PURCHASE OF SERVICE GUIDELINE

7-8-2015	**SPEECH THERAPY**	**FINAL**

I. DEFINITION

Speech Therapy is defined as specialized diagnostic screening and preventive and corrective treatment for persons with speech and language disorders which may include but not limited to speech, language, cognitive, communication, voice, swallowing and/or fluency. These services must be deemed necessary based on informed clinical opinion.

ELARC may purchase speech therapy for consumers beyond the age of 22 who have exited the school system~~,~~ or for school-age children who may require supplemental therapy. All speech therapy services purchased are to be provided by a licensed and qualified speech therapist.

II. CRITERIA

In all cases, purchase of this service may be considered when all other alternative sources of funding have been exhausted, which includes private insurance, private trusts, Medi-Cal or other sources of public health care available to the general public WIC section 4648, subd. (a)(8).

ELARC may purchase speech therapy services for an adult consumer when it is deemed necessary by the planning team and by review through the appropriate clinical consultant for the adult consumer in order to maintain the consumer's current status and to prevent regression of physical condition.

For school-age consumers under the age of 22 and currently enrolled in a school program, the special education system is the primary source for the provision of speech therapy services. Under special circumstances, speech therapy may be provided for school-age consumers where it has been determined by the planning team that supplemental speech therapy may be required; there will be a significant delay in the initiation of speech therapy; there will be a significant regression if speech therapy services are not provided during school breaks; or other individual circumstances would prevent the special education system from providing needed services.
In all above situations, a fair hearing procedure must be initiated with the school system prior to pursuing ELARC funding.

If ELARC identifies the speech therapy service as a need in the IPP, then it may also consider funding the copayment, coinsurance or deductible associated with the private or generic health plan which accepts responsibility for coverage of the service and for which the parent, guardian or caregiver is responsible for; if all of the following conditions are met: (1) The consumer is covered by his or her parent's, guardian's, or caregiver's health care service plan or health insurance policy. (2) The family has an Annual Gross Income (AGI) that does not exceed 400 percent of the Federal Poverty Level (FPL). The Family Cost Participation Program Schedule shall be used to determine AGI not exceeding 400% FPL for the family. (3) There is no other third party having liability for the cost of the service.

ELARC may make an exception to fund for co-payments, coinsurance and deductible for a consumer whose family income exceeds 400 percent of the federal poverty level, when the service is necessary to successfully maintain the child at home or the adult consumer in the least- restrictive setting, and the parents or consumer demonstrate one or more of the following: (1) The existence of an extraordinary event that impacts the ability of the parent, guardian, or caregiver to meet the care and supervision needs of the child or impacts the ability of the parent, guardian, or caregiver, or adult consumer with a health care service plan or health insurance policy, to pay the copayment, coinsurance or deductible. (2) The existence of catastrophic loss that temporarily limits the ability to pay. (3) Significant unreimbursed medical costs associated with the care of the consumer or another child who is also a regional center consumer.

III. AMOUNT OF SERVICE

The amount and duration of service will vary and will be based on current recommendations and evaluations. An evaluation generally is requested prior to the funding of this service to determine the appropriate amount and duration of the service and the service shall also be reviewed by the appropriate clinical consultant.

All supporting documentation from consumer’s health providers should be current within 6 months, recent IEP’s and written denial/ documentation shall include that all resources for payment have been exhausted.

IV. ALTERNATIVE FUNDING RESOURCES

Private trusts, private insurance, Medi-Cal, Medicare, California Children’s Services, the special education school system, EPSDT, CHAMPUS, private health plans, HMOs, Veteran’s benefits, Department of Rehabilitation, ability-to-pay programs at county facilities and clinics, etc.

ELARC shall not purchase any service that would otherwise be available from Medi-Cal, Medicare, The Civilian Health and Medical Program for Uniform Services, In Home

Support Services, California Children's Services, private insurance, or a health care service plan when a consumer or a family meets the criteria of this coverage but chooses not to pursue that coverage [WIC 4659 (c)].

V. PROCESS FOR PURCHASE OF SERVICE:

A. After discussion with the consumer or legally authorized representative regarding a service request as part of the planning team process, the service coordinator completes a R1-11 with as much detail as possible, signs it, obtains his/her supervisor's signature and submits it with the chart and all applicable documentation to the Special Services Secretary. All R-11 requests should be submitted to the Special Services secretary at least four weeks in advance of the expected date of service, agreed to by the planning team, as no retroactive funding requests will be considered for purchase of service.

B. The request will be reviewed by the applicable clinical consultant for input and recommendations on whether the service request is clinically indicated and the submitted documentation is adequate to support this request. If so, the clinical consultant will reflect this in an ID Note/Memo/Record Review Form which will be routed with the R1-11 and chart to the physician consultant for review and signature. The R1-11 will be returned to the Service Coordinator for scheduling of appointments and processing by the respective unit office assistant. Payment will be at the SMA or vendor rate.

   If the clinical consultant has concerns and recommends changes in the request, this will be reflected in an ID Note/Memo/Record Review Form which will be retuned along with the R1-11 to the service coordinator to share with the planning team.

C. Upon planning team agreement to proceed with the service as recommended by the applicable clinical consultant, the service coordinator will note that in a memo, attach the R1-11 and a copy of the ID Note/Memo/Record Review Form originally completed by the clinician and route through the Special Services Secretary to the physician consultant for signature.

   - The R1-11 will be returned to the service coordinator for scheduling of appointments and processing by the respective unit office assistant. Payment will be at the SMA or vendor rate.

I. EVALUATION OF SERVICE EFFECTIVENESS

The planning team, therapist reports, review by the appropriate consultant, and consumer/family feedback will serve as the mechanism for evaluating the effectiveness of the service. If the duration of the service will exceed six months, the purchase of the service will need to be evaluated every six months or more frequently as recommended by the consultant.