ARKANSAS DEPARTMENT OF HUMAN SERVICES

Division of Medical Services

Program Development & Quality Assurance

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TO: **Arkansas Medicaid Health Care Providers – Occupational, Physical, Speech Therapy Services**

DATE: **September 1, 2013**

SUBJECT: **Provider Manual Update Transmittal THERAPY-1-13**

REMOVE		**INSERT**	
Section	**Date**	**Section**	**Date**
214.300	11-1-10	214.300	9-1-13
214.310	8-1-11	214.310	9-1-13
214.320	8-1-11	214.320	9-1-13
214.400	11-1-11	214.400	9-1-13
214.410	1-1-13	214.410	9-1-13

Explanation of Updates

Section 214.300 is updated to clarify verbiage.

Section 214.310 is updated to include additional standardized occupational therapy tests.

Section 214.320 is updated to include additional standardized physical therapy tests.

Section 214.400 is updated to clarify verbiage.

Section 214.410 is updated to clarify verbiage and include additional standardized language tests.

The paper version of this update transmittal includes revised pages that may be filed in your provider manual. See Section I for instructions on updating the paper version of the manual. For electronic versions, these changes have already been incorporated.

If you have questions regarding this transmittal, please contact the HP Enterprise Services Provider Assistance Center at 1-800-457-4454 (Toll-Free) within Arkansas or locally and Out-of-State at (501) 376-2211.

If you need this material in an alternative format, such as large print, please contact the Program Development and Quality Assurance Unit at 501-320-6429.

Arkansas Medicaid provider manuals (including update transmittals), official notices, notices of rule making and remittance advice (RA) messages are available for downloading from the Arkansas Medicaid website: www.medicaid.state.ar.us.

Thank you for your participation in the Arkansas Medicaid Program.

Andrew Allison, PhD
Director

TOC not required

214.300 Occupational and Physical Therapy Guidelines for Retrospective Review 9-1-13

A. Medical Necessity

Occupational and physical therapy services must be medically necessary to the treatment of the individual's illness or injury. A diagnosis alone is not sufficient documentation to support the medical necessity of therapy. To be considered medically necessary, the following conditions must be met:

1. The services must be considered under accepted standards of practice to be a specific and effective treatment for the patient's condition.
2. The services must be of such a level of complexity or the patient's condition must be such that the services required can be safely and effectively performed only by or under the supervision of a qualified physical or occupational therapist.
3. There must be reasonable expectation that therapy will result in a meaningful improvement or a reasonable expectation that therapy will prevent a worsening of the condition. (See the medical necessity definition in the Glossary of this manual.)

B. Evaluations and Report Components

To establish medical necessity, a comprehensive assessment in the suspected area of deficit must be performed. A comprehensive assessment must include:

1. Date of evaluation.
2. Child's name and date of birth.
3. Diagnosis specific to therapy.
4. Background information including pertinent medical history; and, if the child is 12 months of age or younger, gestational age. The child should be tested in the child's dominant language; if not, an explanation must be provided in the evaluation.

   NOTE: To calculate a child's gestational age, subtract the number of weeks born before 40 weeks of gestation from the chronological age. Therefore, a 7-month-old, former 28 week gestational age infant has a corrected age of 4 months according to the following equation:

   7 months - [(40 weeks) - 28 weeks) / 4 weeks]

   7 months - [(12) / 4 weeks]

   7 months - [3]

   4 months
5. Standardized test results, including all subtest scores, if applicable. Test results must be reported as standard scores, Z scores, T scores or percentiles. Age-equivalent scores and percentage of delay cannot be used to qualify for services.
6. If applicable, test results should be adjusted for prematurity (less than 37 weeks gestation) if the child is 12 months of age or younger, and this should be noted in the evaluation.
7. Objective information describing the child's gross/fine motor abilities/deficits, e.g., range of motion measurements, manual muscle testing, muscle tone or a narrative description of the child's functional mobility skills (strengths and weaknesses).
8. An interpretation of the results of the evaluation, including recommendations for therapy/minutes per week.
9. A description of functional strengths and limitations, a suggested treatment plan and potential goals to address each identified problem.
10. Signature and credentials of the therapist performing the evaluation.

C. Interpretation and Eligibility: Ages Birth to 21

1. Tests used must be norm-referenced, standardized and specific to the therapy provided.
2. Tests must be age appropriate for the child being tested.
3. All subtests, components and scores must be reported for all tests used for eligibility purposes.
4. Eligibility for therapy will be based upon a score of -1.5 standard deviations (SD) below the mean or greater in at least one subtest area or composite score on a norm-referenced, standardized test. When a -1.5 SD or greater is not indicated by the test, a criterion-referenced test along with informed clinical opinion must be included to support the medical necessity of services.
5. If the child cannot be tested with a norm-referenced, standardized test, criterion-based testing or a functional description of the child's gross/fine motor deficits may be used. Documentation of the reason a standardized test could not be used must be included in the evaluation.
6. The *Mental Measurement Yearbook* (*MMY*) is the standard reference to determine reliability/validity. Refer to the Accepted Tests sections for a list of standardized tests accepted by Arkansas Medicaid for retrospective reviews.
7. Range of Motion: A limitation of greater than ten degrees and/or documentation of how a deficit limits function.
8. Muscle Tone: Modified Ashworth Scale.
9. Manual Muscle Test: A deficit is a muscle strength grade of fair (3/5) or below that impedes functional skills. With increased muscle tone, as in cerebral palsy, testing is unreliable.
10. Transfer Skills: Documented as the amount of assistance required to perform transfer, i.e., maximum, moderate or minimal assistance. A deficit is defined as the inability to perform a transfer safely and independently.
11. Children (birth to age 21) receiving services outside of the public schools must be evaluated annually.
12. Children (birth to age 2) in the Child Health Management Services (CHMS) program must be evaluated every 6 months.
13. Children (age three to 21) receiving services within public schools, as a part of an Individual Program Plan (IPP) or an Individual Education Plan (IEP), must have a full evaluation every three years; however, an annual update of progress is required. "School-related" means the child is of school age, attends public school and receives therapy provided by the school.

