

## OHCA Guideline

<b>Medical Procedure Class:</b>	Speech Evaluation
Initial Implementation Date:	July 2017
Last Review Date:	May 2025
Effective Date:	June 2, 2025
Next Review/Revision Date:	June 2028
<p>* This document is not a contract, and these guidelines do not reflect or represent every conceivable situation. Although all items contained in these guidelines may be met, this does not reflect or imply any responsibility of this agency or department to change the plan provision to include the stated service as an eligible benefit.</p>	
<input type="checkbox"/> New Criteria <input checked="" type="checkbox"/> Revision of Existing Criteria	
<b>Summary</b>	
<b>Purpose:</b>	To provide guidelines to assure medical necessity and consistency in the prior authorization process.
<b>Definitions</b>	
<p><b>Central Auditory Processing Disorder (CAPD):</b> deficits in the neural processing of auditory information in the Central Auditory Nervous system (CANS) not due to higher order language or cognition (CAPD) may coexist with other disorders (e.g., attention-deficit/hyperactivity disorder [ADHD], language impairment, and learning disability). CAPD is not due to peripheral hearing loss, which includes conductive hearing loss (i.e., outer or middle ear), sensorineural hearing loss at the level of the cochlea or auditory nerve, including auditory neuropathy and synaptopathy (i.e., hidden hearing loss).</p> <p><b>Communication disorder:</b> An impairment in the ability to receive, send, process, and comprehend concepts or verbal, nonverbal and graphic symbol systems. A communication disorder may be evident in the processes of hearing, language, and/or speech. A communication disorder may range in severity from mild to profound. It may be developmental or acquired. Individuals may demonstrate one or any combination of communication disorders. A communication disorder may result in a primary disability, or it may be secondary to other disabilities.</p> <p><b>Disability:</b> According to the World Health Organization (WHO), “disability” is an umbrella term, covering impairments, activity limitations, and participation restrictions. An impairment is a problem in body function or structure; an activity limitation is a difficulty encountered by an individual in executing</p>	

a task or action; while a participation restriction is a problem experienced by an individual in involvement in life situations.

**Licensed Qualified Clinician:** May include a fully licensed Speech-Language Pathologist as described below OR a Speech language pathology Clinical Fellow who has completed the necessary educational requirements and work experience necessary for the Certificate or has completed the academic program and is acquiring supervised work experience to qualify for the Certificate of Clinical Competence.

**Speech Language Pathologist (SLP):** Fully licensed, Master's degree, ASHA certified speech language pathologist holding the Certificate of Clinical Competence in Speech-Language Pathology.

**Qualified health professional:** A medical doctor (MD), osteopathic doctor (DO), physician's assistant (PA), certified nurse practitioner (CNP), or an advanced practice registered nurse (APRN) who is currently contracted with Sooner Care.

**Screening:** For communication needs in infants, toddlers, and older children; a process of identifying young children at risk so that evaluation can be used to establish eligibility, and more in-depth assessment can be provided to guide the development of an intervention program. The aim of screening is to make a determination as to whether a particular child is likely to show deficits in communication development.

**Speech-Generating Device (SGD):** Devices considered augmentative in nature, used to supplement existing speech and alternative when used in place of speech that is absent or non-functional. Durable medical equipment that provides an individual who has a severe speech impairment with the ability to meet his or her functional speaking needs. SGDs are devices that generate speech and are used solely by the individual who has a severe speech impairment or whose natural speech is absent or nonfunctional.

**Speech-Language Therapy (Intervention):** Speech-language therapy is the treatment of speech/language production, voice production, cognitive-linguistic skills, and/or general communication abilities that have been impaired as a result of a disease, injury, developmental delay or surgical procedure.

#### Description

Evaluations for speech, language, or other communication disorders are indicated when there are concerns regarding the development or acquisition of age-appropriate, functional speech and/or language skills. Evaluations are used to identify and develop treatment strategies and when appropriate, address conditions such as stuttering and voice disorders. An individual may present more than one type of communication disorder and may require more than one type of evaluation. Such disorders may be developmental in nature or acquired as a result of accident, injury, or other medical event.

