MEDICAL POLICY

Medical Policy Title	**Speech Pathology and Therapy**
Policy Number	**8.01.13**
Current Effective Date	May 22, 2025
Next Review Date	May 2026

Our medical policies are based on the assessment of evidence based, peer-reviewed literature, and professional guidelines. Eligibility for reimbursement is based upon the benefits set forth in the member's subscriber contract. (Link to Product Disclaimer)

POLICY STATEMENT(S)

I. Speech therapy services (evaluation and restorative, or habilitative treatment) are considered **medically appropriate** for **EITHER** of the following:

A. Adults with a medically determinable impairment, as determined by standardized assessments, resulting from disease, trauma, or previous therapeutic processes (e.g., traumatic brain injury, cardiovascular accident/stroke).

1. In determining the medical appropriateness of speech therapy services, consideration will be given to the degree of limitation/deficit the impairment imposes on the individual and whether the deficit(s) are expected to improve over a short period of time (generally up to two (2) months) with treatment.

2. Services will continue to be considered medically appropriate as a patient makes progress, so long as the patient has not reached a maintenance service level in which no additional functional progress is apparent or expected to occur. In order for ongoing treatment to continue to be considered medically appropriate, significant improvement must be demonstrated in objective measures;

B. Children exhibiting at least a moderate speech delay or disability, as determined by standardized assessments, resulting from disease, trauma, congenital anomaly, or developmental delay.

1. A moderate to severe deficit is generally defined as:

a. A score at least 1.5 standard deviations below the mean (i.e. a standard score of 77 or below for most standardized tests that have an average score of 100 with a standard deviation of 15).

2. Cross-disciplinary and age equivalency scores may be considered, as well as percentage scores, and standard deviation when determining the severity of the impairment.

3. For continuation of speech therapy for children beyond the initial evaluation and approved therapy sessions, speech therapists will need to provide documentation showing continued improvement within the past treatment period, documentation of an updated treatment plan, and documentation that the member is actively participating in therapy sessions.

Dysphagia and Feeding Difficulties

II. Speech therapy is considered **medically appropriate** as a treatment for dysphagia in children with the potential functional ability to feed by mouth and **EITHER** of the following:

A. Evaluation of and diagnosis of aspiration or laryngeal penetration by a physician with expertise in the diagnosis and treatment of dysphagia;

B. The child has a history of or is at high risk for recurrent aspiration or choking or has clinical signs/symptoms of aspiration.

Services will continue to be considered medically appropriate as a patient makes progress, so long as the patient has not reached a maintenance service level in which no additional functional progress is apparent or expected to occur. In order for ongoing treatment to continue to be considered medically appropriate, significant improvement must be demonstrated by improved oral intake and objective standard measures (e.g., repeat barium swallow, FEES, weight gain or non-imaging assessment instruments).

III. Speech therapy is considered **medically appropriate** in children with feeding difficulties when **ALL** of the following criteria are met:

A. Five (5) years of age and under;

B. With feeding difficulties (e.g., picky eaters, difficulty with bottle feeding, etc.);

C. Nutritional status deficiency (e.g., weight loss or at high-risk for weight loss, vitamin and/or mineral deficiencies, or severely restricted diet). (Refer to Policy Guidelines).

<u>Other General Speech Therapy Criteria</u>

IV. Speech therapy is considered **medically appropriate** as a treatment for Vocal Cord Dysfunction (VCD). (Treatment of VCD is not the same as voice therapy).

V. Speech pathology and therapy services are considered **not medically necessary** for the following individuals:

A. With vocal cord polyps, as the usual recommended treatment is excision of the polyps;

B. With untreated conductive hearing loss, as diagnosis of and treatment for the hearing loss should first be provided;

C. Whose prognosis for progress in unexpected/unlikely;

D. Receiving maintenance services, defined as services that consist of activities that preserve the patient's present level of function and prevent regression of that function. Maintenance begins when the therapeutic goals of a treatment plan have been achieved or when no additional functional progress is apparent or expected to occur;

E. With oral myofunctional disorders (e.g., tongue thrust, deviant swallow, reverse swallow, visceral swallow);

F. With pragmatic language disorders/impairments.

<u>Voice Therapy</u>

VI. Voice therapy (Voice therapy is not the same as treatment of Vocal Cord Dysfunction) is considered **medically necessary** for voice disorders when **ALL** of the following criteria has been met:

A. When a pathological process has been identified (e.g., anatomic laryngeal/vocal cord abnormality);

B. Other documented methods of treatment have been ineffective and have not resulted in the resolution of the patient's condition (e.g., a patient with chronic dysphonia/hoarseness and vocal nodules in which a two-week course of voice rest has failed to resolve the condition).

