

**Policy terminated because services and codes are currently covered under
Medicaid policies (10A-Outpatient Specialized Therapies and 5A-Durable
Medical Equipment & Supplies)**

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1.0 Description of the Procedure, Product, or Service

Speech therapy is the treatment of communication disabilities and swallowing disorders. Speech therapy services facilitate the development and maintenance of human communication and swallowing through assessment, diagnosis, and rehabilitation. Speech therapists treat disorders resulting from disease, trauma, congenital anomaly or prior therapeutic process including:

- a. language, speech articulation and voice disorders;
- b. oral-pharyngeal dysfunction and related disorders.

Medically necessary speech therapy defined as skilled services that can only be rendered under state law or regulation by licensed health professionals, such as a licensed speech therapist, will generally involve the mechanics of phonation or deglutition (process of vocal sound or the act of swallowing). Speech therapists are also known as speech pathologists, speech-language pathologists and speech clinicians.

2.0 Eligible Recipients

2.1 General Provisions

To be eligible, NCHC recipients must be enrolled on the date of service.

Note: Most children will be able to get all the services they need under the core (basic) plan of NC Health Choice. A child who qualifies as having special needs may be able to receive additional services not covered by the core plan.

3.0 When the Procedure, Product, or Service Is Covered

3.1 General Criteria

NCHC covers procedures, products, and services related to this policy when they are medically necessary and

- a. the procedure, product, or service is individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the recipient's needs;
- b. the procedure, product, or service can be safely furnished, and no equally effective and more conservative or less costly treatment is available; **AND**
- c. the procedure, product, or service is furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.

3.2 Specific Criteria

- a. Initial speech, language and/or hearing evaluations are covered.
- b. To be considered eligible for coverage, speech therapy services must meet **ALL** the following criteria:

1. Be performed to meet the functional needs of a recipient who suffers from a communication disability and/or swallowing disorder due to illness, injury, congenital anomaly, or prior therapeutic intervention;
 2. Be performed to achieve a specific diagnosis-related goal for a recipient who has a reasonable expectation of achieving measurable improvement in the recipient's condition in a reasonable and predictable period of time;
 3. Be considered by the NCHC Program to be specific, effective and reasonable treatment for the recipient's diagnosis and physical condition;
 4. Be delivered by a qualified provider of speech therapy services. A qualified provider is one who is licensed and certified where required and is performing within the scope of license.
 5. Require the judgment, knowledge and skills of a qualified provider of speech therapy services because of the complexity and sophistication of the therapy and the physical condition of the recipient. **AND**
 6. Documentation must be supplied that demonstrates the ability of the recipient to respond in a positive manner to therapy, i.e. visual and hearing acuity, cognitive ability - the ability to learn and retain information, etc.
- c. Up to three sessions are considered eligible for coverage to establish a speech therapy maintenance program. A maintenance therapy program consists of drills, techniques and exercises that preserve the recipient's present level of function. Maintenance begins when the therapeutic goals of a treatment plan have been achieved, or when no further functional progress is apparent or expected to occur. The maintenance program itself is not eligible for coverage.
- d. Benefits are limited to one hour of speech therapy services on any given day.

4.0 When the Procedure, Product, or Service Is Not Covered

4.1 General Criteria

Procedures, products, and services related to this policy are not covered when

- a. the recipient does not meet the eligibility requirements listed in **Section 2.0**;
- b. the recipient does not meet the medical necessity criteria listed in **Section 3.0**;
- c. the procedure, product, or service unnecessarily duplicates another provider's procedure, product, or service; or
- d. the procedure, product, or service is experimental or investigational.

4.2 Specific Criteria

Speech therapy in the following situations is not covered for the following;

- a. Speech therapy is considered not medically necessary for dysfunctions that are self-correcting, such as language therapy for young children with natural dysfluency or developmental articulation errors that are self-correcting.
- b. Group or family therapy.