D. Frequency, Intensity and Duration of Physical and/or Occupational Therapy Services

The frequency, intensity and duration of therapy services should always be medically necessary and realistic for the age of the child and the severity of the deficit or disorder. Therapy is indicated if improvement will occur as a direct result of these services and if there is a potential for improvement in the form of functional gain.

1. Monitoring: May be used to ensure that the child is maintaining a desired skill level or to assess the effectiveness and fit of equipment such as orthotics and other durable medical equipment. Monitoring frequency should be based on a time interval that is reasonable for the complexity of the problem being addressed.
2. Maintenance Therapy: Services that are performed primarily to maintain range of motion or to provide positioning services for the patient do not qualify for physical or occupational therapy services. These services can be provided to the child as part of a home program implemented by the child's caregivers and do not necessarily require the skilled services of a physical or occupational therapist to be performed safely and effectively.

3. Duration of Services: Therapy services should be provided as long as reasonable progress is made toward established goals. If reasonable functional progress cannot be expected with continued therapy, then services should be discontinued and monitoring or establishment of a home program should be implemented.

E. Progress Notes

1. Child's name.
2. Date of service.
3. Time in and time out of each therapy session.
4. Objectives addressed (should coincide with the plan of care).
5. A description of specific therapy services provided daily and the activities rendered during each therapy session, along with a form measurement.
6. Progress notes must be legible.
7. Therapists must sign each date of entry with a full signature and credentials.
8. Graduate students must have the supervising physical therapist or occupational therapist co-sign progress notes.

214.310 Accepted Tests for Occupational Therapy 9-1-13

Tests used must be norm-referenced, standardized, age appropriate and specific to the suspected area(s) of deficit. The following list of tests is not all-inclusive. When using a test that is not listed below, the provider must include an explanation and justification in the evaluation report to support the use of the chosen test. The *Mental Measurement Yearbook (MMY)* is the standard reference for determining the reliability and validity of the test(s) administered in an evaluation. Providers should refer to the *MMY* for additional information regarding specific tests. These definitions are applied to the lists of accepted tests:

- STANDARDIZED: Tests that are used to determine the presence or absence of deficits; any diagnostic tool or procedure that has a standardized administration and scoring process and compares results to an appropriate normative sample.
- SUPPLEMENTAL: Tests and tools that are used to further document deficits and support standardized results; any non-diagnostic tool that is a screening or is criterion-referenced, descriptive in design, a structured probe or an accepted clinical assessment procedure. Supplemental tests may not replace standardized tests.
- CLINICAL OBSERVATIONS: Clinical observations have a supplemental role in the evaluation process and should always be included. They are especially important when standard scores do not accurately reflect a child's deficits in order to qualify the child for therapy. A detailed narrative or description of a child's limitations and how they affect functional performance may constitute the primary justification of medical necessity when a standardized evaluation is inappropriate (see Section 214.400, part D, paragraph 8).

A. Occupational Therapy Tests — Standardized

Test	Abbreviation
Adaptive Behavior Scale — School Edition	ABS-S
Ashworth Scale	
Box & Block Test of Manual Dexterity	BBT
Bruininks-Oseretsky Test of Motor Proficiency	BOMP
Bruininks-Oseretsky Test of Motor Proficiency — Second Edition	BOT-2
Children's Handwriting Evaluation Scale	CHES
Cognitive Performance Test	CPT

Test	Abbreviation
DeGangi-Berk Test of Sensory Integration	TSI
Developmental Test of Visual Motor Integration	VMI
Developmental Test of Visual Perception, Second Edition	DTVP
Evaluation Tool of Children's Handwriting	ETCH
Functional Independence Measure — young version	WeeFIM
Functional Independence Measure — 7 years of age to adult	FIM
Jacobs Prevocational Skills Assessment	
Kohlman Evaluation of Living Skills	KELS
Milwaukee Evaluation of Daily Living Skills	MEDLS
Motor Free Visual Perception Test	MVPT
Motor Free Visual Perception Test — Revised	MVPT-R
Mullen Scales of Early Learning **NOTE: Although the MSEL is an accepted standardized test, it is felt by the Therapy Advisory Council (TAC) that an additional test should be administered.**	MSEL
Peabody Developmental Motor Scales	PDMS
Peabody Developmental Motor Scales — 2	PDMS-2
Pediatric Evaluation of Disability Inventory **NOTE: The PEDI can also be used for older children whose functional abilities fall below that expected of a 7 ½ year old with no disabilities. In this case, the scaled score is the most appropriate score to consider.**	PEDI
Purdue Pegboard Test	
Range of Motion	ROM
Sensory Integration and Praxis Test	SIPT
Sensory Integration Inventory Revised	SII-R
Sensory Processing Measure	SPM
Sensory Processing Measure—Preschool	SPM-P
Sensory Profile, Adolescent/Adult	
Sensory Profile, Infant/Toddler	
Sensory Profile	
Sensory Profile School Companion	
Test of Handwriting Skills	THS
Test of Infant Motor Performance	TIMP
Test of Visual Motor Integration	TVMI
Test of Visual Motor Skills	TVMS
Test of Visual Motor Skills — R	TVMS-R
Test of Visual Perceptual Skills	TVPS

