Division of Medicaid State of Mississippi Provider Policy Manual	New: Revised: X Current:	Date: Date: ~~07/01/09~~ 09/01/09
Section: Outpatient Speech-Language Pathology (Speech Therapy) Subject: ~~Exclusions~~ Coverage	Section: 49.03 Pages: ~~3~~ 4 Cross Reference: ~~General coverage Criteria 49.04, Maintenance Therapy 49.13~~ Noncoverage 49.04 Group Therapy 49.07 Prior Authorization/Pre-Certification 49.09 Prescribing Provider Orders/Responsibilities 49.10 Evaluation/Re-Evaluation 49.11 Plan of Care 49.12	

~~Outpatient speech-language pathology services **not** covered/reimbursed by the Division of Medicaid include, but are not limited to, the following:~~

- ~~Services not certified/ordered by a physician, physician assistant, or nurse practitioner~~
- ~~Services when the plan of care has not been approved and signed by the physician, physician assistant, or nurse practitioner, within established timeframes~~
- ~~Services that do not meet the general coverage criteria. Refer to Provider Policy Manual Section 49.04 for General Coverage Criteria policy.~~
- ~~Services that do not require the knowledge, skill, and judgment of a licensed speech-language pathologist~~
- ~~Services when documentation supports that the beneficiary has attained the speech-language pathology goals or has reached the point where no further significant functional improvement is apparent and/or can be expected to occur~~
- ~~Services when documentation supports that the beneficiary has not reached speech-language pathology goals and is unable to participate and/or benefit from skilled intervention, refuses to participate, or is otherwise noncompliant with the speech-language pathology regimen~~
- ~~Services that the beneficiary can perform independently or with the assistance of unskilled personnel or family members~~
- ~~Services that duplicate other concurrent therapy (example: occupational therapist and speech-language pathologist providing the same treatment to the same beneficiary)~~
- ~~Maintenance and/or palliative services that maintain function and generally do not involve complex procedures or the professional skill, judgment, or supervision of a licensed speech-language pathologist. Refer to Provider Policy Manual Section 49.13 for Maintenance Therapy policy.~~
- ~~Services for conditions that could be reasonably expected to improve spontaneously without therapy~~
- ~~Services ordered daily or multiple times per day from the initiation of speech-language pathology through discharge, i.e., frequency should decrease as the beneficiary's condition improves~~

- Services provided in multiple settings for the same beneficiary (example: speech-language pathology services provided in both the school and the outpatient clinic).
- Services normally considered part of nursing care
- Services provided through a Comprehensive Outpatient Rehabilitation Facility (CORF)
- Separate fees for self-care/home management training (beneficiary and caregiver education is inclusive in covered services)
- Services which are related solely to employment opportunities (i.e., on-the-job training, work skills, or work settings)
- Services that are primarily general wellness, exercise, and/or recreational programs
- Services when the purpose is vocationally based
- Services provided by student.
- Services provided by speech-language assistants
- Services provided by speech-language pathology aides
- Group therapy
- Co-therapy
- Services that are investigative or experimental
- Acupuncture or biofeedback
- Services outside the scope/and or authority of the therapist's specialty and/or area of practice
- Services and items requiring pre-certification if the pre-certification has not been requested and/or denied, or the pre-certification requirements have not been satisfied by the provider
- Speech-language pathology services that is educational in nature, i.e., services provided under Individuals With Disabilities Education Act (IDEA) or Section 504 of the Rehabilitation Act of 1973 (504 Plan). These are deemed the responsibility of the educational system.
- Speech-language pathology services when the goal is instruction of and/or corroboration with other professionals
- Services not specifically listed as covered by the Division of Medicaid
- Exclusions listed elsewhere in the Mississippi Medicaid Provider Manual, bulletins, or other Mississippi Medicaid publications

Conditions/services that the Division of Medicaid considers **not medically necessary** include, but are not limited to, the following:

- Dysfunctions that are self-correcting (e.g., speech-language pathology services for children with natural dysfluency ; hoarseness; developmental articulation errors that are self-correcting)

