STATEMENT OF BASIS AND PURPOSE

1. Summary of the basis and purpose for the rule or rule change. (State what the rule says or does and explain why the rule or rule change is necessary).

Certain Speech Language Pathology (SLP) benefit documentation requirements are being revised to improve program fidelity by replacing permissive language with mandatory language. This revision is necessary to ensure provider documentation of a client's initial evaluation includes (1) an assessment of the factors which influence the treatment diagnosis and prognosis, and (2) a discussion of the inter-relationship between the diagnoses and disabilities for which the referral was made. In addition, care plans must cover a period no longer than 90 days or the time frame documented in the Individual Family Service Plan. Documentation must follow the Subjective, Objective, Assessment and Plan (SOAP) format for each visit and include a subjective element, an objective element, an assessment component, and a plan component. Mandatory documentation requirements are necessary for program integrity and compliance oversight. Revision also clarifies that payment for therapies provided as part of a client's school requirement are not separately billable to Medicaid. The Department reimburses school districts for SLP services rendered to clients. Providers rendering SLP services to clients as part of the school requirement are reimbursed by the school district and may not submit additional claims to the Department for reimbursement. Finally, the revision includes miscellaneous citation updates, terminology updates, and removal of obsolete language.

2. An emergency rule-making is imperatively necessary

☐ to comply with state or federal law or federal regulation and/or
☐ for the preservation of public health, safety and welfare.

Explain:

3. Federal authority for the Rule, if any:

42 USC 1396d(a)(11) / 42 CFR 440.110

4. State Authority for the Rule:

Sections 25.5-1-301 through 25.5-1-303, C.R.S. (2017);
Section 25.5-4-410, C.R.S. (2018)
REGULATORY ANALYSIS

1. Describe the classes of persons who will be affected by the proposed rule, including classes that will bear the costs of the proposed rule and classes that will benefit from the proposed rule.

Speech Language Pathology providers (SLP providers) and clients utilizing SLP services will be affected by the proposed rule. SLP providers will bear the cost of the mandatory documentation requirements. Clients will benefit from more robust documentation of services rendered. Moreover, the Department's compliance and oversight of the SLP benefit will improve as a result of mandatory documentation.

2. To the extent practicable, describe the probable quantitative and qualitative impact of the proposed rule, economic or otherwise, upon affected classes of persons.

SLP providers must invest time and resources into mandatory documentation requirements. Robust documentation of SLP services will qualitatively improve the recordkeeping of SLP services and the Department's ability to oversee program integrity. Moreover, clarifying reimbursement for SLP services rendered through the School Health Services Program (SHSP) will prohibit double-billing for such services.

3. Discuss the probable costs to the Department and to any other agency of the implementation and enforcement of the proposed rule and any anticipated effect on state revenues.

No costs to the Department or to any other agency to implement and enforce the proposed rule. No anticipated impact on state revenues.

4. Compare the probable costs and benefits of the proposed rule to the probable costs and benefits of inaction.

Cost of the proposed rule is increased documentation requirements for SLP providers. Benefits of the proposed rule include (1) robust SLP benefit utilization documentation, (2) improved SLP benefit compliance and enforcement oversight, and (3) prohibition of double-billing for SLP services rendered through the SHSP. Costs of inaction include (1) inability to enforce permissive SLP service documentation provisions and (2) potential double-billing of SLP services rendered through SHSP. There are no benefits to inaction.

5. Determine whether there are less costly methods or less intrusive methods for achieving the purpose of the proposed rule.
There are no less costly or less intrusive methods to require SLP service documentation or prohibit double-billing of SLP services rendered through SHSP.

6. Describe any alternative methods for achieving the purpose for the proposed rule that were seriously considered by the Department and the reasons why they were rejected in favor of the proposed rule.

There are no alternative methods for codifying the SLP service documentation requirements or prohibiting double-billing of SLP services rendered through SHSP.
8.200.3.D Physician Services Benefit Coverage Standards

Note: 8.200.3.D.1 Podiatry Services Benefit Coverage Standard was moved to §8.810 01/2015.