Test	Abbreviation
Test of Visual Perceptual Skills — Upper Level	TVPS
Toddler and Infant Motor Evaluation	TIME
Wide Range Assessment of Visual Motor Abilities	WRAVMA

B. Occupational Therapy Tests — Supplemental

Test	Abbreviation
Analysis of Sensory Behavior Inventory	
Battelle Developmental Inventory	BDI
Bay Area Functional Performance Evaluation	BaFPE
Brigance Developmental Inventory	BDI
Developmental Assessment of Young Children	DAYC
Early Learning Accomplishment Profile	E-LAP
Erhardt Developmental Prehension Assessment	EDPA
Functional Profile	
Goodenough Harris Draw a Person Scale Test	
Grip and Pinch Strength	
Hawaii Early Learning Profile	HELP
Jordan Left-Right Reversal Test	JLRRT
Knox Preschool Play Scale	
Learning Accomplishment Profile	LAP
Manual Muscle Test	MMT
Miller Assessment for Preschoolers	MAP
School Function Assessment	SFA
Sensorimotor Performance Analysis	SPA
Sensory Integration Inventory	SII
Social Skills Rating System	SSRS

214.320 Accepted Tests for Physical Therapy 9-1-13

Tests used must be norm-referenced, standardized, age appropriate and specific to the suspected area(s) of deficit. The following list of tests is not all-inclusive. When using a test that is not listed below, the provider must include an explanation and justification in the evaluation report to support the use of the chosen test. The *Mental Measurement Yearbook (MMY)* is the standard reference for determining the reliability and validity of the tests administered in an evaluation. Providers should refer to the *MMY* for additional information regarding specific tests. These definitions are applied to the following lists of accepted tests:

- STANDARDIZED: Tests that are used to determine the presence or absence of deficits; any diagnostic tool or procedure that has a standardized administration and scoring process and compares the results to an appropriate normative sample.

- SUPPLEMENTAL: Tests and tools that are used to further document deficits and support standardized results; any non-diagnostic tool that is a screening or is criterion-referenced, descriptive in design, a structured probe or an accepted clinical assessment procedure. Supplemental tests may not replace standardized tests.
- CLINICAL OBSERVATIONS: Clinical observations have a supplemental role in the evaluation process and should always be included. They are especially important when standard scores do not accurately reflect a child's deficits in order to qualify the child for therapy. A detailed narrative or description of a child's limitations and how they affect functional performance may constitute the primary justification of medical necessity when a standardized evaluation is inappropriate (see Section 214.400, part D, paragraph 8).

A. Physical Therapy Tests — Standardized

Test	**Abbreviation**
Alberta Infant Motor Scale	AIMS
Adaptive Behavior Inventory	ABI
Adaptive Behavior Scale — School, Second Edition	ABS-S:2
Ashworth Scale	
Assessment of Adaptive Areas	AAA
Bruininks-Oseretsky test of Motor Proficiency	BOMP
Bruininks-Oseretsky Test of Motor Proficiency, Second Edition	BOT-2
Comprehensive Trail-Making Test	CTMT
Functional Independence Measure for Children	WeeFIM
Functional Independence Measure — 7 years of age to adult	FIM
Gross Motor Function Measure	GMFM
Movement Assessment Battery for Children	Movement ABC
Mullen Scales of Early Learning **NOTE: Although the MSEL is an accepted standardized test, it is felt by the Therapy Advisory Council (TAC) that an additional test should be administered.**	MSEL
Peabody Developmental Motor Scales	PDMS
Peabody Developmental Motor Scales, Second Edition	PDMS-2
Pediatric Balance Scale	PBS
Pediatric Evaluation of Disability Inventory **NOTE: The PEDI can also be used for older children whose functional abilities fall below that expected of a 7 ½ year old with no disabilities. In this case, the scaled score is the most appropriate score to consider.**	PEDI
Range of Motion — Functional Performance Impairments	ROM
Sensory Processing Measure	SPM
Sensory Processing Measure-Preschool	SPM-P
Test of Infant Motor Performance	TIMP
Test of Gross Motor Development, Second Edition	TGMD-2

Test	Abbreviation
Toddler and Infant Motor Evaluation	

B. Physical Therapy Tests — Supplemental

Test	Abbreviation
Battelle Developmental Inventory	BDI
Bayley Scales of Infant Development, Second Edition	BSID-2
Brigance Developmental Inventory	BDI
Developmental Assessment for Students with Severe Disabilities, Second Edition	DASH-2
Developmental Assessment of Young Children	DAYC
Early Learning Accomplishment Profile	E-LAP
Hawaii Early Learning Profile	HELP
Learning Accomplishment Profile	LAP
Manual Muscle Test	MMT
Milani-Comparetti Developmental Examination	
Miller Assessment for Preschoolers	MAP
Neonatal Behavioral Assessment Scale	NBAS

C. Physical Therapy Tests — Piloted

Test	Abbreviation
Assessment for Persons Profoundly or Severely Impaired	APPSI

214.400 Speech-Language Therapy Guidelines for Retrospective Review 9-1-13

A. Medical Necessity

Speech-language therapy services must be medically necessary to the treatment of the individual's illness or injury. A diagnosis alone is not sufficient documentation to support the medical necessity of therapy. To be considered medically necessary, the following conditions must be met:

1. The services must be considered under accepted standards of practice to be a specific and effective treatment for the patient's condition.
2. The services must be of such a level of complexity or the patient's condition must be such that the services required can be safely and effectively performed only by or under the supervision of a qualified speech and language pathologist.
3. There must be a reasonable expectation that therapy will result in meaningful improvement or a reasonable expectation that therapy will prevent a worsening of the condition. (See the medical necessity definition in the Glossary of this manual.)

