COMMUNITY FIRST
HEALTH PLANS

Speech therapy resources for therapists and providers – Pre-Authorization

Initial evaluation requests must come from the PCP or relevant physician.

Requests for **initial speech therapy** visits must be pre-authorized and can be submitted by requesting agency. The evaluation/request must contain the following:

- Current MD signature (within the last 60 days of receipt)
- Diagnosis and reason for referral
- Medical history to include prior treatment history
- Member's primary language and other languages spoken at home
- The language in which therapy will be conducted
- A description of the member's current level of functioning including standard scores and/or criterion referenced age equivalency scores and descriptions of functional delay, behavior and participation. If no standard scores are reported, indicate why standardized testing was not appropriate. For members with speech delay, intelligibility to familiar listeners should also be reported.
- A clear diagnosis and reasonable prognosis
- A statement of the prescribed treatment modalities along with their recommended frequency/duration
- Short and long-term treatment goals, including baseline and mastery levels
- Individualized home exercise program including the responsible adult's expected ongoing involvement in the member's treatment
- Plan for collaboration with ECI, Head Start or SHARS when applicable
- Clearly established, member-specific discharge plan
- Current well child check and developmental screen (if not already on file)
- A scheduled appointment for hearing testing or the results of hearing testing

Requests for **continued speech therapy** visits must be pre-authorized and can be submitted by requesting agency. The re-evaluation must have been performed and dated within 30 days of the previous authorization expiration date and must be current within 60 days of receipt. The evaluation/request must contain the following:

- Current MD signature (within the last 60 days of receipt)
- Diagnosis and reason for referral
- Medical history to include prior treatment history
- Member's primary language and other languages spoken at home
- The language in which therapy will be conducted
- A description of the member's current level of functioning, including improvements towards functional goals resulting from therapy. Include standard scores and/or criterion-referenced

age equivalency scores as appropriate. If no standard scores are reported, indicate why standardized testing was not appropriate. For members with speech delay, intelligibility to familiar listeners, previous and current, should also be reported.

- A clear diagnosis and reasonable prognosis
- A statement of the prescribed treatment modalities along with their recommended frequency/duration
- Short and long-term treatment goals, including baselines, mastery levels and progress. This should include objective progress towards previous treatment goals
- Objective documentation of parental adherence/compliance with attendance to therapy sessions and participation with home exercise program
- Documentation of collaboration with ECI, Head Start or SHARS when applicable
- Clearly established, member-specific discharge plan
- Current well child check and developmental screen (if not already on file)
- Results of objective hearing testing

Quick reference for eligibility:

- Initial speech therapy visits *may* be approved for scores <78 or scaled scores of <6
- Continued speech therapy visits *may* be approved for scores of <80 or scaled scores of <6
- Intelligibility:
    - 18-23 months of age – speech therapy *may* be approved for intelligibility of <10% to familiar or unfamiliar listeners
    - 24-35 months of age – speech therapy *may* be approved for intelligibility of <30% to familiar or unfamiliar listeners
    - 36-47 months of age - speech therapy *may* be approved for intelligibility of <50% to familiar or unfamiliar listeners
    - 48+ months of age - speech therapy *may* be approved for intelligibility of <75% to familiar or unfamiliar listeners

DEFINITIONS:

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

To view the HHSC webinar on functional goal writing, click the following link, create a log-in and choose a password. Once logged in, search for "Writing Functional Goals Webinar".

https://learn.tmhp.com/