2. Speech – Language and Hearing Services Benefit Coverage Standard

a. ELIGIBLE PROVIDERS

i. Eligible providers include individual practitioners and those employed by home care agencies, children’s developmental service agencies, health departments, federally qualified health centers (FQHC), clinics, or hospital outpatient services.

ii. Otolaryngologists, speech-language pathologists (speech therapists), and audiologists shall have a current and active license or registration and be current, active and unrestricted to practice.

iii. Providers shall be enrolled as a Colorado Medicaid Health First Colorado provider in order to be eligible to bill for procedures, products and services in treating a Colorado Medicaid Health First Colorado client.

iv. Rendering Providers include:

1. Otolaryngologist

2. Speech-language pathologist

3. Speech-language pathology assistant

4. Clinical fellows

5. Audiologist

b. PROVIDER AGENCY REQUIREMENTS

i. Providers of in-home health who employ therapists or audiologists shall 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.

1ii. This rule does not apply to providers delivering Early Intervention Services under an Individual Family Service Plan (IFSP) and billing through contracts with the Community Centered Boards.
c. ELIGIBLE PLACES OF SERVICE

i. Eligible Places of Service shall include:

1. Office

2. Home

3. School

A. Therapies provided as part of a member’s school requirement are not separately reimbursable. These services are paid for by the school district which is reimbursed by the Department. Providers may not submit claims for therapy services performed as part of a member’s school requirement.

4. FQHC

5. Outpatient Hospital

6. Community Based Organization

d. ELIGIBLE CLIENTS

i. Eligible Clients include enrolled clients ages twenty (20) and under and adult clients who qualify under medically necessary services. Qualifying adult clients may receive services for non-chronic conditions and acute illness and injuries.

e. COVERED SERVICES

i. Newborn Screening

1. 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 & Diagnostic and Treatment (EPSDT) periodicity schedules.

ii. Early Language Intervention
1. Early language intervention for children 0 through three with a hearing loss may be provided by audiologists, speech therapists, or Colorado Home Intervention Program (CHIP) providers.

iii. Audiology Services

1. 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.

2. 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.
   a. Auditory sensitivity (including pure tone air and bone conduction, speech detection and speech reception thresholds).
   c. Impedance audiometry (tymanometry and acoustic reflex testing).
   d. Hearing aid evaluation (amplification selection and verification).
   e. Central auditory function.
   f. Evoked otoacoustic emissions.
   g. Brainstem auditory evoked response.
   h. Assessment of functional communicative skills to enhance the activities of daily living.
   i. Assessment for cochlear implants (for clients ages 20 and under).
   j. Hearing screening.
   k. Assessment of facial nerve function.
   l. Assessment of balance function.
   m. Evaluation of dizziness/vertigo.
3. Treatment – Service may include one or more of the following, as appropriate:

   a. Auditory training.

   b. Speech reading.

   c. 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.

   d. Purchase, maintenance, repairs and accessories for approved devices.

   e. Selection, testing and fitting of hearing aids for children with bilateral or unilateral hearing loss; and auditory training in the use of hearing aids.

   f. Purchase and training on Department approved assistive technologies.

   g. Balance or vestibular therapy.

iv. Cochlear Implants

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

   a. Six months of age or older.

   b. 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.

   c. Bilateral hearing loss with unaided pure tone average thresholds of 70 dB or greater.
d. 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.

e. Family support and motivation to participate in a post-cochlear aural, auditory and speech language rehabilitation program.

f. Assessment by an audiologist and otolaryngologist experienced in cochlear implants.

g. Bi lateral and hybrid/Electric Acoustic Stimulation cochlear implantation considered on a case by case basis.

h. No medical contraindications.

i. Up-to-date-immunization status as determined by the Advisory Committee on Immunization Practices (ACIP).

j. 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.

v. Speech-language Services

1. 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:

   a. Expressive language.

   b. Receptive language.

   c. Cognition.

   d. Augmentative and alternative communication.

   e. Voice disorder.

   f. Resonance patterns.
g. Articulation/phonological development.

h. Pragmatic language.

i. Fluency.

j. Feeding and swallowing.

k. Hearing status based on pass/fail criteria.

l. Motor speech.

m. Aural rehabilitation (defined by provider’s scope of practice).

