


## MEDICAL POLICY – 8.03.505

# Speech Therapy

Effective Date:	Oct. 1, 2024	RELATED MEDICAL POLICIES:
Last Revised:	Sept. 23, 2024	7.01.557 Gender Transition/Affirmation Surgery
Replaces:	N/A	8.03.502 Physical Medicine and Rehabilitation - Physical Therapy and Medical Massage Therapy
		11.01.508 Skilled Home Health Care Services

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## Introduction

Speech therapy is the treatment of speaking, language and swallowing problems. Speech therapy treatment helps with both developing and maintaining speech, language and swallowing abilities. Problems with speech, language and swallowing may result from brain injury, cleft palate, cerebral palsy, hearing loss, stroke and other conditions.

**Note:** The Introduction section is for your general knowledge and is not to be taken as policy coverage criteria. The rest of the policy uses specific words and concepts familiar to medical professionals. It is intended for providers. A provider can be a person, such as a doctor, nurse, psychologist, or dentist. A provider also can be a place where medical care is given, like a hospital, clinic, or lab. This policy informs them about when a service may be covered.

## Policy Coverage Criteria

Therapy	Medical Necessity
<b>Speech therapy (ST)</b>	<b>Speech therapy (ST) services are considered not medically necessary for communication dysfunctions that are self-correcting, such as the natural developmental dysfluency or</b>

Therapy	Medical Necessity
	developmental articulation (speech) errors that are seen in young children as they learn language production.
<b>Duplicate therapy</b>	<p>Duplicate therapy is considered not medically necessary.</p> <p>Individuals receiving more than one therapy service, such as occupational (OT) and speech therapy (ST), must have separate treatment plans and goals for each therapy provided.</p>
<b>Non-skilled services</b>	Non-skilled services (e.g., routine word drills) that do not require the skills and expertise of a qualified provider of speech therapy services are considered not medically necessary.
<b>Maintenance programs</b>	Maintenance programs for speech therapy are considered not medically necessary.
<b>Speech therapy (ST)</b>	<p>Speech therapy (ST) services may be considered medically necessary for the treatment of communication impairment or swallowing disorders due to disease, trauma, congenital anomalies, or prior therapeutic intervention when ALL of the following criteria are met:</p> <ul style="list-style-type: none"> <li>• ST concentrates on achieving specific diagnosis-related goals for an individual who has a reasonable expectation of making measurable improvement in a reasonable and predictable period of time</li> <li>• ST is specific, effective, and reasonable for the individual's diagnosis and physical condition</li> <li>• ST is delivered by a qualified, licensed provider of speech language pathology services. A qualified provider is one who is licensed where required and performs within the scope of their licensure</li> <li>• ST interventions require the judgment, knowledge and skills of a qualified provider of speech therapy services due to the complexity and sophistication of the therapy and the physical condition of the individual</li> </ul>
<b>Voice therapy for gender transition/affirmation</b>	<p>Voice therapy is considered to be a type of speech therapy. Voice therapy may be considered medically necessary for gender transition/affirmation when ALL of the following criteria are met:</p>



Therapy	Medical Necessity
	<ul style="list-style-type: none"> <li>• The member contract does not exclude coverage of voice therapy or speech therapy for gender dysphoria or gender transition/affirmation.</li> <li>• Individual is 18 years of age or older</li> <li>• Diagnosis of gender dysphoria, confirmed by a physician, nurse practitioner, physician assistant, psychologist, or master’s level mental health clinician</li> <li>• Individual is in the process of male to female or female to male transition/affirmation, confirmed by a physician, nurse practitioner, physician assistant, psychologist, or master’s level mental health clinician.</li> <li>• Voice therapy is provided by a qualified, licensed provider of speech language pathology services. A qualified provider is one who is licensed where required and performs within the scope of their licensure.</li> </ul> <p><b>Note:</b> In some plans, the benefits available for speech therapy/voice therapy may include a fixed number of treatment visits covered per year. Refer to the member contract language for specific benefit determinations.</p>

Topic	Coverage Criteria
<b>Plan of care (POC)</b>	<p><b>The plan of care must be established prior to the treatment starting in order for services to be covered and must include:</b></p> <ul style="list-style-type: none"> <li>• Specific statements of long-and short-term goals</li> <li>• Measurable objectives</li> <li>• A reasonable estimate of when the goals will be reached</li> <li>• The specific treatment techniques and/or exercises to be used in the treatment</li> <li>• Details about frequency and duration of the planned treatment</li> </ul>
<b>POC Update / Recertification</b>	<p><b>The plan of care must be updated as the individual’s condition changes and must be recertified by the referring licensed healthcare provider at least every 60 days.</b></p>