B. Types of Communication Disorders

1. Language Disorders — Impaired comprehension and/or use of spoken, written and/or other symbol systems. This disorder may involve the following components:

forms of language (phonology, morphology, syntax), content and meaning of language (semantics, prosody), function of language (pragmatics) and/or the perception/processing of language. Language disorders may involve one, all or a combination of the above components.

2. Speech Production Disorders — Impairment of the articulation of speech sounds, voice and/or fluency. Speech Production disorders may involve one, all or a combination of these components of the speech production system.

   An articulation disorder may manifest as an individual sound deficiency, i.e., traditional articulation disorder, incomplete or deviant use of the phonological system, i.e., phonological disorder, or poor coordination of the oral-motor mechanism for purposes of speech production, i.e., verbal and/or oral apraxia, dysarthria.

3. Oral Motor/Swallowing/Feeding Disorders — Impairment of the muscles, structures and/or functions of the mouth (physiological or sensory-based) involved with the entire act of deglutition from placement and manipulation of food in the mouth through the oral and pharyngeal phases of the swallow. These disorders may or may not result in deficits to speech production.

C. Evaluation and Report Components

1. STANDARDIZED SCORING KEY:

   Mild: Scores between 84-78; -1.0 standard deviation

   Moderate: Scores between 77-71; -1.5 standard deviations

   Severe: Scores between 70-64; -2.0 standard deviations

   Profound: Scores of 63 or lower; -2.0+ standard deviations

2. LANGUAGE: To establish medical necessity, results from a comprehensive assessment in the suspected area of deficit must be reported. (Refer to Section 214.400, part D, paragraphs 9-12 for required frequency of re-evaluations.) A comprehensive assessment for Language disorder must include:

   a. Date of evaluation.
   b. Child's name and date of birth.
   c. Diagnosis specific to therapy.
   d. Background information including pertinent medical history; and, if the child is 12 months of age or younger, gestational age. The child should be tested in the child's dominant language; if not, an explanation must be provided in the evaluation.

      NOTE: To calculate a child's gestational age, subtract the number of weeks born before 40 weeks of gestation from the chronological age. Therefore, a 7-month-old, former 28 week gestational age infant has a corrected age of 4 months according to the following equation:

      7 months - [(40 weeks) - 28 weeks) / 4 weeks]

      7 months - [(12) / 4 weeks]

      7 months - [3]

      4 months

   e. Results from an assessment specific to the suspected type of language disorder, including all relevant scores, quotients and/or indexes, if applicable. A comprehensive measure of language must be included for initial evaluations. Use of one-word vocabulary tests alone will not be accepted. (Review Section 214.410 — Accepted Tests for Speech-Language Therapy.)
   f. If applicable, test results should be adjusted for prematurity (less than 37 weeks gestation) if the child is 12 months of age or younger, and this should be noted in the evaluation.
   g. Oral-peripheral speech mechanism examination, which includes a description

of the structure and function of the orofacial structures.

h. Formal or informal assessment of hearing, articulation, voice and fluency skills.

i. An interpretation of the results of the evaluation including recommendations for frequency and intensity of treatment.

j. A description of functional strengths and limitations, a suggested treatment plan and potential goals to address each identified problem.

k. Signature and credentials of the therapist performing the evaluation.

3. SPEECH PRODUCTION (Articulation, Phonological, Apraxia): To establish medical necessity, results from a comprehensive assessment in the suspected area of deficit must be reported. (Refer to Section 214.400, part D, paragraphs 9-12 for required frequency of re-evaluations.) A comprehensive assessment for Speech Production (Articulation, Phonological, Apraxia) disorder must include:

a. Date of evaluation.

b. Child's name and date of birth.

c. Diagnosis specific to therapy.

d. Background information including pertinent medical history; and, if the child is 12 months of age or younger, gestational age. The child should be tested in the child's dominant language; if not, an explanation must be provided in the evaluation.

NOTE: To calculate a child's gestational age, subtract the number of weeks born before 40 weeks of gestation from the chronological age. Therefore, a 7-month-old, former 28 week gestational age infant has a corrected age of 4 months according to the following equation:

7 months - [(40 weeks) - 28 weeks) / 4 weeks]

7 months - [(12) / 4 weeks]

7 months - [3]

4 months

e. Results from an assessment specific to the suspected type of speech production disorder, including all relevant scores, quotients and/or indexes, if applicable. All errors specific to the type of speech production disorder must be reported (e.g., positions, processes, motor patterns). (Review Section 214.410 — Accepted Tests for Speech-Language Therapy.)

f. If applicable, test results should be adjusted for prematurity (less than 37 weeks gestation) if the child is 12 months of age or younger, and this should be noted in the evaluation.

g. Oral-peripheral speech mechanism examination, which includes a description of the structure and function of orofacial structures.

h. Formal screening of language skills. Examples include, but are not limited to, the Fluharty-2, KLST-2, CELF-4 Screen or TTFC.

i. Formal or informal assessment of hearing, voice and fluency skills.

j. An interpretation of the results of the evaluation, including recommendations for frequency and intensity of treatment.

k. A description of functional strengths and limitations, a suggested treatment plan and potential goals to address each identified problem.

l. Signature and credentials of the therapist performing the evaluation.