VII. Voice therapy is considered **not medically necessary,** including but not limited to:

A. Voice therapy programs utilizing intensive behavioral therapy (e.g., Lee Silverman Voice Therapy, LSVT LOUD, SPEAK OUT!), with or without the use of a computerized software program.

RELATED POLICIES

Corporate Medical Policy

1.01.03 Augmentative and Alternative Communication Systems (e.g., Speech Generating Devices)

7.01.84 Gender Reassignment and Treatments for Commercial and Medicare Members

POLICY GUIDELINE(S)

I. Speech Pathology/Therapy must:

A. Relate directly to a written treatment plan established by the speech pathologist providing the services;

B. Be reasonable and necessary to the treatment of the individual's illness or injury, considered under accepted standards of practice to be a specific and effective treatment for the patient's condition;

C. Be of such a level of complexity and sophistication, or the patient's condition must be such, that the services required could be safely and effectively performed only by a speech pathologist; and

D. Be expected to improve the patient's condition significantly in a reasonable, and generally predictable, period of time. The amount, frequency, and duration of the services must be reasonable under accepted standards of practice.

II. After the initial evaluation of the disorder, if the restorative potential is judged insignificant, or if, after a reasonable trial period, the patient's response to treatment is judged insignificant or at a plateau, a maintenance program may be established. In these situations, coverage is limited to the initial evaluation and the design of an appropriate maintenance program.

Feeding Difficulties in Children

III. Speech therapy services for children with feeding difficulties are dependent on the child's specific

diagnosis. Typically, up to four visits are allowed for feeding difficulties in neurotypical children. However, additional speech therapy visits may be medically appropriate for neuroatypical children or significant aerodigestive abnormalities with feeding difficulties (e.g., autism).

Contracts

IV. Certain contracts only cover short-term speech therapy services for a limited number of visits per condition, per lifetime, or per contract year. These limits generally apply to all therapies combined (physical therapy, speech therapy, and occupational therapy). The visit limits do not apply when speech therapy is for the treatment of a Mental Disorder (including autism spectrum disorder). Mental Disorder is defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders.

Individualized Education Program (IEP)

V. New York State Department of Health Early Intervention Program (EIP) defines a developmental delay that has been measured by qualified personnel using clinical opinion, appropriate diagnostic procedures and/or instruments as documented as **ANY** of the following:

   A. A 12-month delay in one functional area;

   B. A 33% delay in one functional area or a 25% delay in each of two (2) areas;

   C. If appropriate standardized instruments are individually administered in the evaluation process, a score of at least 2.0 standard deviations below the mean in one functional area or a score of at least 1.5 standard deviations below the mean in each of two functional areas.

VI. If outpatient therapies requested are in addition to the early intervention services, or school-based services noted in the IEP, or the provider does not feel that the child's needs are being met by the school-based services noted in the IEP, or when there is no IEP provided but it is documented that the child receives school-based services, or documentation must include rationale supporting the medical necessity of the additional outpatient services beyond what the child is already receiving at school as noted in the IEP.

VII. Coverage is not available for services provided by school districts, as stipulated in a child's (preschool, ages 3-5 years, and school, ages 5-21 years) IEP, as the services are generally considered free care or a government program.

   A. When applicable, an IEP should be completed through the school district before a request for coverage is submitted to the Health Plan. If an IEP is not submitted, the request for speech therapy will be reviewed by the Health Plan for medical necessity in accordance with member's subscriber contract.

   B. Speech therapy services denied by the school district, including summer services, and not covered in a child's IEP will be reviewed by the Health Plan for medical necessity in accordance with member's subscriber contract.

   C. If a child is home-schooled, an assessment by the school district should be completed prior to submitting a request to the Health Plan for coverage. Requests for home-schooled children outside NYS will be decided in accordance with NYS laws; however, if an appeal is

requested and another state's law is provided or cited, the case should be forwarded for legal review, to determine whether the other state's law should be applied.

D. Interim summer programs are provided by school districts for children whose handicapping conditions are severe enough to warrant a structured learning environment of 12 months' duration in order to maintain developmental levels. For preschool children, summer instruction must be available for those whose disabilities are severe enough to exhibit the need for a structured learning environment of 12 months duration to prevent substantial regression.

DESCRIPTION

Speech pathology and therapy services are those services necessary for the diagnosis and treatment of speech and language impairments/disorders that result in communication disabilities, as well as for the diagnosis and treatment of swallowing disorders, or dysphagia.