## Documentation Requirements

**The clinical impression, diagnosis and treatment care plan documented for the initial and the follow-up visits must clearly support the medical necessity of the speech therapy provided.**

### **Documentation must be legible and include:**

- A key for any symbols, abbreviations or codes that are used by the provider and/or staff
- Brief notations, check boxes, and codes/symbols for treatment are acceptable if the notations refer to a treatment modality that has been described in the current plan of care
- Initials of the provider of service and any staff/employees who provide services

### **Documentation of objective findings include the following information:**

- Diagnosis/condition
- History and physical examination documenting the severity of the condition
- Speech evaluation findings, including motor and expressive results

### **The treatment plan of care:**

- Is patient-centered and appropriate for the symptoms, diagnosis and care of the condition
- Includes objectively measurable short and long-term goals for specific clinical and/or functional improvements in the individual's condition with estimated frequency and length of planned treatment including completion date
- Includes details of the specific treatment exercises and techniques to be used in treatment
- Is approved by the referring physician (if applicable)

### **A re-evaluation of the individual's progress is completed at each follow-up visit and includes documentation of:**

- Objective physical findings of the individual's current status
- The individual's subjective response to treatment
- Measured clinical and/or functional improvement in the individual's condition
- A review of the treatment plan of care along with progress toward the short and long-term goals for discharge from therapy
- Updates to the initial treatment plan of care with new goals that are appropriate to the individual's condition
- Reporting to the referring clinician with prescribing authority about the therapy outcomes and recommendations for follow up



## Coding

Code	Description
<b>CPT</b>	
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
92526	Treatment of swallowing dysfunction and/or oral function for feeding
<b>HCPCS</b>	
G0153	Services of a speech and language pathologist in home health setting, each 15 minutes
S9128	Speech therapy, in the home, per diem
S9152	Speech therapy, re-evaluation

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## Related Information

### Definition of Terms

**Aphasia:** A communication problem involving trouble with word finding and expressing coherent thoughts.

**Aphonia:** The inability to produce vocal sounds from the larynx, due to paralysis or disease of the pharyngeal nerves that affect the ability to speak.

**Apraxia:** The inability to perform purposeful movement in the absence of paralysis or other motor or sensory impairment.

**Duplicate therapy:** When an individual receives both occupational and speech therapy. The therapies should provide different treatments and not duplicate the same treatment. They must also have separate treatment plans and goals.



**Dysarthria:** Impairment of vocalization (speech) related to the muscles used for speech.

**Dysfluency:** Speech that is interrupted in its forward flow by hesitations, repetitions, or prolonged sounds; as experienced during normal speech development in young children.

**Dysphagia:** Difficulty swallowing.

**Dysphasia:** Impairment of speech consisting of a lack of coordination and failure to arrange words in their proper order.

**Dysphonia:** The broad term used to describe any voice impairment, difficulty in speaking, or vocal cord dysfunction.

**Maintenance (therapy):** A program consisting of drills, techniques, and exercises that preserve an individual's present level of function and prevent regression of that function. Maintenance begins when the therapeutic goals of a treatment plan have been achieved and when no further functional progress is apparent or expected to occur.

**Non-skilled services:** Certain types of treatment do not generally require the skills of a qualified provider of speech therapy services, such as treatments which maintain function by using routine, repetitions, and reinforced procedures that are neither diagnostic nor therapeutic (e.g., practicing word drills for developmental articulation errors) or procedures that may be carried out effectively by an individual, family, or caregiver(s).

## Benefit Application

The member's attending physician or other licensed treating health care professional must order ST services and approve the plan of care. Documentation in the plan of care must support the medical necessity of the ST services. Some health plans may have limited benefits for medically necessary ST (see [Scope](#)).

## Evidence Review

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A common reason for speech therapy is due to aphasia, a neurological disorder caused by damage to the part of the brain responsible for language. Aphasia is not a disease but is a symptom of brain damage. The most common cause of the damage is a brain attack (stroke) though it can be the result of a brain tumor, infection, head injury or dementia. "It is estimated



that about 1 million people in the United States today suffer from aphasia. The type and severity of language dysfunction depends on the precise location and extent of the damaged brain tissue “<sup>1</sup>

