



SPEECH – LANGUAGE AND HEARING SERVICES

Brief Coverage Statement

Speech-language and hearing services are medically necessary services for child clients ages 20 and under, with hearing loss, cognitive or other developmental delays, weak oral muscles, birth defects such as cleft palate or cleft lip, motor planning problems, respiratory problems, swallowing disorders, feeding disorders, voice or vocal cord dysfunction, traumatic brain injury, and other qualifying neurological or communication disorders. Audiologists assess and diagnose auditory function, balance, and auditory related disorders including the selecting, fitting, and dispensing of hearing aids and other hearing assistive devices as well as the assessment, follow-up services, and necessary supplies for persons with cochlear implants.

Therapies offered by the Colorado Medicaid may be offered through a number of programs, such as the [Department's waiver programs](#), [Early Intervention](#), [School Health Services](#) and the [Home Health benefit](#). This coverage standard does not describe the benefits or regulations for any of these programs. **This coverage standard describes outpatient therapy benefits only.** Medicaid fee-for service speech therapy and hearing services do not supersede the policies of other programs, such as Early Intervention that may utilize Medicaid therapy services.

Services Addressed in Other Benefit Coverage Standards

1. Augmentative and Alternative Communication Devices

Eligible Providers

Eligible providers may be individual practitioners or may be employed by home care agencies, children's developmental service agencies, health departments, federally qualified health centers (FQHC), clinics, hospital outpatient services. The provider agency or the individual provider must verify that therapists or audiologists are regulated by the Colorado Department of Regulatory Agencies (DORA) and that the certification, license or registration is current, active and unrestricted to practice.

RENDERING PROVIDER

1. Otolaryngologist
2. Speech-language pathologist - Current certification by DORA pursuant to Title 12 Article 43.7.
 - 2.1. Speech-Language Pathology Assistants - support personnel who, following academic and/or on-the-job training, perform tasks prescribed, directed, and supervised by DORA-certified speech-language pathologists. Supervisors must follow the [ASHA guidelines on the training, use, and supervision of assistants](#). (Assistants cannot render services under the Home Health division of the Medical Assistance Program.)



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- 2.2. Clinical Fellow, under the general supervision of a DORA-certified speech-language pathologist.
3. Audiologists - means a person who meets the following requirements:
 - 3.1. Licensed by the Colorado Department of Regulatory Agencies pursuant to Title 12 Article 5.5.
 - 3.2. Colorado Home Intervention Program (CHIP) is administered by The School for the Deaf and Blind. Audiologists must apply and be approved to participate in this program, which is a separately administered program from the fee-for-service, Medical Assistance Program. Providers should contact the Health Care Program for Children with Special Needs (HCP) at the Colorado Department of Public Health and Environment for an application packet. The application will be reviewed and if approved will be sent to Medicaid for a final certification.

Note: A provider must be enrolled as a Colorado Medicaid provider in order to be eligible to bill for procedures, products and services in treating a Colorado Medicaid client. The prescribing provider is the practitioner who orders the service. The rendering provider is the practitioner who can render the service within the scope of their practice, certifications, and licensure. The rendering provider may or may not be the rendering provider on the claim form, as not all provider types are able to enroll as a Colorado Medicaid provider.

PROVIDER AGENCY REQUIREMENTS

Colorado legislation passed in 2008 requires providers of in-home health who employ therapists or audiologists to apply for licensing through the Colorado Department of Public Health and Environment (CDPHE). (§25-27.5-103(1) C.R.S. and 6 CCR 1011-1, Chapter XXVI, Section 5.1) as a home **care** agency on or before January 1, 2010. This differs from the credentials necessary to be considered a home **health** agency and bill revenue codes through long-term care. The link to obtain additional information regarding certification is <http://www.cdphe.state.co.us/hf/homecareagencies/index.html>

This rule does not apply to providers delivering Early Intervention Services under an IFSP and billing through contracts with the Community Centered Boards.