4. SPEECH PRODUCTION (Voice): To establish medical necessity, results from a comprehensive assessment in the suspected area of deficit must be reported. (Refer to Section 214.400, part D, paragraphs 9-12 for required frequency of re-evaluations.) A comprehensive assessment for Speech Production (Voice) disorder must include:

a. A medical evaluation to determine the presence or absence of a physical etiology is not a prerequisite for evaluation of voice disorder; however, it is required for the initiation of treatments related to the voice disorder. See Section 214.400 D4.
b. Date of evaluation.
c. Child's name and date of birth.
d. Diagnosis specific to therapy.
e. Background information including pertinent medical history; and, if the child is 12 months of age or younger, gestational age. The child should be tested in the child's dominant language; if not, an explanation must be provided in the evaluation.

NOTE: To calculate a child's gestational age, subtract the number of weeks born before 40 weeks of gestation from the chronological age. Therefore, a 7-month-old, former 28 week gestational age infant has a corrected age of 4 months according to the following equation:

7 months - [(40 weeks) - 28 weeks) / 4 weeks]

7 months - [(12) / 4 weeks]

7 months - [3]

4 months

f. Results from an assessment relevant to the suspected type of speech production disorder, including all relevant scores, quotients and/or indexes, if applicable. (Review Section 214.410 — Accepted Tests for Speech-Language Therapy.)
g. If applicable, test results should be adjusted for prematurity (less than 37 weeks gestation) if the child is 12 months of age or younger, and this should be noted in the evaluation.
h. Oral-peripheral speech mechanism examination, which includes a description of the structure and function of orofacial structures.
i. Formal screening of language skills. Examples include, but are not limited to, the Fluharty-2, KLST-2, CELF-4 Screen or TTFC.
j. Formal or informal assessment of hearing, articulation and fluency skills.
k. An interpretation of the results of the evaluation, including recommendations for frequency and intensity of treatment.
l. A description of functional strengths and limitations, a suggested treatment plan and potential goals to address each identified problem.
m. Signature and credentials of the therapist performing the evaluation.

5. SPEECH PRODUCTION (Fluency): To establish medical necessity, results from a comprehensive assessment in the suspected area of deficit must be reported. (Refer to Section 214.400, part D, paragraphs 9-12 for required frequency of re-evaluations.) A comprehensive assessment for Speech Production (Fluency) disorder must include:

a. Date of evaluation.
b. Child's name and date of birth.
c. Diagnosis specific to therapy.
d. Background information including pertinent medical history; and, if the child is 12 months of age or younger, gestational age. The child should be tested in the child's dominant language; if not, an explanation must be provided in the evaluation.

NOTE: To calculate a child's gestational age, subtract the number of weeks born before 40 weeks of gestation from the chronological

age. Therefore, a 7-month-old, former 28 week gestational age infant has a corrected age of 4 months according to the following equation:

7 months - [(40 weeks) - 28 weeks) / 4 weeks]

7 months - [(12) / 4 weeks]

7 months - [3]

4 months

e. Results from an assessment specific to the suspected type of speech production disorder, including all relevant scores, quotients and/or indexes, if applicable. (Review Section 214.410 — Accepted Tests for Speech-Language Therapy.)

f. If applicable, test results should be adjusted for prematurity (less than 37 weeks gestation) if the child is 12 months of age or younger, and this should be noted in the evaluation.

g. Oral-peripheral speech mechanism examination, which includes a description of the structure and function of orofacial structures.

h. Formal screening of language skills. Examples include, but are not limited to, the Fluharty-2, KLST-2, CELF-4 Screen or TTFC.

i. Formal or informal assessment of hearing, articulation and voice skills.

j. An interpretation of the results of the evaluation, including recommendations for frequency and intensity of treatment.

k. A description of functional strengths and limitations, a suggested treatment plan and potential goals to address each identified problem.

l. Signature and credentials of the therapist performing the evaluation.

6. ORAL MOTOR/SWALLOWING/FEEDING: To establish medical necessity, results from a comprehensive assessment in the suspected area of deficit must be reported. (Refer to Section 214.400, part D, paragraphs 9-12 for required frequency of re-evaluations.) A comprehensive assessment for Oral Motor/Swallowing/Feeding disorder must include:

a. Date of evaluation.

b. Child's name and date of birth.

c. Diagnosis specific to therapy.

d. Background information including pertinent medical history; and, if the child is 12 months of age or younger, gestational age. The child should be tested in the child's dominant language; if not, an explanation must be provided in the evaluation.

NOTE: To calculate a child's gestational age, subtract the number of weeks born before 40 weeks of gestation from the chronological age. Therefore, a 7-month-old, former 28 week gestational age infant has a corrected age of 4 months according to the following equation:

7 months - [(40 weeks) - 28 weeks) / 4 weeks]

7 months - [(12) / 4 weeks]

7 months - [3]

4 months

e. Results from an assessment specific to the suspected type of oral motor/swallowing/feeding disorder, including all relevant scores, quotients and/or indexes, if applicable. (See Section 214.410 — Accepted Tests for Speech-Language Therapy.)

f. If swallowing problems and/or signs of aspiration are noted, then include a

statement indicating that a referral for a videofluoroscopic swallow study has been made.

g. If applicable, test results should be adjusted for prematurity (less than 37 weeks gestation) if the child is 12 months of age or younger, and this should be noted in the evaluation.

h. Formal or informal assessment of hearing, language, articulation voice and fluency skills.

i. An interpretation of the results of the evaluation, including recommendations for frequency and intensity of treatment.

j. A description of functional strengths and limitations, a suggested treatment plan and potential goals to address each identified problem.

k. Signature and credentials of the therapist performing the evaluation.