Speech disorders refer to disorders affecting the articulation of speech sounds, the fluency with which speech is produced, or quality.

Speech and language disorders range in severity from mild to severe impairments, from simple sound substitutions to the inability to understand or use language or use the oral-motor mechanism for functional speech and feeding. Speech and language impairments are classified according to their level of severity. A mild impairment is less than one standard deviation (SD) from normal; a moderate impairment is one to two standard deviations from normal; and a severe impairment is more than two standard deviations from normal.

Standardized Tests for Evaluation of Speech Disorders (list is not all inclusive)

A common standard score scale has a mean (average) of 100 and a standard deviation of 15.

- Goldman Fristoe Test of Articulation (GFTA)
- Arizona Articulation Proficiency Scale (AAPS)
- Preschool Language Scale (PLS)
- Clinical Evaluation of Language Fundamentals (CLEF)
- Clinical Assessment of Articulation and Phonology (CAAP)
- Stuttering Severity Index (SSI)
- Recessive Expressive Emergent Language (REEL)
- Test of Language Development (TOLD-P)

Common Terms for Speech or Language Disorders

- Aphasia: Absence or impairment of the ability to communicate through speech, writing, or signs because of brain dysfunction;
- Aphonia: Loss of speech sounds from the larynx;

- Apraxia: The inability to form words or speak, despite the ability to use oral and facial muscles to make sounds;
- Dysarthria: Impairments or clumsiness in the uttering of words due to diseases that affect the oral, lingual, or pharyngeal muscles;
- Dysphagia: Inability to swallow or difficulty in swallowing;
- Dysphasia: Impairment of speech resulting from a brain lesion or neurodevelopmental disorder;
- Dysphonia: Any impairment of the voice or speaking ability;
- Neurosensory Hearing Loss: A decreased ability to perceive sounds as compared to normal; or
- Stuttering: A disruption in the fluency of speech in which affected persons repeat letters or syllables, pause or hesitate abnormally, or fragment words when attempting to speak.
- Neurotypical: Someone who thinks and processes information in ways that are typical within their culture. They tend to learn skills and reach developmental milestones around the same time as their peers.
- Neuroatypical: Differing in mental or neurological function from what is considered typical (frequently used with reference to autistic spectrum disorders).

Speech Disorders

Articulation Disorders, also called phonological disorders, include:

- Motor speech disorders which result from damage to the central or peripheral nervous system (e.g., cerebral vascular accident, traumatic brain injury, or neurogenic disorders such as Parkinson's disease, Huntington disease, amyotrophic lateral sclerosis, and perinatal conditions); and
- Functional articulation disorders, which have no known cause or result from causes other than known neurological insults or physical abnormalities. Functional articulation disorders account for the majority of articulation disorders in children.

Fluency Disorders: also referred to as stuttering, involve the interruption in the flow of speaking manifested as an atypical rate, rhythm, repetitions in sounds, syllables, words, and phrases; or some combination of these.

Voice Disorders: characterized by abnormal pitch, loudness, resonance, quality, or duration of voice, or by an inability to use voice, or some combination of these, result from overuse or misuse of vocal cords, medical condition or psychological disorder impacting the ability to communicate effectively. Voice disorders result from abnormal laryngeal, respiratory, or vocal tract functioning.

Language Disorders

Language disorders are disorders of impaired comprehension and/or use of spoken, written, and/or other symbol systems used for communication (e.g., aphasia secondary to cerebral vascular accident, dementia, hearing impairment).

Pragmatics- is the system of combining the form (phonology, morphology, and syntax) and content (semantics) of language into functional and socially appropriate communication. A person with a pragmatic language disorder/impairment may say inappropriate or unrelated things during a conversation, tell stories in a disorganized way, or have little variety in the use of language. Pragmatic disorders may be considered a symptom of other disorders, such as autism spectrum disorders or developmental disorders.

Voice Therapy

Vocal cord dysfunction (VCD), also known as paradoxical vocal fold movement- is a respiratory disorder characterized by paradoxical closure of the vocal cords during the respiratory cycle that leads to airway obstruction. Symptoms can range from wheezing to stridor. VCD can be mistaken for asthma and is distinguished from asthma by the performance of a pulmonary function test and laryngoscopy. VCD is often treated with speech therapy, relaxation techniques, and/or psychotherapy.