- c. Home health speech therapy unless the recipient is homebound.
- d. Communication disabilities solely associated with behavioral, learning, and/or psychological disorders.
- e. Dysfunctions which are self-correcting related to natural dysfluency or developmental articulation errors that are self-correcting.
- f. Duplicate therapy is not considered medically necessary. For example, some recipients may receive both speech and occupational therapy. In such cases, the two therapies should provide different treatments and not duplicate the same treatment.
- g. Speech therapy maintenance program (refer to **Subsection 3.2.c**).
- h. The following treatments are not considered to be a skilled level of treatment:
 - 1. Services which maintain function by using routine, repetitive and reinforced procedures that are neither diagnostic nor therapeutic (e.g., the practicing of word drills without skilled feedback);
 - 2. drills for developmental articulation errors which are self-correcting; or
 - 3. other procedures that may be carried out effectively by the recipient, family or caregivers.
- i. If a recipient improves with therapy such that standardized testing indicates that their performance is within the normal range (i.e. less than 1.5 standard deviation below the mean, above the 7th percentile, or a language quotient or standard score greater than 78, or less than a 25% delay on instruments that determine scores in months), then continued speech therapy will be considered not medically necessary.
- j. Communication equipment, such as a telephone answering machine, is not covered.

5.0 Requirements for and Limitations on Coverage

5.1 Prior Approval

- a. Prior approval is not required for initial speech, language, and/or hearing evaluations.
- b. Prior approval is required for speech therapy and electronic speech aids (such as Electrolarynx, a brand of artificial larynx). Approval periods for therapy are based on 12-week segments pending documentation of the progress and justification for continuation of skilled services.
- c. A letter of medical necessity signed and dated by the speech therapist must be submitted to DMA's vendor prior to rendering the service.
- d. Documentation must include.
 - 1. Recipient demographics, including name, address, NCHC ID number, date of birth;
 - 2. diagnosis, relevant medical history, comprehensive diagnostic assessment/clinical assessment;
 - 3. Documentation that demonstrates the ability of the recipient to respond in a positive manner to therapy, i.e. visual and hearing acuity, cognitive ability - the ability to learn and retain information, etc.;

4. A treatment plan appropriate for the diagnosis, presenting symptoms and findings of the speech therapy evaluation. The treatment plan shall include:
 - (a) specific statements of long and short-term goals;
 - (b) quantitative objectives;
 - (c) a reasonable estimate of when the goals will be reached;
 - (d) the specific treatment techniques and/or exercises to be used in treatment; and
 - (e) the frequency and duration of treatment
- e. In evaluating requests for communication aids, DMA's vendor will apply the following criteria:
 1. The communication aid must be ordered by the physician;
 2. The recipient must be severely handicapped to the extent that vocal or other communication without an aid is clearly unsatisfactory;
 3. The recipient must have experienced little or no improvement in communicative ability as a result of traditional therapy;
 4. The recipient must possess the cognitive ability to use language;
 5. The recipient must possess the physical capacity to use language, and to use the aid in question;
 6. The apparent desire to communicate must be present;
 7. The recipient must have access to an adequate local support system;
 8. The aid selected must represent an appropriate, cost-effective response to the recipient's needs; and
 9. The prognosis with regard to quality of life must be decidedly improved with the introduction of the communication aid.

5.2 Limitations

- a. Speech therapy services are considered medically necessary only if there is a reasonable expectation that speech therapy will achieve measurable improvement in the recipient's condition in a reasonable and predictable period of time. Speech therapy is not medically necessary when services can be rendered under state law by individuals other than licensed health professionals such as a certified speech therapist.
- b. Speech therapy services shall be considered medically necessary only when results of speech and/or language testing indicates performance at least 1.5 standard deviation below the mean (scores at or below the 7th percentile, a language quotient or standard score 78 or less, or at least a 25% delay on instruments that determine scores in months). Additional documentation that the child exhibits functional impairment in one or more language components (syntax, morphology, semantics, or pragmatics) will be considered on an individual basis. Standardized testing should be repeated when clinically indicated, or at a minimum of every 12 months. A comprehensive speech and /or

language evaluation is considered to include hearing screening, oral peripheral examination, expressive and receptive language, articulation, phonological analysis, etc. A non-standard assessment in conjunction with a standardized assessment is a necessary part of a comprehensive assessment and is used to determine the need for therapeutic intervention.