D. Interpretation and Eligibility: Ages Birth to 21

1. LANGUAGE: Two language composite or quotient scores (i.e., normed or standalone) in the area of suspected deficit must be reported, with at least one being a norm-referenced, standardized test with good reliability and validity. (Use of two one-word vocabulary tests alone will not be accepted.)

   a. For children age birth to three: criterion-referenced tests will be accepted as a second measure for determining eligibility for language therapy.

   b. For children age three to 21: criterion-referenced tests will not be accepted as a second measure when determining eligibility for language therapy. (When use of standardized instruments is not appropriate, see Section 214.400, part D, paragraph 8).

   c. Age birth to three: Eligibility for language therapy will be based upon a composite or quotient score that is -1.5 standard deviations (SD) below the mean or greater from a norm-referenced, standardized test, with corroborating data from a criterion-referenced measure. When these two measures do not agree, results from a third measure that corroborate the identified deficits are required to support the medical necessity of services.

   d. Age three to 21: Eligibility for language therapy will be based upon 2 composite or quotient scores from 2 tests, with at least 1 composite or quotient score on each test that is -1.5 standard deviations (SD) below the mean or greater. When -1.5 SD or greater is not indicated by both of these scores, a third standardized score indicating a -1.5 SD or greater is required to support the medical necessity of services.

2. ARTICULATION AND/OR PHONOLOGY: Two tests and/or procedures must be administered, with at least one being from a norm-referenced, standardized test with good reliability and validity.

   Eligibility for articulation and/or phonological therapy will be based upon standard scores (SS) of -1.5 SD or greater below the mean from two tests. When -1.5 SD or greater is not indicated by both of these tests, corroborating data from accepted procedures can be used to support the medical necessity of services (review Section 214.410 — Accepted Tests for Speech-Language Therapy).

3. APRAXIA: Two tests and/or procedures must be administered, with at least one being a norm-referenced, standardized test with good reliability and validity.

   Eligibility for apraxia therapy will be based upon standard scores (SS) of -1.5 SD or greater below the mean from two tests. When -1.5 SD or greater is not indicated by both of these tests, corroborating data from a criterion-referenced test and/or accepted procedures can be used to support the medical necessity of services (review Section 214.410 — Accepted Tests for Speech-Language Therapy).

4. VOICE: Due to the high incidence of medical factors that contribute to voice deviations, a medical evaluation is a requirement for eligibility for voice therapy.

Eligibility for voice therapy will be based upon a medical referral for therapy and a functional profile of voice parameters that indicates a moderate or severe deficit/disorder.

5. FLUENCY: At least one norm-referenced, standardized test with good reliability and validity, and at least one supplemental tool to address affective components.

   Eligibility for fluency therapy will be based upon an SS of -1.5 SD below the mean or greater on the standardized test.

6. ORAL MOTOR/SWALLOWING/FEEDING: An in-depth, functional profile of oral motor structures and function.

   Eligibility for oral-motor/swallowing/feeding therapy will be based upon an in-depth functional profile of oral motor structures and function using a thorough protocol (e.g., checklist, profile) that indicates a moderate or severe deficit or disorder. When moderate or severe aspiration has been confirmed by a videofluoroscopic swallow study, the patient can be treated for pharyngeal dysphagia via the recommendations set forth in the swallow study report.

7. All subtests, components and scores used for eligibility purposes must be reported.
8. When administration of standardized, norm-referenced instruments is inappropriate, the provider must submit an in-depth functional profile of the child's communication abilities. An in-depth functional profile is a detailed narrative or description of a child's communication behaviors that specifically explains and justifies the following:
   a. The reason standardized testing is inappropriate for this child,
   b. The communication impairment, including specific skills and deficits, and
   c. The medical necessity of therapy.
   d. Supplemental instruments from Accepted Tests for Speech-Language Therapy may be useful in developing an in-depth functional profile.
9. Children (birth to age 21) receiving services outside of the schools must be evaluated annually.
10. Children (birth to 24 months) in the Child Health Management Services (CHMS) Program must be evaluated every 6 months.
11. Children (age three to 21) receiving services within schools as part of an Individual Program Plan (IPP) or an Individual Education Plan (IEP) must have a full evaluation every three years; however, an annual update of progress is required. "School-related" means the child is of school age, attends public school and receives therapy provided by the school.
12. Children (age three to 21) receiving privately contracted services, apart from or in addition to those within the schools, must have a full evaluation annually.
13. IQ scores are required for all children who are school age and receiving language therapy. Exception: IQ scores are not required for children under ten (10) years of age.

E. Progress Notes

1. Child's name.
2. Date of service.
3. Time in and time out of each therapy session.
4. Objectives addressed (should coincide with the plan of care).
5. A description of specific therapy services provided daily and the activities rendered during each therapy session, along with a form of measurement.
6. Progress notes must be legible.
7. Therapists must sign each date of the entry with a full signature and credentials.
8. Graduate students must have the supervising speech-language pathologist co-sign progress notes.