Eligible Place of Service

1. Office
2. Clinic
3. Home
4. School
5. FQHC
6. Outpatient Hospital
7. Community Based Organization



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Eligible Clients

Enrolled clients ages 20 and under and adult clients in limited circumstances qualify for medically necessary services.

Adult clients may receive the above speech and audiology services for non-chronic conditions and acute illness and injuries.

Covered Services and Limitations

NEWBORN SCREENINGS

Screening shall include a comprehensive health assessment performed soon after birth or as early as possible in a child's life and repeated at periodic intervals of time as recommended by the Colorado Early & Periodic Screening & Diagnosis and Treatment (EPSDT) periodicity schedules.

Colorado requires all hospitals to offer a newborn hearing screen and all midwives to give parents information on where to obtain a screen. The screens are performed by hospital nursery staff using automated auditory brainstem response (AABR) or Otoacoustic Emissions (OAE) technology. If an infant fails his/her newborn hearing screen (either initially or as an outpatient) he/she should then be referred to a licensed audiologist who has the equipment and expertise to evaluate young infants. Audiologists should follow the Colorado Infant Hearing Guidelines, which can be found at: <http://www.cdphe.state.co.us/ps/hcp/hearing/audiologyguide.pdf>. Audiologists who fail to follow the guidelines can be reported to DORA for noncompliance.

EARLY LANGUAGE INTERVENTION

Early language intervention for children age birth through three with a hearing loss may be provided by audiologists, speech therapists, and Colorado Home Intervention Program (CHIP) providers. CHIP is an outreach service of the Early Education Department providing services to children who are deaf or hard of hearing and their families throughout Colorado. This program, offered by the Colorado School for the Deaf and the Blind, is designed specifically to serve families with children with who are deaf or hard of hearing, from newborn to preschool, in their own homes. Most children who are deaf or hard of hearing, newborn to age three, are eligible for the program. All families are invited to participate in the program. Public funding is available and is determined by family size, income, and resources. Insurance co-payments are accepted. In addition, through Early Intervention Colorado, families receive assistance with their children's transition to preschool.

AUDIOLOGY SERVICES

Audiological benefits include identification, diagnostic evaluation and treatment for children with hearing loss, neurologic, dizziness/vertigo, or balance disorders. Conditions treated may be either congenital or acquired.



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Assessment – Service may include testing or clinical observation or both, as appropriate for chronological or developmental age, for one or more of the following areas, and must yield a written evaluation report.

1. Auditory sensitivity (including pure tone air and bone conduction, speech detection and speech reception thresholds).
2. Auditory discrimination in quiet and noise.
3. Impedance audiometry (tympanometry and acoustic reflex testing).
4. Hearing aid evaluation (amplification selection and verification).
5. Central auditory function.
6. Evoked otoacoustic emissions.
7. Brainstem auditory evoked response.
8. Assessment of functional communicative skills to enhance the activities of daily living.
9. Assessment for cochlear implants (clients ages 20 and under).*
10. Hearing screening.
11. Assessment of facial nerve function
12. Assessment of balance function.
13. Evaluation of dizziness/vertigo.

Treatment – Service may include one or more of the following, as appropriate:

1. Auditory training.
2. Speech reading.
3. Augmentative and alternative communication training including training on how to use cochlear implants for clients ages 20 and under. Adults with chronic conditions may qualify for augmentative and alternative communication services when justified and supported by medical necessity to allow the individual to achieve or maintain maximum functional communication for performance of Activities of Daily Living.
4. Purchase, maintenance, repairs and accessories for approved devices.
5. Selection, testing and fitting of hearing aids for children with bilateral or unilateral hearing loss; and auditory training in the use of hearing aids.
6. Purchase and training on Department approved assistive technologies.
7. Balance or vestibular therapy.