- c. Benefits are limited to speech, language, voice and swallowing disorders with underlying organic etiology:
 1. Speech
 - (a) velopharyngeal inadequacy (hypernasality)
 - i. cleft lip and/or cleft palate
 - ii. Submucous cleft palate
 - iii. congenital short palate
 - iv. palatopharyngeal paresis/paralysis (neuropraxia of palate)
 - v. neuromuscular (myasthenia gravis, multiple sclerosis, ALS, etc.)
 - (b) hyponasality
 - i. adenoidal hypertrophy
 - ii. choanal atresia
 - (c) speech disturbance secondary to dysarthria
 - (d) speech disturbance secondary to apraxia/dyspraxia (confirmed by complete, standardized speech motor exam).
 - (e) central auditory processing disorder (when confirmed by speech pathology and audiology examination).
 - (f) speech disturbance secondary to ankyloglossia or macroglossia.
 - (g) all speech disorders related to hearing loss.
 - (h) laryngectomy (alaryngeal)
 - (i) stuttering
 - (j) speech disorder secondary to structural (orthognathic, dental) anomaly.
 2. Language
 - (a) aphasia/dysphasia (CVA, TBI)
 - (b) cognitive dysfunction (CVA, TBI)
 - (c) language disorders related to hearing loss
 3. Voice (Dysphonia) (generally limited to 5 sessions)
any voice disturbance related to:
 - (a) vocal cord pathology
 - i. nodules
 - ii. polyps
 - iii. web
 - iv. mucosal edema
 - v. granulomatosis
 - (b) vocal cord dysfunction
 - i. paralysis/paresis
 - ii. hyperkinesis (muscle tension dysphonia)

- iii. hypokinesis (vocal fold bowing); aphonia
- iv. laryngeal dystonia (spasmodic dysphonia)
- v. paradoxical vocal fold dysfunction
- 4. Swallowing (dysphagia) all are considered acquired and medically necessary.
- d. The treatment goals and subsequent documentation of treatment results must specifically demonstrate that speech therapy services are contributing to the recipient's measured improvement.

6.0 Providers Eligible to Bill for the Procedure, Product, or Service

To be eligible to bill for procedures, products, and services related to this policy, providers shall

- a. meet NCHC qualifications for participation;
- b. be currently enrolled with NCHC; **AND**
- c. bill only for procedures, products, and services that are within the scope of their clinical practice, as defined by the appropriate licensing entity.

Speech therapy must be provided by a licensed health professional, such as a licensed speech therapist. Speech therapists are also known as speech pathologists, speech-language pathologists and speech clinicians.

7.0 Additional Requirements

7.1 Compliance

Providers must comply with all applicable federal, state, and local laws and regulations, including the Health Insurance Portability and Accountability Act (HIPAA) and record retention requirements.

8.0 Policy Implementation/Revision Information

Original Effective Date: July 1, 2010

Revision Information:

Date	Section Revised	Change
July 1, 2010	Throughout	Policy Conversion: Implementation of Session Law 2009-451, Section 10.32 “NC HEALTH CHOICE/PROCEDURES FOR CHANGING MEDICAL POLICY.”
February 29, 2012	Throughout	Policy Termination

Attachment A: Claims-Related Information

Reimbursement requires compliance with all NCHC guidelines.

A. Claim Type

Professional (CMS-1500/837P transaction)

Institutional (UB-04/837I transaction)

B. Diagnosis Codes

Providers must bill the ICD-9-CM diagnosis codes(s) to the highest level of specificity that supports medical necessity.

C. Procedure Code(s)

CPT codes				
92506	92507	92526	92626	92627
92630	92633	21084		
HCPCS code				
S9152				
L8500	L8507	L8509	L8510	
Procedure codes				
93.7	93.71	93.72	93.73	93.74
93.75				

Speech aids are classified as prosthesis and are subject to the same prior approval guides as Durable Medical Equipment.

D. Modifiers

Providers are required to follow applicable modifier guidelines.

E. Billing Units

The appropriate procedure code(s) used determines the billing unit(s).

F. Place of Service

Outpatient Hospital, Office, Home

G. Co-payments

Co-payment(s) may apply to covered prescription drugs and services.

H. Reimbursement

Providers must bill their usual and customary charges.