214.410 Accepted Tests for Speech-Language Therapy 9-1-13

Tests used must be norm-referenced, standardized, age appropriate and specific to the disorder being assessed. The following list of tests is not all-inclusive. When using a test that is not listed below, the provider must include an explanation and justification in the evaluation report to support the use of the chosen test. The *Mental Measurement Yearbook (MMY)* is the standard reference to determine the reliability and validity of the test(s) administered in the evaluation. Providers should refer to the *MMY* for additional information regarding specific tests. These definitions are applied to the following lists of accepted tests:

- STANDARDIZED: Tests that are used to determine the presence or absence of deficits; any diagnostic tool or procedure that has a standardized administration and scoring process and compares results to an appropriate normative sample.
- SUPPLEMENTAL: Tests and tools that are used to further document deficits and support standardized results; any non-diagnostic tool that is a screening, a criterion-referenced measure, descriptive in design, a structured probe or an accepted clinical analysis procedure (see next paragraph). Supplemental tests may not replace standardized tests. Exception: A tool(s) from a supplemental list may be used to guide data collection for the purpose of generating an in-depth, functional profile. See Section 214.400, part D, paragraph 8.
- CLINICAL ANALYSIS PROCEDURES: Specific analysis methods used for in-depth examination of clinical data obtained during assessment and used to further document deficits and support standardized results. Clinical analysis procedures may not replace standardized tests. Exception: Procedures from this list may be used to analyze data collected and assist in generating an in-depth, functional profile. (See Section 214.400, part D, paragraph 8.)
- CLINICAL OBSERVATIONS: Clinical observations have a supplemental role in the evaluation process and should always be included. They are especially important when standard scores do not accurately reflect a child's deficits in order to qualify the child for therapy. A detailed narrative or description of the child's communication behaviors (in-depth, functional profile) may constitute the primary justification of medical necessity.
- STANDARDIZED SCORING KEY:

  Mild: Scores between 84-78; -1.0 standard deviation

  Moderate: Scores between 77-71; -1.5 standard deviations

  Severe: Scores between 70-64; -2.0 standard deviations

  Profound: Scores of 63 or lower; -2.0+ standard deviations

A. Language Tests — Standardized (Newer editions of currently listed tests are also acceptable.)

Test	Abbreviation
Assessment of Language-Related Functional Activities	ALFA
Assessment of Literacy and Language	ALL
Behavior Rating Inventory of Executive Function	BRIEF
Behavioural Assess of the Dysexecutive Syndrome for Children	BADS-C
Brief Test of Head Injury	BTHI
Children's Communication Checklist [Diagnostic for pragmatics]	CCC
Clinical Evaluation of Language Fundamentals — Preschool	CELF-P
Clinical Evaluation of Language Fundamentals, Fourth Edition	CELF-4

Test	Abbreviation
Clinical Evaluation of Language Fundamentals, Third Edition	CELF-3
Communication Abilities Diagnostic Test	CADeT
Communication Activities of Daily Living, Second Edition	CADL-2
Comprehensive Assessment of Spoken Language	CASL
Comprehensive Receptive and Expressive Vocabulary Test, Second Edition	CREVT-2
Comprehensive Test of Phonological Processing	CTOPP
Diagnostic Evaluation of Language Variation — Norm-Referenced	DELV-NR
Emerging Literacy and Language Assessment	ELLA
Expressive Language Test	ELT
Expressive One-Word Picture Vocabulary Test, 2000 Edition	EOWPVT
Fullerton Language Test for Adolescents, Second Edition	FLTA
Goldman-Fristoe-Woodcock Test of Auditory Discrimination	GFWTAD
HELP Test-Elementary	HELP
Illinois Test of Psycholinguistic Abilities, Third Edition	ITPA-3
Language Processing Test — Revised	LPT-R
Language Processing Test, Third Edition	LPT-3
Listening Comprehension Test Adolescent	LCT-A
Listening Comprehension Test, Second Edition	LCT-2
Montgomery Assessment of Vocabulary Acquisition	MAVA
Mullen Scales of Early Learning **NOTE: Although the MSEL is an accepted standardized test, it is felt by the Therapy Advisory Council (TAC) that an additional test should be administered.**	MSEL
Oral and Written Language Scales	OWLS
Peabody Picture Vocabulary Test, Fourth Edition	PPVT-4
Peabody Picture Vocabulary Test, Third Edition	PPVT-3
Phonological Awareness Test	PAT
Preschool Language Scale, Fourth Edition	PLS-4
Preschool Language Scale, Third Edition	PLS-3
Receptive One-Word Picture Vocabulary Test, Second Edition	ROWPVT-2
Receptive-Expressive Emergent Language Test, Second Edition	REEL-2
Receptive-Expressive Emergent Language Test, Third Edition	REEL-3
Ross Information Processing Assessment — Primary	RIPA-P
Ross Information Processing Assessment, Second Edition	RIPA-2
Scales of Cognitive Ability for Traumatic Brain Injury	SCATBI
Social Competence and Behavior Evaluation, Preschool Edition	SCBE

Test	Abbreviation
Social Language Development Test—Adolescent	SLDT-A
Social Language Development Test—Elementary	SLDT-E
Social Responsiveness Scale	SRS
Social Skills Rating System — Preschool & Elementary Level	SSRS-PE
Social Skills Rating System — Secondary Level	SSRS-S
Strong Narrative Assessment Procedure	SNAP
Structured Photographic Expressive Language Test	SPELT-3
Test of Adolescent and Adult Language, Third Edition	TOAL-3
Test of Adolescent /Adult Word Finding	TAWF
Test for Auditory Comprehension of Language, Third Edition	TACL-3
Test of Auditory Perceptual Skills — Revised	TAPS-R
Test of Auditory Perceptual Skills, Third Edition	TAPS-3
Test of Auditory Reasoning and Processing Skills	TARPS
Test of Early Communication and Emerging Language	TECEL
Test of Early Language Development, Third Edition	TELD-3
Test of Language Competence — Expanded Edition	TLC-E
Test of Language Development — Intermediate, Third Edition	TOLD-I:3
Test of Language Development — Primary, Third Edition	TOLD-P:3
Test of Narrative Language	TNL
Test of Phonological Awareness	TOPA
Test of Pragmatic Language	TOPL
Test of Pragmatic Language, Second Edition	TOPL-2
Test of Problem Solving — Adolescent	TOPS-A
Test of Problem Solving — Revised Elementary	TOPS-R
Test of Reading Comprehension, Third Edition	TORC-2
Test of Semantic Skills: Intermediate	TOSS-I
Test of Semantic Skills: Primary	TOSS-P
Test of Word Finding, Second Edition	TWF-2
Test of Word Knowledge	TOWK
Test of Written Language, Third Edition	TWL-3
The Listening Test	
Wepman's Auditory Discrimination Test, Second Edition	ADT
Word Test — 2 Adolescent	WT2A
Word Test — 2 Elementary	WT2E

