Molina Healthcare of South Carolina

South Carolina Clinical Policy Speech Therapy for Developmental Delay, Swallowing and Feeding

State(s):	**South Carolina**	Document #:	SC_MCP_601 Speech Therapy
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DISCLAIMER

This South Carolina Molina Clinical Policy (SC-MCP) is intended to facilitate the Utilization Management process. Policies are not a supplementation or recommendation for treatment; Providers are solely responsible for the diagnosis, treatment, and clinical recommendations for the Member. It expresses Molina's determination as to whether certain services or supplies are medically necessary, experimental, investigational, or cosmetic for purposes of determining appropriateness of payment. The conclusion that a particular service or supply is medically necessary does not constitute a representation or warranty that this service or supply is covered (e.g., will be paid for by Molina) for a particular Member. The Member's benefit plan determines coverage – each benefit plan defines which services are covered, which are excluded, and which are subject to dollar caps or other limits. Members and their Providers will need to consult the Member's benefit plan to determine if there are any exclusion(s) or other benefit limitations applicable to this service or supply. If there is a discrepancy between this policy and a member's plan of benefits, the benefits plan will govern. In addition, coverage may be mandated by applicable legal requirements of a State, the Federal government or CMS for Medicare and Medicaid Members. CMS's Coverage Database can be found on the CMS website. The coverage directive(s) and criteria from an existing National Coverage Determination (NCD) or Local Coverage Determination (LCD) will supersede the contents of this SC-MCP and provide the directive for all Medicare members.[1] References included were accurate at the time of policy approval and publication.

OVERVIEW

Speech Language Pathology (SLP) services are defined by the American Speech Language Hearing Association (ASHA) as those necessary for the diagnosis and treatment of swallowing, speech-language, and cognitive-communication disorders that result in communication disabilities. Speech disorders include:

- Sound production (e.g., articulation, apraxia, dysarthria)
- Resonance (e.g., hypernasality, hyponasality)
- Voice (e.g., phonation quality, pitch, respiration)
- Fluency (e.g., stuttering)
- Language (e.g., comprehension, expression, pragmatics, semantics, syntax)
- Cognition (e.g., attention, memory, problem solving, executive functioning)
- Feeding and swallowing (e.g., oral, pharyngeal, and dysphagia)

Speech-language pathologists (SLPs) specialize in the evaluation and treatment of communication and swallowing disorders and work with individuals who have physical or cognitive deficits/disorders resulting in difficulty communicating. Speech therapy services are classified as either rehabilitative or habilitative. Rehabilitative services aid in the restoration or enhancement of abilities that have been lost or impaired because of illness. Habilitative services are intended to maintain, develop, or improve skills that have not (but would normally have) developed or are at risk of being lost because of illness, injury, loss of a body part, or congenital abnormality (ASHA 2015).

State Resources

Early intervention is the process of providing services, education, and support to young children who are deemed to have an established condition, those who are evaluated and deemed to have a diagnosed physical or mental condition (with a high likelihood of resulting in a developmental delay), an existing delay, or a child who is at-risk of developing a delay or special need that may affect their development or impede their education.

Early Intervention Programs (EIPs) are typically the first option for children under the age of three who are eligible and who meet certain criteria. Each state offers education and related services through state-specific programs. Early intervention aims to mitigate the impact of a disability or delay. Services are intended to identify and meet a child's developmental needs in five domains: physical, cognitive, communicative, social or emotional, and adaptive. An EIP program is available within each state (refer to state-specific criteria).

SOUTH CAROLINA COVERAGE POLICY

State Resources Each state has special programs available for special education and related services. The Individuals with Disabilities Act (IDEA) is a federally mandated program that provides free and appropriate public education for children with diagnosed learning disabilities. Public school districts pay for the necessary services. These services include social workers, speech therapists, occupational therapists, school nurse, aide and school psychologist. An individualized Education Program (IEP) is a list of goals agreed upon by the family and the school. An annual meeting is scheduled with the family to review progress and to adjust the plan. Early intervention is the process of providing services, education and support to young children who are deemed to have an established condition, those who are evaluated and deemed to have a diagnosed physical or mental condition (with a high probability of resulting in a developmental delay), an existing delay or a child who is at-risk of developing a delay or special need that may affect their development or impede their education. The purpose of early intervention is to lessen the effects of the disability or delay. Services are designed to identify and meet a child's needs in five developmental areas, including: physical development, cognitive development, communication, social or emotional development, and adaptive development. An early intervention program is available within each state for children under the age of three. These services are typically provided by a state contracted program for toddlers with disabilities. Services may be provided in the home or at another designated place. The plan of care is reviewed every 6 months.