In 2016 Brady et al updated a 2012 Cochrane Systematic Review that reported on speech language therapy (SLT) for aphasia following stroke. The authors reviewed 57 randomized controlled trials (RCTs) involving 3002 participants. Twenty-seven randomised comparisons (1620 participants) assessed SLT versus no SLT; SLT resulted in clinically and statistically significant benefits to an individuals' functional communication, reading, writing, and expressive language, but (based on smaller numbers) benefits were not evident at follow-up. Nine randomised comparisons (447 participants) assessed SLT with social support and stimulation; meta-analyses found no evidence of a difference in functional communication, but more participants withdrew from social support interventions than SLT. Thirty-eight randomised comparisons (1242 participants) assessed two approaches to SLT. Functional communication was significantly better in people with aphasia that received therapy at a high intensity, high dose, or over a long duration compared to those that received therapy at a lower intensity, lower dose, or over a shorter period of time. The benefits of a high intensity or a high dose of SLT were confounded by a significantly higher dropout rate in these intervention groups. Generally, trials randomized small numbers of participants across a range of characteristics (age, time since stroke, and severity profiles), interventions, and outcomes.

The authors concluded that the review provided evidence of the effectiveness of SLT for people with aphasia following stroke in terms of improved functional communication, reading, writing, and expressive language compared with no therapy. There is some indication that therapy at high intensity, high dose or over a longer period may be beneficial. However, high-intensity and high dose interventions may not be acceptable to all.<sup>2</sup>

Another indication for speech therapy is dysphagia or swallowing disorders where the muscles and nerves used for swallowing are weakened or damaged. A stroke, brain injury, cancer of any of the structures involved in the swallow function or nervous system disorders are some examples of the causes for a swallowing problem. Swallowing disorders may lead to malnutrition, dehydration and/or aspiration.<sup>3</sup> Published clinical trials about specific speech therapy interventions for dysphagia are limited.

In 2008 Foley et al. reported on a systematic review of randomized controlled trials that evaluated dysphagia treatment post-stroke. Fifteen studies were included that covered a broad range of treatments, including: texture-modified diets, general dysphagia therapy programs, non-oral (e.g., enteral) feeding, medication and physical and olfactory stimulation. There was heterogeneity of the treatments evaluated and the outcomes assessed that precluded the use of pooled analyses. The review reports that general swallowing treatment programs are associated



with a reduced risk of pneumonia in the acute stage of stroke. Swallowing therapies and interventions in current practice appear to be based on clinical experience approaches that are physiologically based. The authors concluded that there is a need for high-quality research to identify effective dysphagia treatments post-stroke.<sup>4</sup>

In 2014 Godecke et al. stated that studies of very early rehabilitation have shown mixed results and that differences in therapy intensity and therapy type contribute significantly to the equivocal results. They performed a cohort study to compare a standardized, prescribed very early aphasia therapy regimen with a historical usual care control group at therapy completion (4-5 weeks post-stroke) and again at follow-up (6 months). This study compared two cohorts from successive studies conducted in four acute/sub-acute hospitals. The studies had near identical recruitment, blinded assessment and data-collection protocols. The Very Early Rehabilitation (VER) cohort (N = 20) had mild-severe aphasia and received up to 20 1-h sessions of impairment-based aphasia therapy, up to 5 weeks. The control cohort (n = 27) also had mild-severe aphasia and received usual care (UC) therapy for up to 4 weeks post-stroke. The primary outcome measure was the Aphasia Quotient (AQ) and a measure of communicative efficiency (DA) at therapy completion. Outcomes were measured at baseline, therapy completion and 6 months post-stroke and were compared using Generalized Estimating Equations (GEE) models. After controlling for initial aphasia and stroke disability, the GEE models demonstrated that at the primary end-point participants receiving VER achieved 18% greater recovery on the AQ and 1.5% higher DA scores than those in the control cohort. At 6 months, the VER participants maintained a 16% advantage in recovery on the AQ and 0.6% more on DA scores over the control cohort participants. They concluded that a prescribed, impairment-based aphasia therapy regimen, provided daily in very early post-stroke recovery, resulted in significantly greater communication gains in people with mild-severe aphasia at completion of therapy and at 6 months, when compared with a historical control cohort. However, they cautioned that further research is required to demonstrate large-scale and long-term efficacy.<sup>6</sup>

## Medicare National Coverage

Speech-language pathology services are covered under Medicare for the treatment of dysphagia, regardless of the presence of a communication disability.<sup>5</sup>

## References





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## History

Date	Comments
05/05/97	Add to Therapy Section - New Policy
11/12/02	Replace Policy - Policy reviewed without literature review; new review date only.
05/11/04	Replace Policy - Policy reviewed without literature review; HCPC code added. No change in policy statement.