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

a. Articulation/phonological therapy

b. Language therapy including expressive, receptive, and pragmatic language.

c. 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

d. Auditory processing/discrimination therapy

e. Fluency therapy.

f. Voice therapy.

g. Oral motor therapy.

h. Swallowing therapy.

i. Speech reading.


k. Necessary supplies and equipment.
f. DOCUMENTATION

i. General Requirements for Client’s Record of Service:

1. Rendering providers shall 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.

2. Documentation shall support both the medical necessity of services and the need for the level of skill provided.

3. Rendering providers shall copy the client’s prescribing provider and medical home/primary care provider on all relevant records.

ii. Documentation shall include all of the following:

1. The client’s 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.

iii. Documentation categories

1. Provider shall keep documentation for the following episodes of care: Initial Evaluation, Re-evaluation, Visit/Encounter Notes, and Discharge Summary.

2. Written documentation of the Initial Evaluation shall include the following:
a. The reason for the referral and reference source.

b. Diagnoses pertinent to the reason for referral, including:
   i. Date of onset;
   ii. Any cognitive, emotional, or physical loss necessitating referral, and the date of onset, if different from the onset of the relevant diagnoses;
   iii. Current functional limitation or disability as a result of the above loss, and the onset of the disability;
   iv. Pre-morbid functional status, including any pre-existing loss or disabilities;
   v. Review of available test results;
   vi. Review of previous therapies/interventions for the presenting diagnoses, and the functional changes (or lack thereof) as a result of previous therapies or interventions.

c. 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 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 must be discussed.

d. Plan of Care: A detailed Plan of Care must include the following
   i. Specific treatment goals for the entire episode of care which are functionally-based and objectively measured.

e. Proposed interventions/treatments to be provided during the episode of care.
f. Proposed duration and frequency of each service to be provided.

g. Estimated duration of episode of care.

7. 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 27-10.5-702(7), C.R.S. (2017) 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.)

8. 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.

9. 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: Reason for re-evaluation; Client’s health and functional status reflecting any changes; findings from any repeated or new examination elements; and, Changes to plan of care.

iv. Visit/Encounter Notes

1. 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:

a. The total duration of the encounter.

b. The type and scope of treatment provided, including procedure codes and modifiers used.

c. The time spent providing each service. The number of units billed/requested must match the documentation.

d. Identification of the short or long term goals being addressed during the encounter.

2. Documentation must 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:

a. 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;

b. An objective element which includes the practitioner’s findings, including abnormal and pertinent normal findings from any procedures or tests performed;

c. 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

d. A plan component which states the plan for next visit(s).

v. Discharge Summary
1. 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:

   a. Highlights of a client’s progress or lack of progress towards treatment goals.

   b. Summary of the outcome of services provided during the episode of care.

2. NON-COVERED SERVICES AND GENERAL LIMITATIONS

   i. Health First 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.

   ii. Maintenance programs beginning 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.

   iii. 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 Individual Family Service Plan (IFSP).

   iv. 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 Individual Family Service Plan (IFSP).

   v. Any service that is not determined by the provider to be medically necessary according to the definition of medical necessity in the Speech Language-Hearing Services Benefit Coverage Standard is not covered in Section 8.076.1.8.

   vi. Hearing aids for adults are not a covered service.

   vii. Hearing exams and evaluations are a benefit for adults only when a concurrent medical condition exists.

   viii. Initial placement of cochlear implants for adults is not covered.
ix. 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.

x. Services not documented in the client’s Plan of Care are not covered.

xi. 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.

xii. 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.

xiii. A rehabilitative and therapeutic service that is denied Medicare payment because of the provider’s failure to comply with Medicare requirements is not covered.

xiv. Vocational or educational services, including functional evaluations, except as provided under IEP-related services are not covered.

xv. Services provided by unsupervised therapy assistants as defined by the American Speech-Language Hearing Association (ASHA) are not covered.

xvi. Treatment for dysfunction that is self-correcting (for example, natural dysfluency or developmental articulation errors) is not covered.

xvii. Psychosocial services are not covered.

xviii. Costs associated with record keeping documentation and travel time are not covered.

xix. Training or consultation provided by an audiologist to an agency, facility, or other institution is not covered.

xx. Therapy that replicates services that are provided concurrently by another type of therapy is not covered. Particularly, occupational therapy which should provide different treatment goals, plans, and therapeutic modalities from speech therapy.