Lee Silverman Voice Therapy, LSVT LOUD has been proposed as an intensive behavioral voice therapy program for individuals with Parkinson disease and other neurological disorders and is aimed at improving the vocal loudness of these patients. The LSVT Companion System may be used as a technical adjunct to the program, to complement person-to-person voice therapy. The sound produced by a patient's voice is received by a calibrated microphone and converted to a visual display that consists of different visual and auditory feedback. The patient is given a target range of both vocal intensity (loudness) and fundamental frequency (pitch) and instructed to maintain a given loudness and or pitch for a given duration.

SPEAK OUT! is a program designed for individuals with Parkinson’s disease to improve speech (speaking with intent) and swallowing. The exercises used target vocal function and speech clarity and moving it from an automatic function to an intentional task.

Dysphagia

Dysphagia is a frequently occurring impairment for children with disabilities because many disabling conditions are associated with oropharyngeal or esophageal dysfunction. The workup for dysphagia usually includes an evaluation by a speech therapist and may also include a video fluoroscopic barium study (often referred to as a cookie swallow) or a fiber-optic endoscopic evaluation of swallow. Speech and occupational therapists often collaborate in feeding therapy for children with poor oral motor and swallowing skills on the basis of the child’s needs and the expertise of the providers involved.

SUPPORTIVE LITERATURE

Sackley et al. (2024) conducted a multicenter, three arm, unblinded, randomized controlled trial to assess the clinical effectiveness of two speech and language therapy approaches versus no speech and language therapy for dysarthria in people with Parkinson’s disease. The study comprised of 388 people with Parkinson’s disease and dysarthria, they were randomly assigned to one of three groups: 130 to Lee Silverman voice treatment (LSVT LOUD), 129 to NHS speech language therapy, and 129 to no speech and language therapy. The primary outcome was total score at three months of self-

reported voice handicap index. People who received LSVT LOUD reported lower voice handicap index scores at three months after randomization than those who did not receive speech and language therapy (−8.0 points (99% confidence interval −13.3 to −2.6); P<0.001). No evidence suggests a difference in voice handicap index scores between NHS speech and language therapy and no speech and language therapy (1.7 points (−3.8 to 7.1); P=0.43). Patients in the LSVT LOUD group also reported lower voice handicap index scores than did those randomized to NHS speech and language therapy (−9.6 points (−14.9 to −4.4); P<0.001). 93 adverse events (predominately vocal strain) were reported in the LSVT LOUD group, 46 in the NHS speech and language therapy group, and none in the no speech and language therapy group. No serious adverse events were recorded. LSVT LOUD was more effective at reducing the participant reported impact of voice problems than was no speech and language therapy and NHS speech and language therapy. NHS speech and language therapy showed no evidence of benefit compared with no speech and language therapy.

Namasivayam et al. (2021) conducted a two-arm randomized control trial studying the effectiveness of Prompts for Restructuring Oral Muscular Phonetic Targets (PROMPT) in children with severe speech motor delays (SMD). The study was comprised of 49 children with SMD. The intervention group received 45min of PROMPT intervention two times a week for 10 weeks or were waitlisted for the same duration and received only home training instructions. Outcome measures for speech motor control, articulation, speech intelligibility, and functional communication were assessed at baseline and at 10 weeks. PROMPT interventions were found to be clinically effective intervention for children with SMD.

Behrman et al. (2020) conducted a prospective study on 40 individuals with idiopathic Parkinson's disease (PD) to assess the outcome of the SPEAK OUT! and the LOUD Crowd therapy programs. Of the 40 individuals, 12 received 40 minute sessions, 3 times per week of SPEAK OUT!, for 4 weeks. Assessments were conducted at baseline, within one week and 6 weeks after completion of the SPEAK OUT! sessions, while also participating in LOUD Crowd. 25 adults without communication disorders were assessed at the same schedule as the SPEAK-OUT! recipients. In the PD group reading and monologue intensity increased significantly. The mean values of intensity for the PD group were lower than those of the control group at baseline, but posttherapy values for the two groups were equivalent. Posttherapy, it was determined that there is evidence of effectiveness of this program on hypokinetic dysarthria secondary to PD.

PROFESSIONAL GUIDELINE(S)

In the American Speech-Language-Hearing Association (ASHA) 2015 Speech-Language Pathology Medical Review Guidelines they state that eligibility for services or evaluation is indicated if one or more of the following factors are present:

- When a referral is made from a teacher, family member, or a professional in hearing, speech and language.
- Failure to pass a screening assessment for function of communication and/or swallowing.
- Individual is unable to communicate functionally or optimally across environments.
- Individual is unable to swallow to maintain adequate nutrition or hydration.