#### CPT Codes Covered Requiring Prior Authorization (PA)

**92521** Evaluation of speech fluency (e.g., stuttering, cluttering)

**92522** Evaluation of speech sound production (e.g., articulation, phonological process, apraxia, dysarthria)

**92523** Evaluation of speech sound production (e.g., articulation, phonological process, apraxia, dysarthria); with evaluation of language comprehension and expression (e.g., receptive and expressive language)

**92524** Behavioral and qualitative analysis of voice and resonance

### Approval Criteria

#### I. GENERAL

- A. Medical necessity must be met. All documentation submitted to request services or substantiate previously provided services must demonstrate, through adequate medical records, evidence sufficient to justify the member's needs for the service in accordance with the **OAC 317:30-3-1(f)**.
- B. Speech-language pathology evaluation is covered for the pediatric population (ages 0-20 at the time of evaluation) when it is medically appropriate.

#### II. ELIGIBILITY for evaluation is indicated if one or more of these factors are present:

- A. Referral from the individual, family member, audiologist, physician, teacher, other speech-language pathologist, or interdisciplinary team because of a suspected speech, language, or communication, disorder.
- B. Failure to pass a screening assessment for communication and/or swallowing function.
- C. The individual is unable to communicate functionally across environments and communication partners.
- D. The individual's communication abilities are not comparable to those of others of the same chronological age, gender, ethnicity, or cultural and linguistic background.
- E. The individual's communication skills negatively affect health, safety, social or vocational status.
- F. The individual, family, and/or guardian seek services to achieve and/or maintain functional communication (including alternative and augmentative means of communication).

#### III. DOCUMENTATION

Prior Authorization (PA) request for evaluation of speech fluency, speech sound production, speech sound production with evaluation of language comprehension and expression, behavioral and qualitative analysis of voice and resonance must include **all** the following documentation.

- A. Supporting evidence must include a signed and dated order from a contracted qualified health professional (MD, DO, PA, CNP, APRN) requesting the services. The referral/Rx must designate speech therapy and the applicable ICD-10-CM diagnosis/description. The evaluation must be completed within 90 days of the date the order was signed; **AND**
- B. Clinical documentation from the ordering provider (such as a well child visit which is current within one year) supporting medical necessity for the requested ICD-10 code referenced in the documentation. Requests for 92521, 92522, and 92524 require documentation to support the need for the specific code requested; **AND**
- C. A completed HCA-61 Therapy Prior Authorization Request form; **AND**
- D. If applicable, Change of Provider Form (SC-16) should also be submitted.

Note: Additional information may be requested.

### Continuation Criteria

#### I. EVALUATION

Evaluation procedures are required annually for continued services as symptoms and level of impairment will change over time and may no longer be medically necessary.

#### II. LINGUISTIC DIFFERENCE VS DISORDER

- A. When evaluating, the Speech-Language Pathologist (SLP) should consider whether a child who appears to have a language problem is demonstrating a linguistic *difference* or a *disorder*.
- B. SLP is responsible for choosing an appropriate instrument that meets criteria for fairness and efficiency. It is generally not acceptable to translate a test standardized in English into another language for use because the psychometric properties of the test are not valid when the test has been translated.
- C. This issue pertains to any child who comes from a background with cultural or linguistic differences from the normative sample used in the evaluation tool. For example, using a test normed on native Standard English speakers without scoring that takes into account dialect differences is inadequate to test a Spanish-speaking child or one who uses another dialect of English, such as African American English. In recent years, a number of tests, both for screening and evaluation, have been translated into Spanish and a small number of other languages.

