member's progress towards previous treatment goals.

8.3.4.11.1. Functional goals refer to a series of behaviors or skills that allow the member to achieve an outcome relevant to his/her health, safety, or independence within the context of everyday environments. Functional goals must be specific to the member, objectively measurable within a specified time frame, attainable in relation to the member's prognosis or developmental delay, relevant to member and family, and based on a medical need.

8.3.4.12. Prescribed home exercise program including the guardian's expected involvement in the member's treatment and objective compliance with the program

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8.3.4.13. List any adaptive equipment or assistive devices that contribute toward member function. If the member does not have adaptive equipment or assistive devices, indicate that this element is not applicable.

8.3.4.14. Documentation of collaboration with ECI, Head Start, PPECC or SHARS when applicable

8.3.5. Routine reassessments that occur during each treatment session or visit or for a progress report required for an extension of services or discharge summary are not considered a comprehensive re-evaluation.

9. Special documentation considerations:

9.1. Requests for co-treatment services will follow current guidance in the Texas Medicaid Provider Manual Physical Therapy, Occupational Therapy, and Speech Therapy Services Handbook.

9.2. Change of therapy provider:

9.2.1. If a provider or member discontinues therapy during an existing prior authorized period and the member requests services through a new provider, outside the current group or agency, the provider must start a new request for authorization and submit all of the following:

9.2.1.1. A change-of-therapy provider letter that includes the following:

9.2.1.1.1. Signature of the member or responsible adult,

9.2.1.1.2. Documents the date that the member ended therapy (effective date of change) with the previous provider, or last date of service,

9.2.1.1.3. The name of the new provider and previous provider

9.2.1.2. When a provider or member discontinues therapy during an existing prior authorization period and the member requests services through a new provider located within the same enrolled group of providers or within a group of independently enrolled providers collaboratively working together, the new provider can use the same evaluation and plan of care. Therefore, the authorization period will not change.

9.3. Change of coverage/Continuity of Care:

9.3.1. When services were not prior authorized by Texas Children's Health Plan, (through another MCO or TMHP) the authorization request must includeA copy of the previously approved authorization letter.

9.3.2. The services will be honored for the shorter of 90 days or until expiration of the authorization.

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9.3.2.1. If an ***in-network provider*** submits all documentation required by TCHP for the service requested and it meets medical necessity criteria outlined in this Guideline– TCHP will honor the authorization request for the duration of the original authorization even if it extends past 90 days.

9.3.3. If a request to transfer an authorization is submitted after the end date of the previous authorization - it will have to meet all of the documentation requirements and submission guidelines for the specific service type.

9.4. Coordination of care with PPECC:

9.4.1. When the member receives therapy services in a PPECC setting, the therapy provider must provide evidence of care coordination with the prescribed pediatric extended care center (PPECC) provider.

10. Specific criteria for approval of frequency of therapy services:

10.1. High Frequency (three times per week) Therapy services- can only be considered for a limited duration (approximately four weeks or less) or as recommended by the prescribing provider with documentation of the medical need to achieve an identified new skill or recover function lost due to surgery, illness, trauma or acute medical condition, with well-defined specific, achievable goals within the intensive period requested.

10.1.1. Therapy provided three times a week may be considered for two or more of these exceptional situations:

10.1.1.1. The member has a medical condition that is rapidly changing

10.1.1.2. 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)

10.1.1.3. The member's therapy plan and home program require frequent modification by the licensed therapist

10.1.1.4. 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:

10.1.1.4.1. Letter of medical need from the prescribing provider documenting the member’s rehabilitation potential for achieving the goals identified

10.1.1.4.2. Therapy summary documenting all of the following:

10.1.1.4.2.1. Purpose of the high frequency requested (e.g., close to achieving a milestone)

10.1.1.4.2.2. Identification of the functional skill which will be achieved with high frequency therapy

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10.1.1.4.2.3. Specific measurable goals related to the high frequency requested and the expected date the goal will be achieved.

10.1.2. A higher frequency (4 or more times per week) may be considered on a case-by-case basis with clinical documentation supporting why 3 times a week will not meet the member's medical needs.

10.2. Moderate Frequency: Therapy provided two times a week may be considered when documentation shows one or more of the following:

10.2.1. The member is making very good functional progress toward goals.

10.2.2. The member is in a critical period to gain new skills or restore function or is at risk of regression.

10.2.3. 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.