- Evaluation by ASHA-certified speech-language pathologist shows the presence of a speech or swallowing disorder.
- Individual's communications skills are not comparable to others of the same age, gender, ethnicity, or cultural and linguistic background.
- Communication skills are negatively affecting health, safety, social, emotional, educational or vocational status.
- Swallowing skills negatively affect his or her nutritional health or safety.
- Family or guardian want to achieve and/or maintain optimal communication and/or swallowing skills.
- Individual or family is looking for services to enhance communications skills.

The 2016 Guidelines for Adults Stoke Rehabilitation and Recovery by the American Heart Association (AHA) and American Stroke Association (ASA) (Winstein et al., 2016), which were accepted by the ASHA state:

- Speech and language therapy is recommended for individuals with aphasia (class I, level of evidence A).
- Computerized treatment may be considered to supplement treatment provided by a speech language pathologist (class IIb, level of evidence A).

REGULATORY STATUS

As of January 1, 2014, the Patient Protection and Affordable Care Act (PPACA) required all health insurers to provide coverage for essential health benefits, including habilitative services. Under PPACA, habilitative services are health care services that help a person keep, learn or improve skills and functioning for daily living and include the management of limitations and disabilities, including services or programs that help maintain or prevent deterioration in physical, cognitive, or behavioral function.

Under the New York Insurance Law, all medical, major medical or comprehensive-type contracts providing physician services must provide coverage for the medically necessary screening, diagnosis, and treatment of autism spectrum disorders when prescribed or ordered by a licensed physician or a licensed psychologist. Covered services may include treatment by a licensed or certified speech therapist, occupational therapist, physical therapist, and/or social worker, when the policy generally provides such coverage. Therapeutic treatment must include care that is deemed habilitative or non-restorative.

CODE(S)

- Codes may not be covered under all circumstances.
- Code list may not be all inclusive (AMA and CMS code updates may occur more frequently than policy updates).
- (E/I)=Experimental/Investigational

- (NMN)=Not medically necessary/appropriate

CPT Codes

Code	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, Two (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)
92524	Behavioral and qualitative analysis of voice and resonance
92526	Treatment of swallowing dysfunction and/or oral function for feeding
92610	Evaluation of oral and pharyngeal swallowing function
96105	Assessment of aphasia (includes assessment of expressive and receptive speech and language function, language comprehension, speech production ability, reading, spelling, writing, e.g., by Boston Diagnostic Aphasia Examination) with interpretation and report, per hour

HCPCS Codes

Code	Description
S9128	Speech therapy; in the home, per diem (This policy does not address home care services, please refer to InterQual for review.)
S9152	Speech therapy, re-evaluation

Modifier Code

Code	Description
96	Habilitative Services
97	Rehabilitative Services

ICD10 Codes

Code	Description
Several	

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SEARCH TERMS

Not Applicable

CENTERS FOR MEDICARE AND MEDICAID SERVICES (CMS)

Speech-Language Pathology Services for the Treatment of Dysphagia (NCD 170.3) [accessed 2025 Feb 02]

Speech-Language Pathology (LCD L33580) [accessed 2025 Feb 02]

Article - Billing and Coding: Speech-Language Pathology (A52866) [accessed 2025 Feb 02]

PRODUCT DISCLAIMER

- Services are contract dependent; if a product does not cover a service, medical policy criteria do not apply.
- If a commercial product (including an Essential Plan or Child Health Plus product) covers a specific service, medical policy criteria apply to the benefit.
- If a Medicaid product covers a specific service, and there are no New York State Medicaid guidelines (eMedNY) criteria, medical policy criteria apply to the benefit.
- If a Medicare product (including Medicare HMO-Dual Special Needs Program (DSNP) product) covers a specific service, and there is no national or local Medicare coverage decision for the service, medical policy criteria apply to the benefit.
- If a Medicare HMO-Dual Special Needs Program (DSNP) product DOES NOT cover a specific service, please refer to the Medicaid Product coverage line.

POLICY HISTORY/REVISION

Committee Approval Dates

10/18/01, 03/28/02, 05/22/03, 03/25/04, 04/28/05, 04/27/06, 02/22/07, 04/24/08, 04/23/09, 04/29/10, 04/28/11, 04/26/12, 06/27/13, 06/26/14, 06/25/15, 08/25/16, 08/25/17, 06/28/18, 06/27/19, 06/25/20, 06/24/21, 06/16/22, 06/22/23, 06/20/24, 05/22/25

Date	Summary of Changes
05/22/25	• Annual policy review; added SPEAK OUT! to the list of investigational services.

	Added standard deviation requirements for speech therapy for children.
01/01/25	• Summary of changes tracking implemented.
10/18/01	• Original effective date