South Carolina Department of Health and Human Services (SCDHHS) regulations on speech therapy are defined below.

Please review individual State and Federal mandates and applicable health plan regulations before applying the criteria below. Please refer to requirements, criteria, and guidance from the State in which the Member is receiving treatment as the State's documents will supersede this Molina Clinical Policy.

1. **Speech-language pathology (SLP)** services may be considered medically necessary in speech sound production disorders (e.g., articulation, apraxia, dysarthria); language disorders (e.g., comprehension, expression, pragmatics, semantics and syntax); when ALL of the following criteria are met: **[ALL]**
   - Prescriber is the member's primary care physician or their physician designee and provides a written order; AND
   - Based on a plan of care, the therapy sessions achieve a specific diagnosis-related goal with a Reasonable expectation of achieving measurable significant functional improvement in a reasonable and predictable period of time; AND
   - The therapy sessions provide specific, effective, and reasonable treatment for the individual's diagnosis and physical condition; AND
   - The services are delivered by a qualified provider who holds the appropriate credentials in Speech-language pathology; has pertinent training and experience; and is certified, licensed, or otherwise regulated by the State or Federal governments, (such as: Speech-Language Pathology (CCC-SLP)
   - Speech therapy assistants may provide services under the direction and supervision of a speech language pathologist; AND
   - The services require the judgment, knowledge, and skills of a qualified provider of SLP services due to the complexity of the
   - therapy and the medical condition of the individual; AND
   - Documentation that physician referral to an Early Intervention program (EIP) for children who qualify and are up to age 3 years or a school-based therapy program for children and adolescents ages 3 to 21 years is required to be tried as a first option.
   - Individualized speech therapy is considered not medically necessary if the services are being provided concurrently by any state or federal agency such as EIP, or local school district.

2. **Swallowing and Feeding Services may be considered medically necessary when the following criteria are met:**
   - Swallowing therapy is ordered for the treatment of an **organic** medical condition, **OR**
   - In the immediate postoperative or convalescent state of the patient's illness; **OR**
   - Documented evidence of Failure to Thrive / Weight Loss:
     - Unresponsive to standard age-appropriate interventions over four (4) weeks with clinical signs and symptoms of nutritional risk from failure to thrive as indicated by the following for neonates, infants and children < 18 years of age:
       - Weight for height or BMI for age ≤ 10 percent (≤10%); **OR**
       - Crossed (downward) at least 2 percentile lines of weight for age on growth chart.
   - Poor weight gain or abnormal swallow studies related to feeding or swallowing disorder.

Swallowing/feeding therapy for food aversion is **not covered** because this is considered a behavioral problem. ***Note**: treatment for behavioral problems is not covered under the speech therapy benefit.*

3. **Developmental Language Delay**: Speech therapy may be authorized in patients with developmental language delay when ALL of the following criteria are met: **[ALL]**

Developmental language delay diagnosis in members who are 12 months of age or older when one of the following criteria are met: **[ONE]**

- There is a State Mandate specifically for coverage of "developmental delay"; **OR**
- There is a severe speech delay, AND o Documentation that developmental SCREENING 46 47 test has been completed and the results, **AND**
- Indicate a speech delay or communication deficit that validates a referral to a speech language pathologist. These screening tests identify a child who is at risk of developmental delay. (It is not necessary to spell out specific test used.)

4. **Documentation review includes the following: [ALL]**

A. **Evaluation**: A comprehensive evaluation is essential to determine if SLP services are medically necessary, gather baseline data, establish a treatment plan, and develop goals based on the data. An evaluation is needed before implementing any SLP treatment. Evaluation begins with the administration of appropriate and relevant assessments using standardized assessments and tools. The evaluation must include:

- Prior functional level, or baseline condition.
- Specific standardized and non-standardized tests, assessments, and tools that are scored to assess the individual's level of functional communication and or swallowing. The results of testing must show standardized scores as well as scaled scores when applicable and must include the following:
    - A **Total Score** of 70 or below on tests where a Total standard score is based on 100; or
    - A Total score of at least 2 standard deviations from the mean; and
    - Analytic interpretation and synthesis of all data, including a summary of the baseline findings in written report(s) of the individual's current communication and or swallowing skills; and Objective, measurable, and functional descriptions of an individual's deficits using comparable, consistent and standard methods;
    - The results of testing must show standardized scores as well as scaled scores when applicable.
    - Summary of clinical findings with recommendations
    - Articulation disorders may be authorized when there is:
        - Standardized Total scoring for articulation language of 70 or below; **and**
        - A speech sample of a minimum of 50 utterances to validate the speech disorder
- Treatment plan including the frequency and duration;
- Functional, measurable, and time-framed long-term and short-term goals based on appropriate and relevant evaluation data;
- Rehabilitation prognosis;
- Discharge plan that is initiated at the start of SLP treatment

B. **Treatment Sessions**: A speech language pathology treatment session is usually thirty minutes to one hour of speech therapy on any given day, depending on the age and diagnosis and ability to sustain attention for therapy. Documentation of treatment sessions must include: **[ALL]**

- Date of treatment;
- Specific treatment(s) provided that match the CPT codes billed
- Total treatment time
- The individual's response to treatment;
- Skilled ongoing reassessment of the individual's progress toward the goals in objective, measurable terms using consistent and comparable methods;
- Reasonable estimate of when goals will be reached
- Level and complexity of services requested can only be rendered safely and effectively by a licensed speech- language pathologist
- Objective, measurable, and functional descriptions of an individual's deficits including any problems or changes to the plan of care

- Feasibility of training parent(s) or caregiver(s) based on outlined goals; strategy to transition care to patient or caregiver maintenance program
- Name and credentials of the treating clinician

C. **Progress Reports**: Intermittent progress reports need to demonstrate that the individual is making functional progress and must include all of the following: **[ALL]**

- Start of care date;
- Time period covered by the report;
- Communication and or swallowing diagnosis;
- Statement of the individual's functional communication/swallowing at the beginning of the progress report period;
- Statement of the individual's current status as compared to evaluation baseline data and the prior progress reports, including objective measures of member communication/swallowing performance in functional terms that relate to the treatment goals;
- Changes in prognosis, plan of care and goals and reason for the change;
- Consultations with other professionals or coordination of services, if applicable;
- Signature and title of qualified professional responsible for the therapy services.

D. **Re-evaluation:** A re-evaluation is usually indicated when there are new significant clinical findings, a rapid change in the individual's status, failure to respond to SLP interventions or after every 6 months of treatment. Re- evaluation is a more comprehensive assessment that includes all the components of the initial evaluation.

- **To continue speech therapy after 6 months a re-evaluation must be done** that includes documentation of scores from specific standardized and non-standardized tests, assessments, and tools to assess the individual's level of functional communication and or swallowing.
- If the re-evaluation and submitted clinicals support treatment is needed beyond 12 months, the review nurse may approve up to an additional 3 months of therapy at a given time for a total of 6 additional months, provided services meet medical necessity as found in this MCP.
  - Member must also show consistent attendance at treatment visits (70%)
- Member must show progress for additional therapy to be approved (e.g. consistent attendance, making progress toward goals, compliance with treatment plan). Clinicals that fail to show progress require the request to be referred to the medical director for review.
- .
- Formal re-evaluation is required after every 6 months of treatment.

Discontinuation of Services: Indications for discontinuation of services include one or more of the following criteria: [ONE]

- Goals have been achieved
- Treatment is refused or the member is non-compliant
- The speech, language, communication disorder is within normal limits or consistent with the individual's premorbid status.
- Maximum potential for improvement has been achieved
- Development of a maintenance program once the member has completed the speech/language therapy initial goals and/or the skills of a therapist are not required
- Medical condition develops that precludes treatment
- Measurable improvements/no change in status have not been demonstrated as indicated by the treatment plan after 3 consecutive sessions
- Feeding and/or swallowing skills no longer adversely affect the individual’s health status
- Individual state benefit coverage limitations have been exhausted

5. **Amount, frequency and duration of speech therapy services is reasonable, necessary, specific, effective and skilled, as consistent with accepted clinical practice standards:**

Reasonable: appropriate amount, frequency, and duration of treatment in accordance with accepted standards of practice.

Necessary: appropriate treatment for the patient's diagnosis and condition.

Specific: targeted to particular treatment goals.

Effective: expected to yield improvement within a reasonable time.

Skilled: requiring the knowledge, skills, and judgment of a speech-language pathologist, that is, complex and sophisticated.