- ~~Developmental problems (includes but is not limited to developmental delays)~~
- ~~Learning disabilities~~
- ~~Intellectual and developmental disabilities~~
- ~~Psychosocial speech delay~~
- ~~Behavioral problems~~
- ~~Attention disorders~~
- ~~Stammering, stuttering~~
- ~~Conceptual handicap (e.g., Asperger's Syndrome)~~
- ~~Semantic and pragmatic disorders~~
- ~~Computer-based learning programs~~
- ~~Altered auditory feedback devises such as SpeechEasy, the Fluency Master, and Fluency Enchancer~~
- ~~Untreated conductive hearing loss~~
- ~~Hippotherapy~~
- ~~Facilitated communication~~
- ~~Treatment of dialect and/or accent reduction~~
- ~~Functional speech disorders~~
- ~~Functional/developmental articulation disorders~~
- ~~Phonological disorders~~
- ~~Functional dysphonia (hoarseness)~~
- ~~Auditory/Sensory integration therapy~~
- ~~Oral myofunctional disorders (e.g., deviant swallow, reverse swallow, visceral swallow, tongue thrust) in children unless there is a diagnosed neuromuscular disease adversely affecting swallowing~~

General Coverage

Outpatient speech-language pathology services must meet **all** general coverage criteria as follows:

- The services must be medically necessary and appropriate for the diagnosis and treatment of communication impairment and/or swallowing disorder due to disease, trauma, or congenital anomaly.
- The beneficiary must be under the care of and referred for speech-language pathology services by a state-licensed physician, physician assistant, or nurse practitioner. (The Certificate of

Medical Necessity for Initial Referral/Orders form must be completed by the prescribing provider prior to therapy evaluation.)

- The services must require the knowledge, skill and judgment of a speech-language pathologist.
- The services must be provided according to a plan of care (POC) developed by the speech-language pathologist and authenticated (signed and dated) by the prescribing provider. The prescribing provider must sign and date the POC before initiation of treatment **OR** within thirty (30) calendar days of the verbal order approving the treatment plan. This applies to both initial and revised plans of care.
- The POC must include specific diagnosis-related goals and there must be a reasonable expectation that the beneficiary can achieve measurable improvement in a reasonable period of time (generally four to six months).
- The discipline in which the speech-language pathologist is licensed must match the order for speech-language pathology services, i.e., only a state-licensed speech-language pathologist may evaluate, plan care, and deliver speech-language pathology services.
- The services must be individualized, consistent with the symptomatology/diagnosis, and not in excess of the beneficiary's needs.
- Treatments must result in significant, practical improvement in the level of functioning within a reasonable period of time **OR** must be necessary for establishment of a maintenance program. The improvement potential must be significant in relationship to the extent and duration of the therapy requested.
- The services must require one-to-one intervention and supervision of a speech-language pathologist. Group therapy is not covered. Refer to Provider Policy Manual Section 49.07 for Group Therapy Policy.
- The services must not duplicate another provider's services (i.e., occupational therapist and speech-language pathologist performing the same services on the same day; two speech-language pathologists performing the same services).
- The services, when provided by multiple providers, must be coordinated by the providers to ensure that:
  - Therapy services are coordinated
  - Duplicate services are not being provided
  - Services are medically necessary
  - Beneficiary is receiving quality care

Clinical Criteria

DOM covers medically necessary speech-language pathology services. The Utilization Management and Quality Improvement Organization (UM/QIO) for the Division of Medicaid determines medical necessity by considering multiple criteria. Criteria include, but are not limited to, the following:

1. The beneficiary presents with one or more of the following signs/symptoms:

- Aphagia-inability to swallow
- Aphasia-absence/impairment of the ability to communicate through speech, writing, or signs because of brain dysfunction. It is considered total/complete when both sensory and motor areas are involved
- Aphonia-inability to produce sounds from the larynx due to excessive muscle tension, paralysis, or disease of the laryngeal nerves
- Apraxia-inability to form words to speak despite an ability use facial and oral muscles to make sounds
- Dsyarthria-defective or difficult speech that involves disturbances in muscular control (e.g., weakness, lack of coordination, paralysis) of the speech mechanism (oral, lingual, respiratory or pharyngeal muscles) resulting from damage to the peripheral or central nervous system
- Dysphagia-difficulty swallowing
- Dysphasia-language impairment from neurodevelopmental disorder or brain lesion
- Dysphonia-difficulty speaking due to impairment of the muscles involving vocal production
- Vocal cord dysfunction-impairment of vocal cord mobility due to functional or structural abnormalities resulting from organic or neurological diseases

2. The Certificate of Medical Necessity for Initial Referral/Orders. Refer to Provider Policy Manual Section 49.10 for Prescribing Provider Orders/Responsibilities policy.