#### III. EVALUATION REPORT

The evaluation report must consist of:

- A. Relevant case history – including pertinent birth, development and medical history (vision, hearing and motor status, comorbidities) and linguistic background, previous services (including number of sessions used and approved during the last authorization period).
- B. Hearing screening – should be performed within one year of initial evaluations. A failed hearing screening should result in a referral to an audiologist for further evaluation. Should a member fail due to inability to comply with screening procedure, rationale and plan for assessment of hearing status should be documented. If a member has passed a hearing screening or previous audiological evaluation and the results were within normal range, another evaluation is not necessary unless there is concern, change in medical status or another risk factor known. Follow-up on all failed hearing screening or audiological assessment must occur annually.
- C. Oral mechanism examination.
- D. Information regarding respiratory status, voice and fluency.
- E. Spoken language standardized tests and/or professionally acceptable therapeutic observational techniques using a formalized checklist or observational tool. Standardized testing shall address and report on all areas addressed in the test, including all subtests given (receptive/expressive language, articulation/phonology, etc.). If a full battery cannot be conducted, rationale should be given by the evaluating provider. Providers should use

the most updated version of standardized testing whenever possible. If an older version is used when a newer version is available rationale should document.

*\*The evaluation should include a standardized objective measure; however, if it is not possible to attain a standardized score a valid rationale should be given. Documentation of speech-language deficits should be supported by dynamic assessment processes (e.g. checklists, rating scales, and observation schedules). Detailed information should be attained regarding functional communication status. Informal assessment is also a critical piece of the assessment process and should focus and elaborate on the member's spontaneous functional communication ability. Informal assessment information (observation and parent report) other than items failed on standardized assessment is to be included within the assessment.*

*\*If a standardized articulation assessment cannot be completed then a detailed narrative analysis should be included that addresses specific examples of types of consonant and vowel productions, sound combinations (e.g. CVC, CVCV), phonological processes (if present) and intelligibility as observed by the SLP. Narrative should include the SLP's analysis of the disordered speech observed versus typical development. Narrative should be based on SLP observations rather than solely on parent report.*

- F. Analysis of results - should include interpretation of all assessment measures (parent/caregiver report, standardized and dynamic assessment, informal assessment). Interpretation should include rationalization of medical necessity, prognosis for intervention and plans for skilled service delivery.
- G. Plan of care - developed to address functional communication goals and objectives, which encourage increased participation in home, school and/or community. Plan should also include type of therapy, functional and measurable short and long-term goals (specific, measurable, attainable, relevant and timely), baseline measures for short-term goals, and level of support (type and level of prompting and/or cues) to be utilized by skilled provider. Plan should also address parental involvement, home program and be culturally sensitive to the child and family. Parental support (resources, community support, programs) should also be addressed to increase opportunity for generalization. The plan should also be in accordance with evidence-based practices.
- H. ALL documents completed by a Clinical Fellow or SLP-A must be co-signed by a licensed, certified Speech Language Pathologist (CCC-SLP).

**IV. RE-EVALUATION** must include the same procedures given above as well as detailed information regarding progress toward goals addressed in previous authorization period.

**V. Prior Authorization (PA)** for the evaluation may be approved for up to 90 days from the date of the physician's signature on the order/referral for the service requested.

**VI.** Requests outside this guideline will be referred for medical director review.

Note: Additional information may be requested.

## References

1. Oklahoma Health Care Authority; Policies & Rules, OAC 317: 30-3-1; 317:30-3-65.5; 317:30-5, Part 17.
2. <http://www.asha.org/Practice/reimbursement/medicaid/Medicaid-Toolkit-Medical-Necessity/>
3. <http://www.asha.org/practice/reimbursement/modules/>
4. <http://www.asha.org/policy/>
5. <http://www.asha.org/policy/PP2004-00191.htm>
6. <http://www.who.int/topics/disabilities/en/>
7. [https://www.asha.org/practice-portal/clinical-topics/autism/#5collapse\\_5](https://www.asha.org/practice-portal/clinical-topics/autism/#5collapse_5)
8. <http://ajslp.pubs.asha.org/article.aspx?articleid=1757632>
9. <https://www.asha.org/NJC/Evidence-Based-Practice/>
10. <http://www.asha.org/Practice/reimbursement/medicare/Examples-of-Documentation-of-Skilled-and-Unskilled-Care-for-Medicare-Beneficiaries/>
11. <http://www.asha.org/Code-of-Ethics/>
12. <https://www.asha.org/Practice-Portal/Clinical-Topics/Central-Auditory-Processing-Disorder>
13. <https://www.asha.org/public/speech/disorders/speech-sound-disorders/>
14. <https://www.asha.org/policy/slpa-scope-of-practice/>