6. **School based therapy:** Speech therapy provided by the member's school district may be considered medically necessary for all of the following:

- During the summer months to maintain the therapy services provided in the school are considered a continuation of therapy services when there is no change in patient's diagnosis or function; and
- If a school-aged patient receives medically necessary therapy services in both a school setting (as part of an Individualized Education Plan (IEP) and in an outpatient setting, coordination of therapy between the providers is required. Providers are to maintain documentation of coordination in the member's file.

7. **Medical Director Referral**: the following scenarios require mandatory MD review:

A. Requests for ongoing speech therapy beyond 18 months duration and every 6 months thereafter;
B. Request for group therapy (CPT 92508) AND individual therapy (CPT 92507) during the same treatment period.

Note: State Education codes allow for speech therapy services for children aged 3 and older who demonstrate significant speech/language deficits interfering with the child' education potential to be obtained through the school system following an evaluation process. In addition, each state has an early intervention process to address the needs associated with children ages 0-3.

COVERAGE EXCLUSIONS

All other requests for treatment that do not meet the above section above are excluded because they are considered not medically necessary or experimental/investigational and unproven. These include all of the following: **[ALL]**

- Self-correcting dysfunctions such as language therapy for normal non-fluency
    - Children between the ages of 2 and 5 years may experience normal non-fluency and speech therapy may not be authorized for this condition
- Computer-based learning programs for speech training such as Fast-For-Word
- Duplicate therapies of the same treatment from two different rehabilitative providers
    - (Occupational or Physical Therapy in conjunction with Speech Therapy)
- Education services, testing and school performance tests (e.g. SIPT, praxis testing)
- Facilitated Communication (FC), auditory integration training (AIT), and sensory integration (SI) Therapy
- Long term rehabilitative services when significant therapeutic improvement is not expected
- Maintenance therapy in which no additional functional progress is being made or unless a change in status occurs
- that would require a reevaluation.
- Speech therapy for all of the following conditions: Note: check if specific regulations or mandates apply:
    - Developmental, neurogenic, or psychogenic stuttering
    - Learning disabilities, behavioral problems, attention disorders
    - Mental retardation

- Therapy to improve or enhance school, recreational, or job performance
- Therapy when intended to improve communication skills beyond premorbid levels (e.g., beyond the functional communication status prior to the onset of a new diagnosis or change in medical status).
- If continuation is maintenance in nature
- If Medicare does not consider the service medically necessary
- Therapy that does not require the skills of a qualified provider of speech therapy services, such as treatments which maintain function and are neither diagnostic nor therapeutic or procedures that may be carried out efficiently by the patient, family or caregivers in the home
- Therapy that is considered primarily for the enhancement of educational purposes whereas services are provided by public or private educational agencies (e.g. developmental delay)
- If services are required to be provided by another public agency including the patient's school district
- Swallowing/feeding therapy for food aversion is not covered because this is considered a behavioral problem. *Note:*
- *treatment for behavioral problems is not covered under the speech therapy benefit.*

END South Carolina Department of Health and Human Services (SCDHHS) regulations on Speech Therapy

DOCUMENTATION REQUIREMENTS. *Molina Healthcare reserves the right to require that additional documentation be made available as part of its coverage determination; quality improvement; and fraud; waste and abuse prevention processes. Documentation required may include, but is not limited to, patient records, test results and credentials of the provider ordering or performing a drug or service. Molina Healthcare may deny reimbursement or take additional appropriate action if the documentation provided does not support the initial determination that the drugs or services were medically necessary, not investigational or experimental, and otherwise within the scope of benefits afforded to the member, and/or the documentation demonstrates a pattern of billing or other practice that is inappropriate or excessive.*

SUMMARY OF MEDICAL EVIDENCE

There is robust published peer-reviewed literature on the effectiveness of speech therapy for a wide range of conditions. The published evidence consists of systematic reviews, randomized controlled trials, controlled clinical trials and retrospective comparison studies that compare speech and language therapy to placebo, no intervention and other communication interventions for speech problems. However, there are no universal guidelines on the number of speech therapy treatments for any diagnosis, nor is there consistent evidence based on any diagnosis on which to base a treatment decision.