3. Risk factors that have been identified and documented. Such factors can include, but are not limited to, the following:

    - Neurological disorders/dysfunctions (e.g., hearing loss or cerebral palsy)
    - Surgical procedures (e.g., partial/comprehensive/radical laryngectomy, repaired cleft palate, glossectomy)
    - Cognitive impairments that affect communication functions
    - Medical conditions resulting in communication disorders that may require restorative therapy. Examples are as follows:
        - Laryngeal carcinoma requiring partial/total largyngectomy that results in dysphonia or aphonia
        - Traumatic brain injury that may exhibit inadequate respiratory volume, apraxia, dysphagia, or dysarthria
        - Progressive/static neurological conditions (e.g., amyotrophic lateral sclerosis, Parkinson's disease, myasthenia gravis, multiple sclerosis, Huntington's disease)
        - Mental retardation with disorders of dysarthria, dyphagia, apraxia, or aphagia

- Cerebrovascular disease, such as cerebrovascular accident, presenting with apraxia, aphasia, dysphagia, or dysarthria

4. A comprehensive evaluation conducted to determine the beneficiary's current medical status, level of functioning, disability, health/psychosocial state, and need for treatment. Refer to Provider Policy Manual Section 49.11 for Evaluation/Re-evaluation policy.

5. A comprehensive written treatment plan to treat the speech-language pathology disorder. Refer to Provider Policy Manual Section 49.12 for Plan of Care policy.

6. The type of service requested includes one or more of the following:

   - Diagnostic and evaluation services:

     - To determine the type, causal factors, severity of speech-language or swallowing disorders, and the extent of service required to restore functions of speech, language, voice fluency, and swallowing, **OR**

     - The beneficiary demonstrates changes in functional speech or remission of a medical condition that previously contradicted speech-language therapy

   - Therapeutic services (i.e., services requiring active corrective/restorative therapy) for communication disorders that result from:

     - Laryngeal carcinoma requiring partial/total largyngectomy that results in aphonia so the beneficiary can develop new communication skills through esophageal speech or the use of an electrolarynx

     - Cerebrovascular disease, such as cerebrovascular accident, presenting with apraxia, aphasia, dysphagia, or dysarthria, **OR**

     - Medical and neurological conditions (e.g., traumatic brain injury, Parkinson's disease, or multiple sclerosis) exhibiting inadequate respiratory volume/control, aphonia, dysphagia, or dysarthria, or dysphonia)

Pre-Certification

Certain CPT codes require prior authorization from the DOM Utilization Management and Quality Improvement Organization (UM/QIO). All procedures and criteria set forth by the UM/QIO are applicable to speech-language pathology providers and are approved by the Division of Medicaid. Refer to Provider Policy Manual Section 49.09 for Prior Authorization/Pre-Certification policy.

NOTE: Facilities who are Medicaid providers and who contract with an individual or group to provide speech-language pathology services must ensure compliance with all speech-language pathology program policies.

Division of Medicaid State of Mississippi Provider Policy Manual	New: Revised: X Current:	Date: Date: ~~07/01/09~~ 09/01/09
Section: Outpatient Speech-Language Pathology (Speech Therapy) Subject: ~~General Coverage Criteria~~ Noncoverage	Section: 49.04 Pages: 2 Cross Reference: ~~Exclusions 49.03~~ ~~Group Therapy 49.07~~ ~~Prior Authorization/Pre-Certification 49.09~~ Coverage 49.03 Maintenance Therapy 49.13	

~~Outpatient speech-language pathology services must meet all general coverage criteria as follows:~~

- ~~The services must be medically necessary and appropriate for the diagnosis and treatment of communication impairment and/or swallowing disorder due to disease, trauma, or congenital anomaly.~~

- ~~The beneficiary must be under the care of and referred for speech-language pathology services by a state-licensed physician, physician assistant, or nurse practitioner. (The Certificate of Medical Necessity for Initial Referral/Orders form must be completed by the prescribing provider prior to therapy evaluation.)~~

- ~~The services must require the knowledge, skill and judgment of a speech-language pathologist. Services provided by speech-pathology assistants and/or aides are not covered.~~

- ~~The services must be provided according to a plan of care (POC) developed by the speech-language pathologist and authenticated (signed and dated) by the prescribing provider. The prescribing provider must sign and date the POC before initiation of treatment OR within thirty (30) calendar days of the verbal order approving the treatment plan. This applies to both initial and revised plans of care.~~

- ~~The POC must include specific diagnosis-related goals and there must be a reasonable expectation that the beneficiary can achieve measurable improvement in a reasonable period of time (generally four to six months).~~