COCHLEAR IMPLANTS

Cochlear implants may be indicated for clients aged 12 months through 20 years under the following pre-authorization criteria:

1. Six months of age or older
2. Limited benefit from appropriately fitted binaural hearing aids (with different definitions of “limited benefit” for children 4 years of age or younger and those older than 4 years) and a 3-6 month hearing aid trial.
3. Bilateral hearing loss with unaided pure tone average thresholds of 70 dB or greater



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4. Minimal speech perception measured using recorded standardized stimuli-speech discrimination scores of 50-60% or below with optimal amplification at 1000, 2000 and 4000 Hz
5. Family support and motivation to participate in a post-cochlear aural, auditory and speech language rehabilitation program
6. Assessment by an audiologist and otolaryngologist experienced in cochlear implants
7. Bi lateral and hybrid/Electric Acoustic Stimulation cochlear implantation considered on a case by case basis
8. No medical contraindications
9. Up-to-date-immunization status as determined by the Advisory Committee on Immunization Practices (ACIP)

Replacement of an existing cochlear implant for all ages is a benefit when the currently used component is no longer functional and cannot be repaired.

SPEECH-LANGUAGE SERVICES

Assessment – Service may include testing and/or clinical observation, as appropriate for chronological or developmental age, for one or more of the following areas, and must yield a written evaluation report.

1. Expressive language.
2. Receptive language.
3. Cognition.
4. Augmentative and alternative communication.
5. Voice disorder.
6. Resonance patterns.
7. Articulation/phonological development.
8. Pragmatic language.
9. Fluency.
10. Feeding and swallowing.
11. Hearing status based on pass/fail criteria.
12. Motor speech.
13. Aural rehabilitation (defined by provider's scope of practice).

Treatment – Service may include one or more of the following, as appropriate:

1. Articulation/phonological therapy.
2. Language therapy including expressive, receptive, and pragmatic language.
3. Augmentative and alternative communication therapy. Adults with chronic conditions may qualify for augmentative and alternative communication services when justified and supported by medical necessity to allow the individual to achieve or maintain maximum functional communication for performance of Activities of Daily Living.
4. Auditory processing/discrimination therapy.
5. Fluency therapy.



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6. Voice therapy.
7. Oral motor therapy.
8. Swallowing therapy.
9. Speech reading.
10. Cognitive treatment.
11. Necessary supplies and equipment.
12. Aural rehabilitation (defined by provider's scope of practice).

Documentation

CLIENT'S RECORD OF SERVICE – GENERAL REQUIREMENTS

Rendering providers must document all evaluations, re-evaluations, services provided, client progress, attendance records, and discharge plans. All documentation must be kept in the client's records along with a copy of the referral or prescribing provider's order. Documentation must support both the medical necessity of services and the need for the level of skill provided. Rendering providers must copy the client's prescribing provider and medical home/primary care provider on all relevant records.

All documentation should include the following:

1. The recipients name and date of birth
2. The date and type of service provided to the client
3. A description of each service provided during the encounter including procedure codes and time spent on each
4. The total duration of the encounter
5. The name or names and titles of the persons providing each service and the name and title of the therapist supervising or directing the services.

Colorado Medicaid requires the following types of documentation as a record of services provided within an episode of care: initial evaluation, re-evaluation, visit/encounter notes and a discharge summary.

INITIAL EVALUATION

Written documentation of the initial evaluation must include the following:

1. **Referral Information:** Reason for referral and referral source
2. **History:** Must include diagnoses pertinent to the reason for referral, including date of onset; any cognitive, emotional, or physical loss necessitating referral, and the date of onset, if different from the onset of the relevant diagnoses; current functional limitation or disability as a result of the above loss, and the onset of the disability; pre-morbid functional status, including any pre-existing loss or disabilities; review of available test results; review of previous therapies/interventions for the presenting diagnoses, and the functional changes (or lack thereof) as a result of previous therapies or interventions.
3. **Assessment:** Include a summary of the client's impairments, and functional limitations and disabilities, based on a synthesis of all findings gathered from the evaluation. Highlight



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pertinent factors which influence the treatment diagnosis and prognosis, and discuss the inter-relationship between the diagnoses and disabilities for which the referral was made should be discussed.