10.2.4. The member has complex needs requiring on-going education of the responsible adult.

10.3. Low Frequency: Therapy provided one time per week or every other week may be considered when the documentation shows one or more of the following:

10.3.1. The member is making progress toward 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.

10.3.2. 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.

10.3.3. 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.

10.4. Maintenance Level/Prevent Deterioration: This frequency level (e.g., every other week, monthly, every three 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, or the therapy plan requires infrequent updates by the skilled therapist. A maintenance level or preventive 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:

10.4.1. Progress has slowed or stopped, but documentation supports that ongoing skilled therapy is required to maintain the progress made or prevent deterioration,

10.4.2. The documentation submitted shows the member may be making limited progress toward goals, or goal attainment is extremely slow

10.4.3. 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),

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10.4.4. 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.

11. Medical Necessity of therapy services:

11.1. Speech therapy services must be medically necessary to the treatment of the individual's chronic or acute need. A diagnosis alone is not sufficient documentation to support the medical necessity of therapy. To be considered medically necessary, all of the following conditions must be met:

11.1.1. The services requested must be considered under the accepted standards of practice to be a specific and effective treatment for the patient's condition.

11.1.2. The services requested must be of a level of complexity or the patient's condition must be such that the services required can only be effectively performed by or under the supervision of a licensed speech-language pathologist, and requires the skills and judgment of the licensed therapist to perform education and training.

11.1.2.1. Speech-language pathologists treat speech sound and motor speech disorders, stuttering, voice disorders, aphasia and other language impairments, cognitive disorders, social communication disorders and swallowing (dysphagia) deficits.

11.1.3. Functional goals refer to a series of behaviors or skills that allow the member to achieve an outcome relevant to his/her health, safety, or independence within the context of everyday environments. Functional goals must be specific to the member, objectively measurable within a specified time frame, attainable in relation to the member's prognosis or developmental delay, relevant to member and family, and based on a medical need.

11.1.4. For members who are 20 years of age and younger, the following conditions must be met:

11.1.4.1. The goals of the requested services to be provided are directed at improving, adapting, restoring, or maintaining functions which have been lost or impaired due to a recent illness, injury, loss of body part or congenital abnormality or as a result of developmental delay or the presence of a chronic medical condition.

11.1.4.2. Testing must establish a member with developmental delays meets the medical necessity criteria

11.1.5. For members who are 21 years of age and older, the following conditions must be met:

11.1.5.1. The goals of the requested services to be provided are directed at improving, adapting or restoring functions which have been lost or impaired due to a recent illness, injury, loss of body part and restore member's function to within normal activities of daily living (ADL).

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11.1.5.2. There must be reasonable expectation that therapy will result in a meaningful or practical improvement in the member's ability to function within a reasonable and predictable time period.

11.2. Speech therapy is medically necessary for the treatment of chronic (for member who are 20 years of age and younger), acute, or acute exacerbations of pathological or traumatic conditions of the head or neck, which affect speech production, speech communication and oral motor, feeding and swallowing disorders.

11.2.1. Speech therapy is designed to ameliorate, restore, or rehabilitate speech language communication and swallowing disorders that have been lost or damaged because of a chronic, acute or acute exacerbation of a medical condition due to a recent injury, disease or other medical conditions, or congenital anomalies or injuries.

11.2.1.1. Types of disorders:

11.2.1.1.1. Language Disorders—Impaired comprehension and/or use of spoken, written and/or other symbol systems. This disorder may involve the following components: forms of language (phonology, morphology, and syntax), content and meaning of language (pragmatics) and/or the perception/ processing of language. Language disorders may involve one, all or a combination of the above components.

11.2.1.1.1.1. Dysphasia – impairment of language from a brain lesion or neurodevelopmental disorder.

11.2.1.1.1.2. Aphasia – Absence or impairment of the ability to communicate through speech, writing, or signs because of brain dysfunction. It is considered complete or total when both sensory and motor areas are involved.

11.2.1.1.1.3. Pragmatic dysfunction - an impairment in understanding the social aspects of language

11.2.1.1.1.4. Voice disorder –conditions involving abnormal pitch, loudness or
quality of the sound produced by the larynx and thereby affecting speech production

11.2.1.1.2. Speech Production Disorders—Impairment of the articulation of speech sounds, voice and/or fluency. Speech Production Disorders may involve one, all or a combination of these components of the speech production system. An articulation disorder may manifest as an individual sound deficiency, i.e., traditional articulation disorder, incomplete or deviant use of the phonological system, i.e., phonological disorder, or poor coordination of the oral-motor mechanism for purposes of speech production, i.e., verbal and/or apraxia, dysarthria.