- ~~The discipline in which the speech-language pathologist is licensed must match the order for speech-language pathology services, i.e., only a state-licensed speech-language pathologist may evaluate, plan care, and deliver speech-language pathology services.~~

- ~~The services must be individualized, consistent with the symptomatology/diagnosis, and not in excess of the beneficiary's needs.~~

- ~~Treatments must result in significant, practical improvement in the level of functioning within a reasonable period of time OR must be necessary for establishment of a maintenance program. The improvement potential must be significant in relationship to the extent and duration of the therapy requested.~~

- ~~The services must require one-to-one intervention and supervision of a speech-language pathologist. Group therapy is not covered. Refer to Provider Policy Manual Section 49.07 for Group Therapy Policy.~~

- ~~The services must not duplicate another provider's services (i.e., occupational therapist and speech-language pathologist performing the same services on the same day; two speech-language pathologists performing the same services).~~

Exclusions

Refer to Provider Policy Manual Section 49.03 for Exclusions policy.

Pre-Certification

Certain CPT codes require prior authorization from the DOM Utilization Management and Quality Improvement Organization (UM/QIO). All procedures and criteria set forth by the UM/QIO are applicable to speech-language pathology providers and are approved by the Division of Medicaid. Refer to Provider Policy Manual Section 49.09 for Prior Authorization/Pre-Certification policy.

NOTE: Facilities who are Medicaid providers and who contract with an individual or group to provide speech-language pathology services must ensure compliance with all speech-language pathology program policies.

Outpatient speech-language pathology services **not** covered/reimbursed by the Division of Medicaid include, but are not limited to, the following:

- Services not certified/ordered by a physician, physician assistant, or nurse practitioner
- Services when the plan of care has not been approved and signed by the physician, physician assistant, or nurse practitioner, within established timeframes.
- Services that do not meet the general coverage criteria. Refer to Provider Policy Manual Section 49.03 for Coverage Criteria policy.
- Services that do not require the knowledge, skill, and judgment of a licensed speech-language pathologist.
- Services when documentation supports that the beneficiary has attained the speech-language pathology goals or has reached the point where no further significant functional improvement is apparent and/or can be expected to occur.
- Services when documentation supports that the beneficiary has not reached speech-language pathology goals and is unable to participate and/or benefit from skilled intervention, refuses to participate, or is otherwise noncompliant with the speech-language pathology regimen.
- Services that the beneficiary can perform independently or with the assistance of unskilled personnel or family members.
- Services that duplicate other concurrent therapy (example: occupational therapist and speech-language pathologist providing the same treatment to the same beneficiary).
- Maintenance and/or palliative services that maintain function and generally do not involve complex procedures or the professional skill, judgment, or supervision of a licensed speech-language pathologist. Refer to Provider Policy Manual Section 49.13 for Maintenance Therapy policy.
- Services for conditions that could be reasonably expected to improve spontaneously without therapy.

- Services ordered daily or multiple times per day/week from the initiation of speech-language pathology through discharge, i.e., frequency should decrease as the beneficiary's condition improves.
- Services normally considered part of nursing care.
- Services provided through a Comprehensive Outpatient Rehabilitation Facility (CORF).
- Separate fees for self care/home management training (beneficiary and caregiver education is inclusive in covered services).
- Services which are related solely to employment opportunities (i.e., on-the-job training, work skills, or work settings).
- Services that are primarily general wellness, exercise, and/or recreational programs.
- Services when the purpose is vocationally based.
- Services provided by student.
- Services provided by speech-language assistants.
- Services provided by speech-language pathology aides.
- Group therapy
- Co-therapy
- Services that are investigative or experimental.
- Acupuncture or biofeedback
- Services outside the scope/and or authority of the therapist's specialty and/or area of practice.
- Services and items requiring pre-certification if the pre-certification has not been requested and/or denied, or the pre-certification requirements have not been satisfied by the provider.
- Speech-language pathology services that are educational in nature, i.e., services provided under Individuals With Disabilities Education Act (IDEA) or Section 504 of the Rehabilitation Act of 1973 (504 Plan). These are deemed the responsibility of the educational system.
- Consultation services between speech-language pathologists or other providers.
- Services when clinical documentation and/or plan of care does not support the need for or the continuation of the services.
- Services when the treatment is for a dysfunction that is self-correcting (e.g., developmental articulation errors or natural dysfluency).
- Services not specifically listed as covered by the Division of Medicaid.
- Noncovered services listed elsewhere in the Mississippi Medicaid Provider Manual, bulletins, or other Mississippi Medicaid publications.