4. **Plan of Care:** A detailed Plan of Care must be included in the documentation of an initial evaluation. This care plan must include the following:
 - 4.1. Specific treatment goals for the entire episode of care which are functionally-based and objectively measured
 - 4.2. Proposed interventions/treatments to be provided during the episode of care
 - 4.3. Proposed duration and frequency of each service to be provided
 - 4.4. Estimated duration of episode of care.

An episode of “care” is defined as the period of time from the first day the patient is under the care of the clinician for the current condition(s) being treated by one therapy discipline until the last date of service for that plan of care for that discipline in that setting.

The therapist’s Plan of Care must be reviewed, revised if necessary, and signed, as medically necessary by the client’s physician, or other licensed practitioner of the healing arts within the practitioner’s scope of practice under state law at least once every 90 days. The care plan should not cover more than a 90-day period or the time frame documented in the Individual Family Service Plan (IFSP). (Senate bill 07-004 states the IFSP “shall qualify as meeting the standard for medically necessary services.” Therefore no physician is required to sign a work order for the IFSP.)

A plan of care must be certified. Certification is the physician’s, physician’s assistant or nurse practitioner’s approval of the plan of care. Certification requires a dated signature on the plan of care or some other document that indicates approval of the plan of care. If the service is a Medicare covered service and is provided to a recipient who is eligible for Medicare, the plan of care must be reviewed at the intervals required by Medicare.

RE-EVALUATION

A re-evaluation must be done whenever there is an unanticipated change in the client’s status, a failure to respond to interventions as expected or there is a need for a new Plan of Care based on new problems and goals that require significant changes to the Plan of Care. The documentation for a re-evaluation need not be as comprehensive as the initial evaluation, but must include at least the following:

1. Reason for re-evaluation
2. Client’s health and functional status reflecting any changes
3. Findings from any repeated or new examination elements
4. Changes to plan of care



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VISIT/ENCOUNTER NOTES:

Written documentation of each encounter must be in the client's record of service. These visit notes document the implementation of the plan of care established by the therapist at the initial evaluation. Each visit note must include the following:

1. The total duration of the encounter
2. The type and scope of treatment provided, including procedure codes and modifiers used.
3. The time spent providing each service. *The number of units billed/requested must match the documentation.*
4. Identification of the short or long term goals being addressed during the encounter.

Colorado Medicaid recommends but does not require that documentation follow the Subjective, Objective, Assessment and Plan (SOAP) format. In addition to the above required information, the visit note should include:

1. A *subjective* element which includes the reason for the visit, the client or caregiver's report of current status relative to treatment goals, and any changes in client's status since the last visit;
2. An *objective* element which includes the practitioner's findings, including abnormal and pertinent normal findings from any procedures or tests performed;
3. An *assessment* component which includes the practitioner's assessment of the client's response to interventions provided, specific progress made toward treatment goals, and any factors affecting the intervention or progression of goals, and
4. A *plan* component which states the plan for next visit(s).

DISCHARGE SUMMARY

At the conclusion of therapy services, a discharge summary must be included in the documentation of the final visit in an episode of care. This may include the following:

1. Highlights of a client's progress or lack of progress towards treatment goals
2. Summary of the outcome of services provided during the episode of care

RECORD RETENTION

Providers must maintain records that fully disclose the nature and extent of services provided. Upon request, providers must furnish information about payments claimed for Colorado Medical Assistance Program services. Records must match and support submitted claim information. Such records include but are not limited to:

1. Treatment plans
2. Prior authorization requests
3. Medical records and service reports
4. Records and original invoices for items, including drugs that are prescribed, ordered, or furnished
5. Claims, billings, and records of Colorado Medical Assistance Program payments and amounts received from other payers



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Each medical record entry must be signed and dated by the person ordering and providing the service. Computerized signatures and dates may be applied if the electronic record keeping system meets Colorado Medical Assistance Program security requirements. Records must be retained for at least six years or longer if required by regulation or a specific contract between the provider and the Colorado Medical Assistance Program.