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11.2.1.1.2.1. Aphonia – inability to produce sounds from the larynx due to paralysis, excessive muscle tension, or disease of laryngeal nerves.

11.2.1.1.2.2. Apraxia – inability to form words to speak, despite an ability to use oral and facial muscles to make sounds.

11.2.1.1.2.3. Dysarthria – difficult or defective speech that involves disturbances in muscular control (paralysis, weakness, or lack of coordination) of the speech mechanism (oral, lingual, pharyngeal, or respiratory muscles) resulting from damage to the central or peripheral nervous system.

11.2.1.1.2.4. Dysphonia – difficulty in speaking due to impaired ability of muscles involving voice production.

11.2.1.1.3. Oral Motor/Swallowing/Feeding Disorders—Impairment of the muscles, structures and/or functions of the mouth (physiological or sensory-based) involved with the entire act of deglutition from placement and manipulation of food in the mouth through the oral and pharyngeal phases of the swallow. These disorders may or may not result in deficits to speech production.

11.2.1.1.3.1. Aphagia – inability to swallow.

11.2.1.1.3.2. Dysphagia – difficulty in swallowing.

11.3. SLP services are considered NOT medically necessary if any of the following is determined:

11.3.1. The therapy is not intended to ameliorate, restore, or rehabilitate speech language communication and swallowing disorders that have been lost or damaged as a result of a chronic, acute or acute exacerbation of a medical condition due to a recent injury, disease or other medical conditions, or congenital anomalies or injuries.

11.3.2. The therapy is for dysfunctions that are self-correcting, such as:

11.3.2.1. Language therapy for young children with *natural* disfluency (stuttering);

11.3.2.1.1. Disfluency is a common condition in young children with onset after age 3 and is usually self-correcting by age six to seven. This is sometimes referred to as normal non-fluency and is not an indication for speech therapy.

11.3.2.2. Developmental articulation errors that are self-correcting.

11.3.3. The expectation does not exist that the speech therapy will result in a practical improvement in the level of functioning within a reasonable and predictable period of time.

11.3.4. Separate reimbursement for VitalStim therapy for dysphagia.

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11.3.5. Services that do not require the skills of a qualified provider of SLP services including, but not limited to, the following:

11.3.5.1. Treatments that maintain function using routine, repetitious, or reinforced procedures that are neither diagnostic nor therapeutic (for example, practicing word drills for developmental articulation errors);

11.3.5.2. Procedures that may be carried out effectively by the individual, family, or caregivers.

11.3.6. The therapy requested is for educational, recreational or work-related activities that do not require the skills of a therapist

11.3.7. Treatments that are not supported in medically peer-reviewed literature.

11.3.8. Services are duplicative. When individuals receive physical, occupational, or speech therapy, the therapists should provide different treatments that reflect each therapy discipline's unique perspective on the individual's impairments and functional deficits and not duplicate the same treatment. They must also have separate evaluations, treatment plans, and goals.

11.3.8.1. Repetitive therapy services that are designed to maintain function once the maximum level of improvement has been reached, which no longer require the skills of a therapist to provide or oversee.

11.3.8.2. A child being bilingual is not considered developmental delay and speech therapy is usually not a covered health service, except when other criteria for speech therapy are met.

11.3.8.3. Treatment solely for the instruction of other agency or professional personnel in the member's ST program.

11.3.8.4. Therapy services provided by a licensed therapist who is the member's responsible adult (e.g., biological, adoptive, or foster parents, guardians, court-appointed managing conservators, other family members by birth or marriage).

11.4. Initial Speech therapy may be approved for scores > 1.5 standard deviations below the mean in at least one subtest area for norm-referenced standardized tests with a mean of 100 (<78), and > 1.33 standard deviations below the mean in at least one subtest for norm-referenced standardized tests with a mean of 10 (<6). Behavioral observations, psychosocial factors, and pertinent past history should be included in the assessment.

11.4.1. For members whose norm-referenced standardized test scores do not match their conversational intelligibility – treatment may be approved according to Member's age and intelligibility standards noted below:

Age	Expected Intelligibility for familiar listeners	Expected intelligibility for non-familiar listeners	Clinically significant variance level indicating treatment need

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18 months	25%	0-25%	10% or less to familiar listeners
24 months	50-75%	50%	30% or less to familiar or unfamiliar listeners
36 months	75-100%	75%	50% or less to familiar or unfamiliar listeners
48 + months	100%	100%	75% or less to familiar or unfamiliar listeners

11.4.2. For members who receive speech therapy for swallowing or feeding, documentation must include an in-depth, functional profile of oral motor structures and function.