Date	Comments
02/14/06	Replace Policy - Policy reviewed without literature review. Benefit Application revised to delete definition of a "session" due to new guidelines released by Fee Schedule Committee.
06/23/06	Update Scope and Disclaimer - No other changes
09/18/06	Cross References Updated - No other changes.
07/10/07	Cross Reference Update - No other changes.
05/13/08	Replace Policy - Policy updated with literature search; no change to the policy statement. Status changed from AR to BC. Code added.
08/12/08	Cross Reference Update - No other changes.
08/11/09	Replace Policy - Policy updated with literature search; no change to the policy statement.
01/11/11	New PR Policy - Policy updated with literature search; added a statement that the plan of care must be made prior to treatment for services to be covered. Also, the plan of care should be updated every 60 days and as the patient's condition changes. Policy statement on speech therapy for dysfunctions which are self-correcting has been changed from investigational to not medically necessary. The policy has been converted to a PR policy replacing BC.8.03.04.
01/06/12	Replace Policy – Policy reviewed. No changes.
09/10/12	Update Related Policy – Change titles for 1.01.518 and 1.01.502.
10/26/12	Update Related Policies. Title for 8.03.502 has been changed to say "Medical Massage Therapy".
01/29/13	Replace policy. Policy guideline updated with addition of the statement "Require the judgment, knowledge and skills of a qualified provider of speech therapy services due to the complexity and sophistication of the therapy and the physical condition of the patient". Benefit application section has clarifying statement that the plan of care requires orders and approval from an appropriate health care professional. Rationale section updated based on a literature review through November 2012. References 1-4 added. Added definitions to the Appendix section. Policy statement unchanged.
12/23/13	Coding Update. CPT code 92506 discontinued effective 12/31/13.
02/24/14	Replace policy. Moved definition of terms from Benefit Application section to the Policy Guidelines section. A literature search through January 23, 2014 did not prompt the addition of any new references. Policy statements unchanged.
05/02/14	Update Related Policies. Change title of policy 10.01.500.
08/11/15	Annual Review. Policy updated with a literature search through June, 2015. Definition of Terms moved from Appendix to Policy Guidelines section. Minor edits for readability. Reference 2 revised reference 5 added. Policy statements unchanged. ICD-9 diagnosis and procedure codes removed; these are not utilized in adjudication.



Date	Comments
02/09/16	Annual Review. Policy updated with a literature search through January 2016. Reference 6 added. No change to the policy statements.
04/01/17	Annual Review, approved March 14, 2017. Policy moved to new format. Policy updated with a literature search through February 2017. No change to the policy statements.
06/01/18	Annual Review, approved May 3, 2018. Policy updated with a literature search through April 2018. No change to the policy statements.
03/01/19	Annual Review, approved February 25, 2019. No references added. Policy statement unchanged.
03/01/20	Annual Review, approved February 4, 2020. Policy reviewed. Literature search through January 2020 performed. No references added. References updated. Minor edits made; intent of policy unchanged.
02/01/21	Annual Review, approved January 21, 2021. Policy reviewed. Policy statement unchanged.
12/01/21	Interim Review, approved November 18, 2021. Policy reviewed. References added. Minor edits made for clarity; otherwise policy statements unchanged.
01/01/22	Interim Review, approved December 14, 2021. Added criteria for coverage of voice therapy for gender transition/affirmation, and a related reference.
08/01/22	Annual Review, approved July 25, 2022. Policy updated with a literature search through June 30, 2022; references added. Policy statements unchanged.
05/01/23	Annual Review, approved April 24, 2023. Policy statements unchanged. No references added. Changed the wording from "patient" to "individual" throughout the policy for standardization.
06/01/24	Interim Review, approved May 13, 2024. For voice therapy for gender transition/affirmation, added psychologists as clinicians who can confirm a diagnosis of gender dysphoria and can confirm that the individual is in the process of male to female or female to male transition/affirmation.
10/01/24	Annual Review, approved September 23, 2024. Policy reviewed. No references added. Policy statements unchanged.

**Disclaimer:** This medical policy is a guide in evaluating the medical necessity of a particular service or treatment. The Company adopts policies after careful review of published peer-reviewed scientific literature, national guidelines and local standards of practice. Since medical technology is constantly changing, the Company reserves the right to review and update policies as appropriate. Member contracts differ in their benefits. Always consult the member benefit booklet or contact a member service representative to determine coverage for a specific medical service or supply. CPT codes, descriptions and materials are copyrighted by the American Medical Association (AMA). ©2024 Premera All Rights Reserved.

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