Speech – Language and Hearing Services Offered Through Other Programs

This coverage standard describes outpatient therapy benefits only, and does not describe the benefits or regulations for any of the following programs.

SUPPORTED LIVING SERVICES WAIVER (SLS WAIVER)

1. Provides supported living services in the home or community to persons ages 18 or older, with developmental disabilities, supported living services in the home or community.
2. Case managers help determine client needs which may include hearing services.
3. Hearing aids are a covered benefit for adults under the specialized medical equipment and supplies portion of the waiver.

HOME HEALTH SERVICES

1. Speech/Language Pathology Home Health Services are a benefit available to all Medicaid clients when all program and services requirement described in 10 CCR 2505-10, Section 8.520 *et seq.* are met.
2. To be eligible for Long Term Home Health services, clients age 18 and over must meet the Level of Care Screening Guidelines for Long Term Care Services described at 10 CCR 2505-10, Section 8.401.

Non-Covered Services and General Limitations

1. Colorado Medicaid does not cover items and services which generally enhance the personal comfort of the eligible person but are not necessary in the diagnosis of, do not contribute meaningfully to the treatment of an illness or injury, or the functioning of a malformed body member.
2. Maintenance programs begin when the therapeutic goals of a treatment plan have been achieved and no further functional progress is apparent or expected to occur are **not** covered for adult clients.
3. Services provided without a written referral from a physician or other licensed practitioner of the healing arts within the practitioner's scope of practice under state law are not covered, unless they are covered by an IFSP.
4. Treatment of speech and language delays not associated with an acquired or chronic medical condition, neurological disorder, acute illness, injury, or congenital defect are not covered, unless they are covered by an IFSP



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5. Any service that is not determined by the provider to be medically necessary according to the definition of medical necessity in this document is not covered.
6. Hearing aids for adults are not a covered service.
7. Hearing exams and evaluations are a benefit for adults only when a concurrent medical condition exists.
8. Initial placement of cochlear implants for adults **is not covered**.
9. The upgrading of a cochlear implant system or component (e.g., upgrading processor from body worn to behind the ear, upgrading from single to multi-channel electrodes) of an existing properly functioning cochlear implant is not covered.
10. Services not documented in the client's Plan of Care are not covered.
11. Services specified in a plan of care that is not reviewed and revised as medically necessary by the client's attending physician or by an IFSP are not covered.
12. Services that are not designed to improve or maintain the functional status of a recipient with a physical loss or a cognitive or psychological deficit are not covered.
13. A rehabilitative and therapeutic service that is denied Medicare payment because of the provider's failure to comply with Medicare requirements is not covered.
14. Vocational or educational services, including functional evaluations, except as provided under IEP-related services are not covered.
15. Services provided by unsupervised therapy assistants as defined by ASHA are not covered.
16. Treatment is for dysfunction that is self-correcting (for example, natural dysfluency or developmental articulation errors) is not covered.
17. Psychosocial services are not covered.
18. Costs associated with record keeping documentation and travel time are not covered.
19. Training or consultation provided by an audiologist to an agency, facility, or other institution is not covered.
20. Therapy that replicates services that are provided concurrently by another type of therapy, particularly occupational therapy which should provide different treatment goals, plans, and therapeutic modalities is not covered.



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References

CRS 12-43.7 Speech-language Pathology Practice Act

CRS 25.5-5-102(2) and 25.5-5-202(3) - Amount, scope, and duration

42 CFR 440.230 - Amount, scope, and duration

42 CFR 440.110 – Services for individuals with speech, hearing, and language disorders

10 CCR 2505-10 § 8.076 – Medical Necessity

10 CCR 2505-10 § 8.200 – Physician Services

10 CCR 2505-10 § 8.290 – School Health Services

10 CCR 2505-10 § 8.520 – Home Health Services

10 CCR 2505-10 § 8.590 – Durable Medical Equipment & Disposable Supplies

Title IX, section 9101

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Medicaid Director Signature

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Date