B. Language Tests — Supplemental

Test	Abbreviation
Assessment for Persons Profoundly or Severely Impaired	APPSI
Behavior Analysis Language Instrument	BALI
Birth to Three Checklist	
Clinical Evaluation of Language Fundamentals-4 Screening Test	CELF-4
Children's Communication Checklist [Language Screener]	CCC-2
CID Early Speech Perception	CID-ESP
CID Speech Perception Evaluation	CID-SPICE
CID Teacher Assessment of Grammatical Structures	CID-TAGS
Communication Matrix	
Developmental Sentence Scoring [Lee]	DSS
Differential Screening Test for Processing	DSTP
Evaluating Acquired Skills in Communication — Revised	EASIC-R
Evaluating Acquired Skills in Communication, Third Edition	EASIC-3
Fluharty Preschool Speech and Language Screening Test, Second Edition	Fluharty-2
Functional Communication Profile — Revised	FCP-R
Joliet 3-Minute Preschool Speech and Language Screen	Joliet-P
Joliet 3-Minute Speech and Language Screen — Revised	Joliet-R
Kindergarten Language Screening Test	KLST-2
MacArthur Communicative Development Inventories	CDIs
MacArthur-Bates Communicative Development Inventories	CDIs
Nonspeech Test for Receptive/Expressive Language	Nonspeech
Preschool Language Scale — 4 Screening Test	
Preverbal Assessment-Intervention Profile	PAIP
Reynell Developmental Language Scales	Reynell
Rossetti Infant-Toddler Language Scale	Rossetti
Screening Test of Adolescent Language	STAL
Social Communication Questionnaire	SCQ
Social-Emotional Evaluation	SEE
Test for Auditory Processing Disorders in Children — Revised	SCAN-C
Token Test for Children, Second Edition	TTFC-2

C. Language — Clinical Analysis Procedures — Language sampling and analysis, which may include the following:

Test	Abbreviation
Mean Length of Utterance	MLU

Test	Abbreviation
Type Token Ratio	TTR
Developmental Sentence Score	DSS
Structural analysis (Brown's stages)	
Semantic analysis	
Discourse analysis	

D. Speech Production Tests — Standardized (Newer editions of currently listed tests are also acceptable.)

Test	Abbreviation
Arizona Articulation Proficiency Scale, Third Edition	Arizona-3
Assessment of Intelligibility of Dysarthric Speech	AIDS
Assessment of Phonological Processes — Revised	APPS-R
Bernthal-Bankson Test of Phonology	BBTOP
Clinical Assessment of Articulation and Phonology	CAAP
Diagnostic Evaluation of Articulation and Phonology, U.S. Edition	DEAP
Goldman-Fristoe Test of Articulation, Second Edition	GFTA-2
Hodson Assessment of Phonological Patterns — Third Edition	HAPP-3
Kaufman Speech Praxis Test	KSPT
Khan-Lewis Phonological Analysis	KLPA-2
Photo Articulation Test, Third Edition	PAT-3
Slosson Articulation Language Test with Phonology	SALT-P
Smit-Hand Articulation and Phonology Evaluation	SHAPE
Structured Photographic Articulation Test II Featuring Dudsberry	SPAT-D II
Stuttering Severity Instrument for Children and Adults	SSI-3
Weiss Comprehensive Articulation Test	WCAT

E. Speech Production Tests — Supplemental

Test	Abbreviation
A-19 Scale for Children Who Stutter	A-19
Apraxia Profile	
Assessment of the Child's Experience of Stuttering	ACES
CALMS Rating Scale for School-Age Children Who Stutter	CALMS
Children's Speech Intelligibility Measure	CSIM
CID Phonetic Inventory	CID-PI
CID SPeech INtelligibility Evaluation	CID-SPINE

Test	Abbreviation
Communication Attitude Test for Preschool and Kindergarten Children Who Stutter	KiddyCAT
Communication Attitude Test — Revised	CAT-R
Computerized Articulation and Phonology Evaluation System	CAPES
Marshalla Oral Sensorimotor Test	MOST
Modified Erickson Scale of Communication Attitudes	
Procedures for the Phonological Analysis of Children's Language [Ingram]	
Screening Test for Developmental Apraxia of Speech, Second Edition	STDAS-2
Secord Contextual Articulation Tests	S-CAT
Verbal-Motor Production Assessment for Children	VMPAC
Voice Assessment Protocol for Children and Adults	VAP

F. Speech Production — Clinical Analysis Procedures — Speech sampling and analysis, which may include the following:

1. Debra Beckman's oral-motor assessment procedures
2. Food chaining questionnaire
3. Instrumentation-based voice evaluation
4. Item and replica analysis
5. Percentage of consonants correct
6. Percentage of intelligibility
7. Percentage of phonemes correct
8. Percentage of syllables stuttered
9. Perceptual voice evaluation
10. Phonetic inventory
11. Phonological process analysis
12. Suzanne Evans-Morris oral-motor assessment procedures