11.4.3. For members who receive speech therapy for Voice—a medical evaluation is required for eligibility and based on medical referral

11.5. Ongoing therapy may not be approved when any of the following:

11.5.1. Testing shows member no longer meets criteria for a developmental delay

11.5.2. All test scores have improved to within 1.33 SD from the mean

11.5.2.1. 80 or more for tests with a mean of 100

11.5.2.2. 7 or more for tests with a mean of 10

11.5.3. The member/guardian is not compliant with attendance or home exercise program expectations.

11.5.4. The member has adapted to the impairment with assistive equipment or devices and is able to perform ADL's with minimal to no assistance from caregiver

11.5.5. Member can continue therapy and maintain status with a home exercise program and deficits no longer require a skilled therapy intervention

11.5.6. Member no longer demonstrates functional impairment or has achieved goals set forth in the treatment plan or plan of care.

11.5.7. Member has returned to baseline function.

11.5.8. Member has achieved maximum functional benefit from therapy in progress or will no longer benefit from additional therapy.

11.5.9. 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.

11.5.10. Member demonstrates a plateau in response to therapy/lack of progress towards therapy goals. This may be an indication for therapeutic pause in treatments or for those under age 21, transition to maintenance level therapy.

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12. The following services are excluded from coverage and NOT a benefit:

12.1. Chronic speech therapy is not a benefit for members who are 21 years of age or older.

12.2. Speech therapy provided in the home to members who are 21 years of age and older

12.3. Therapy services provided by a licensed therapist who is the member's responsible adult (e.g., biological, adoptive, or foster parents, guardians, court-appointed managing conservators, other family members by birth or marriage)

12.4. Equipment and supplies used during therapy visits are not reimbursed separately; they are considered part of the therapy services provided

13. Providers should bill for therapy services in accordance with guidance in the current Texas Medicaid Provider Procedure Manual

14. All requests for speech therapy evaluations and treatment that do not meet the guidelines referenced here will be referred to a TCHP Medical Director/Physician Reviewer for review and the Denial Policy will be followed.

15. Preauthorization is based on medical necessity and not a guarantee of benefits or eligibility. Even if preauthorization is approved for treatment or a particular service, that authorization applies only to the medical necessity of treatment or service. All services are subject to benefit limitations and exclusions. Providers are subject to State and Federal Regulatory compliance and failure to comply may result in retrospective audit and potential financial recoupment.

ADDITIONAL INFORMATION

**Tests used must be norm-referenced, standardized, age appropriate and specific to the suspected area(s) of deficit. The following list of tests is not all-inclusive.
Language Tests — Standardized *(Newer editions of currently listed tests are also acceptable.)*

Test	Abbreviation
Assessment of Language-Related Functional Activities	ALFA
Assessment of Literacy and Language	ALL
Behavior Rating Inventory of Executive Function	BRIEF
Behavioural Assess of the Dysexecutive Syndrome for Children	BADS-C
Brief Test of Head Injury	BTHI

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Test	Abbreviation
Children's Communication Checklist [Diagnostic for pragmatics]	CCC
Clinical Evaluation of Language Fundamentals — Preschool	CELF-P
Clinical Evaluation of Language Fundamentals, Fourth Edition	CELF-4
Clinical Evaluation of Language Fundamentals, Third Edition	CELF-3
Communication Abilities Diagnostic Test	CADeT
Communication Activities of Daily Living, Second Edition	CADL-2
Comprehensive Assessment of Spoken Language	CASL
Comprehensive Receptive and Expressive Vocabulary Test, Second Edition	CREVT-2
Comprehensive Test of Phonological Processing	CTOPP
Diagnostic Evaluation of Language Variation — Norm-Referenced	DELV-NR
Emerging Literacy and Language Assessment	ELLA
Expressive Language Test	ELT
Expressive One-Word Picture Vocabulary Test, Fourth Edition	EOWPVT-4
Fullerton Language Test for Adolescents, Second Edition	FLTA
Goldman-Fristoe-Woodcock Test of Auditory Discrimination	GFWTAD
HELP Test-Elementary	HELP
Illinois Test of Psycholinguistic Abilities, Third Edition	ITPA-3
Language Processing Test — Revised	LPT-R
Language Processing Test, Third Edition	LPT-3
Listening Comprehension Test Adolescent	LCT-A
Listening Comprehension Test, Second Edition	LCT-2
Montgomery Assessment of Vocabulary Acquisition	MAVA
Oral and Written Language Scales	OWLS
Peabody Picture Vocabulary Test, Fourth Edition	PPVT-4
Peabody Picture Vocabulary Test, Third Edition	PPVT-3
Phonological Awareness Test	PAT