Diaféria et al. (2022) conducted a randomized controlled clinical trial to evaluate the impact of the ATAXIA–Myofunctional Orofacial and Vocal Therapy (A-MOVT) program on the quality of life (QOL) of patient with spinocerebellar ataxia type 3 (SCA3). Forty-eight participants (33 females and 15 males) were divided into either the intervention group (STG) or the control group (CG). Participants in the STG underwent therapy once a week with a total of 12 session and the CG participants were patients on the waiting list for speech therapy. Inclusion criteria for the study included diagnosis of SCA3, between 18 and 70 years of age, and complaints related to voice or swallowing. Exclusion criteria included inability to follow instructions, other neurological disorders, severe clinical or psychiatric diseases, and previous participation in speech therapy programs. Outcomes were measured using the World Health Organization's Quality of Life (WHOQOL-BREF) assessment, Living with Dysarthria (LwD), Quality of Life in Swallowing Disorders (SWAL-QOL), and Food Assessment Tool (EAT-10). The LwD QOL data for STG showed a significant score reduction postintervention, but CG scores increased ($p < 0.001$). The SWAL-QOL scores showed a significant improvement in the communication domain in the STG at 3 months of intervention ($p = 0.007$) while lower scores were identified in the CG group at 3 months ($p = 0.007$). EAT-10 score revealed a reduction in swallowing symptoms ($p = 0.018$) and showed significant improvement in the EAT-10 scores in the STG at the end of 3-months ($p = 0.024$). LwD showed higher total scores and individual subscale scores for the STG when compared to the CG ($p < 0.050$ for all comparisons). There were no significant changes found in the WHOQOL-BREF scores. Limitations of this study include small sample size and short duration of the rehabilitation program. These study results showed the positive impact speech therapy rehabilitation programs have on QOL of individuals living with SCA3.

Stahl et al. (2018) performed a randomized, parallel-group, blinded assessment-controlled trial to assess the appropriate quantity of speech-language therapy (SLT) in the rehabilitation of chronic post-stroke aphasia. Thirty patients were included in the study with an average age of 60.1 years with an average of 65.2 months post-onset of stroke. Patients were assigned either highly intensive practice where they received 4 hours of SLT daily or moderately intensive practice with 2 hours of SLT daily. Inclusion criteria for the study included diagnosis of aphasia confirmed by the Aachen Aphasia Test (AAT), chronic stage of aphasia confirmed by symptoms at least 1-year post-onset of stroke, German as native language and right handedness according to the Edinburg Handedness Inventory. Exclusion criteria included aphasia due to traumatic brain injury or other neurodegenerative disease, severe non-verbal cognitive deficits, severe uncorrected vision or hearing disorders, or intensive SLT in the previous 2 years. Outcomes in the study were scored with the AAT measured by the Token Test, repetition, naming and comprehension and the Action Communication Test (ACT). AAT scores showed significant progress in each of the two training intervals. Progress did not depend on the intensity level applied. ACT scores showed only patients with moderately intensive practice continued to make progress which patients with highly intensive practice did not. This study demonstrated a 2-week increase in treatment duration a 2-hour daily dosage of SLT contributes to recovery from chronic post-stroke aphasia.

Osman et al. (2023) conducted a systematic review to assess effects of early initiation of speech therapy on children diagnosed with autism spectrum disorder (ASD). The review consisted of 12 articles with 501 participants (78% male and 22% female). Inclusion criteria included participants that received speech therapy as intervention for autism and children that had been clinically diagnosed with ASD. Articles were excluded if they were not aligned with targeted research goals, gray literature, and articles without full text or missing abstracts. Through the systematic review improvements in cognitive ability, communication, and social skills were reported. One study reported improved eye contact, verbal reciprocity, and better self-expression from participants. Another study reported a decrease in anxiety level among children with ASD. Limitations of the review included a small number of articles reviewed, the ratio of randomized to nonrandomized studies, and a short follow-up period.

National and Specialty Organizations

The **American Speech Language Hearing Association (ASHA)** published *Speech-Language Pathology Medical Review Guidelines* to provide an overview of standard practices, descriptions of services, documentation of services, medical necessity of services, and treatment data. The guidelines provide an overview of the prevalence and incidence of communication and swallowing disorders. The ASHA outlines medical necessity of speech-language pathology services and indications for treatment. Information in the publication is updated on an as-needed basis.