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Test	Abbreviation
Preschool Language Scale, Fifth Edition	PLS-5
Receptive One-Word Picture Vocabulary Test, Fourth Edition	ROWPVT-4
Receptive-Expressive Emergent Language Test, Second Edition	REEL-2
Receptive-Expressive Emergent Language Test, Third Edition	REEL-3
Ross Information Processing Assessment — Primary	RIPA-P
Ross Information Processing Assessment, Second Edition	RIPA-2
Rossetti Infant-Toddler Language Scale	
Scales of Cognitive Ability for Traumatic Brain Injury	SCATBI
SKI-HI Language Development Scale	
Social Competence and Behavior Evaluation, Preschool Edition	SCBE
Social Language Development Test—Adolescent	SLDT-A
Social Language Development Test—Elementary	SLDT-E
Social Responsiveness Scale	SRS
Social Skills Rating System — Preschool & Elementary Level	SSRS-PE
Social Skills Rating System — Secondary Level	SSRS-S
Strong Narrative Assessment Procedure	SNAP
Structured Photographic Expressive Language Test	SPELT-3
Test of Adolescent and Adult Language, Third Edition	TOAL-3
Test of Adolescent /Adult Word Finding	TAWF
Test for Auditory Comprehension of Language, Third Edition	TACL-3
Test of Auditory Perceptual Skills — Revised	TAPS-R
Test of Auditory Perceptual Skills, Third Edition	TAPS-3
Test of Auditory Reasoning and Processing Skills	TARPS
Test of Early Communication and Emerging Language	TECEL
Test of Early Language Development, Third Edition	TELD-3
Test of Language Competence — Expanded Edition	TLC-E

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Test	Abbreviation
Test of Language Development — Intermediate, Third Edition	TOLD-I:3
Test of Language Development — Primary, Third Edition	TOLD-P:3
Test of Narrative Language	TNL
Test of Phonological Awareness	TOPA
Test of Pragmatic Language	TOPL
Test of Pragmatic Language, Second Edition	TOPL-2
Test of Problem Solving — Adolescent	TOPS-A
Test of Problem Solving — Revised Elementary	TOPS-R
Test of Reading Comprehension, Third Edition	TORC-2
Test of Semantic Skills: Intermediate	TOSS-I
Test of Semantic Skills: Primary	TOSS-P
Test of Word Finding, Second Edition	TWF-2
Test of Word Knowledge	TOWK
Test of Written Language, Third Edition	TWL-3
The Listening Test	
Wepman's Auditory Discrimination Test, Second Edition	ADT
Word Test — 2 Adolescent	WT2A
Word Test — 2 Elementary	WT2E

Speech Production Tests — Standardized *(Newer editions of currently listed tests are also acceptable.)*

Test	Abbreviation
Apraxia Battery for Adults, Second Edition	ABA-2
Arizona Articulation Proficiency Scale, Third Edition	Arizona-3
Assessment of Intelligibility of Dysarthric Speech	AIDS
Assessment of Phonological Processes — Revised	APPS-R
Bernthal-Bankson Test of Phonology	BBTOP
Clinical Assessment of Articulation and Phonology	CAAP
Diagnostic Evaluation of Articulation and Phonology, U.S. Edition	DEAP
Goldman-Fristoe Test of Articulation, Third Edition	GFTA-3

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Test	Abbreviation
Hodson Assessment of Phonological Patterns — Third Edition	HAPP-3
Kaufman Speech Praxis Test	KSPT
Khan-Lewis Phonological Analysis	KLPA-3
Photo Articulation Test, Third Edition	PAT-3
Slosson Articulation Language Test with Phonology	SALT-P
Smit-Hand Articulation and Phonology Evaluation	SHAPE
Structured Photographic Articulation Test II Featuring Dudsberry	SPAT-D II
Stuttering Severity Instrument for Children and Adults	SSI-4
Weiss Comprehensive Articulation Test	WCAT

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