SUPPLEMENTAL INFORMATION

Individuals with Disabilities Act (IDEA) and State Resources for Children and Adolescents

The Individuals with Disabilities Act (IDEA) is a federally mandated program that provides free and appropriate public education for children with diagnosed learning disabilities throughout the nation and ensures special education and related services to those children.** Funding is governed by IDEA and determines how states and public agencies (such as schools) provide early intervention, special education, and related services to over 7.5 million eligible infants, toddlers, children, and youth with disabilities.

- Children and youth ages 3 through 21 receive special education and related services under IDEA Part B
- Infants and toddlers (birth through age 2) with disabilities and their families receive early intervention services under IDEA Part C
- Formula grants are awarded to States to support special education and related services and early intervention services.
- Discretionary grants are awarded to State educational agencies, institutions of higher education, and other non-profit organizations to support research, demonstrations, technical assistance and dissemination, technology development, personnel development, and parent-training and -information centers.
- Services provided include, but are not limited to social workers, speech therapists, occupational therapists, school nurses, school psychologists, and/or health or other support staff (e.g., aides). Congress reauthorized the IDEA in 2004 and amended the IDEA through the Every Student Succeeds Act in December 2015.

** Refer to State guidance regarding coverage of speech therapy for the conditions noted above.

CODING & BILLING INFORMATION

CPT (Current Procedural Terminology) Codes

Codes	Description
92507	Treatment of speech, language, voice, communication, and/or auditory processing disorder; individual
92508	Treatment of speech, language, voice, communication, and/or auditory processing disorder; group, 2 or more individuals
92521	Evaluation of speech fluency (e.g., stuttering, cluttering)
92522	Evaluation of speech sound production (e.g., articulation, phonological process, apraxia, dysarthria);
92523	Evaluation of speech sound production (e.g., articulation, phonological process, apraxia, dysarthria); with evaluation of language comprehension and expression (e.g., receptive and expressive language)
92526	Treatment of swallowing dysfunction and/or oral function for feeding

HCPCS (Healthcare Common Procedure Coding System) Codes

Codes	Description
G0153	Services performed by a qualified speech-language pathologist in the home health or hospice setting, each 15 minutes
G0161	Services performed by a qualified speech-language pathologist, in the home health setting, in the establishment or delivery of a safe and effective speech-language pathology maintenance program, each 15 minutes
S9128	Speech therapy, in the home, per diem
S9152	Speech therapy, re-evaluation

CODING DISCLAIMER. *Codes listed in this policy are for reference purposes only and may not be all-inclusive. Deleted codes and codes which are not effective at the time the service is rendered may not be eligible for reimbursement. Listing of a service or device code in this policy does guarantee coverage. Coverage is determined by the benefit document. Molina adheres to Current Procedural Terminology (CPT®), a registered trademark of the American Medical Association (AMA). All CPT codes and descriptions are copyrighted by the AMA; this information is included for informational purposes only. Providers and facilities are expected to utilize industry standard coding practices for all submissions. When improper billing and coding is not followed, Molina has the right to reject/deny the claim and recover claim payment(s). Due to changing industry practices, Molina reserves the right to revise this policy as needed.*

REFERENCES

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APPROVAL HISTORY

Review	Revision	MCP-Committee Approval Date	Comments
02/14/2025	02/14/2025	2/17/2025	Formatting; updated header, re-evaluation criteria; Medical Director Referral criteria and added code 92526
09/09/2024	09/09/2024	09/12/2024	Updated Overview, Medical Evidence, Coding, Reference, and disclaimer (footer)
9/11/2023		9/11/2023	HCS Committee reviewed and approved
9/19/2022	9/19/2022	9/19/2022	Reviewed against MHI, SC Providers Plan, Medicaid Contract. Approved by CMO, Medical Directors and VP HCS, D Enigl and Dr. Shrouds
12/8/2021	12/8/2021	12/8/2021	MHI Policy reviewed, reorganized Coverage Policy section, updated Summary of Medical Evidence and References.
9/15/2021	9/15/2021	9/15/2021	State specific policy updates
4/5/2021	4/5/2021	4/5/2021	MHI Policy reviewed, no changes to criteria. References updated.
4/23/2020	4/23/2020	4/23/2020	MHI Policy reviewed, no changes to criteria. References updated.
6/19/2019	6/19/2019	6/19/2019	MHI Policy reviewed, no changes to criteria. References updated.
1/22/2019	1/22/2019	1/22/2019	State specific policy updates
3/8/2018			MHI Policy reviewed, no changes to criteria. References updated
6/22/2016	6/22/2016	6/22/2016	State specific policy updates