

Medical Policy



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BCN Policy Effective Date: 7/13/23
(See policy history boxes for previous effective dates)

Title: Speech/Swallowing Therapy

Description/Background

Speech-language pathology (SLP) services, also known as speech therapy, is therapy professionally administered by a certified or licensed speech therapist to provide for the identification, assessment, and correction of a speech impairment or communication disorder in children or adults. SLP services can be offered as either rehabilitative or habilitative services.

- SLP *rehabilitative* services are intended to improve, adapt or restore functions which have been impaired or permanently lost as a result of illness, injury, loss of a body part, or congenital abnormality involving goals an individual can reach in a reasonable period of time.
- SLP *habilitative* services are intended to maintain, develop or improve skills which have not (but normally would have) developed or which are at risk of being lost as a result of illness, injury, loss of a body part, or congenital abnormality. Examples include therapy for a child who is not speaking at the expected age.

Speech therapy covers a wide range of services for all ages, from birth to very old age, and is provided in schools, hospitals, home care, rehabilitation centers, and nursing homes. Speech-language pathologists (SLPs) work with individuals who have physical or cognitive deficits or disorders which result in communication difficulties. Communication includes speech (articulation, voice, linguistics) and language (phonology, morphology, syntax, semantics, pragmatics, both receptive and expressive language, including reading and writing). SLPs treat acquired reading and writing impairments in adults and children who have previously learned how to read and write and are diagnosed with neurologic impairments. SLP also provide services for individuals with dysphagia (difficulty swallowing).

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Speech therapy definitions:

Aural rehabilitation

Aural rehabilitation is an integral component of the care of a patient following the insertion of a cochlear implant. Among the professionals who may work as part of the cochlear implant team are audiologists, speech-language pathologists, educators, surgeons, medical specialists, psychologists and counselors. Audiologists help determine the candidacy of an individual for implantation and are actively involved in activating and programming the speech processor after surgery.

Apraxia of speech:

Apraxia of speech, also known as verbal apraxia or dyspraxia, is a speech disorder caused by damage to the brain in which a person has trouble saying what he or she wants to say correctly and consistently. It is a disorder of the brain and nervous system which makes it difficult to coordinate muscle movements needed to pronounce words, even though:

- The request or command is understood
- The patient is willing to perform the task
- The muscles needed to perform the task work properly
- The task may have already been learned

Developmental apraxia of speech (DAS) occurs in children and is present from birth. It appears to affect more boys than girls. This speech disorder goes by several other names, including developmental verbal apraxia, developmental verbal dyspraxia, articulatory apraxia, and childhood apraxia of speech. DAS is different from what is known as a developmental delay of speech, in which a child follows the “typical” path of speech development but does so more slowly than normal.

When apraxia develops in a person who was previously able to perform the tasks or abilities, it is called *acquired* apraxia. The most common causes of acquired apraxia are:

- Brain tumors
- Conditions that cause gradual worsening of the brain and nervous system (neurodegenerative illness)
- Dementia
- Stroke
- Traumatic brain injury

Vocal cord nodules/polyps

Vocal cord nodules are noncancerous growths on both vocal cords that are caused by vocal abuse. Over time, repeated abuse of the vocal cords (e.g., from yelling, screaming, etc.) results in spots on each vocal cord that are soft and swollen. Over time, the soft growths become harder, callous-like growths called nodules. The nodules will become larger and stiffer the longer the vocal abuse continues.

Polyps can take a number of forms. Polyps appear on either one or both of the vocal cords. They appear as a swelling or bump (like a nodule), a stalk-like growth, or a blister-like lesion. Most polyps are larger than nodules and may be called by other names, such as polypoid degeneration or Reinke's edema. The difference between nodules and polyps is similar to the difference between a callous and a blister.

Nodules and polyps may be treated medically, surgically and/or behaviorally. Surgical intervention involves removing the nodule or polyp from the vocal cord. This approach only occurs when the nodules or polyps are very large or have existed for a long time. Surgery is rare for children. Medical problems may be treated to reduce their impact on the vocal cords. This includes treatment for gastroesophageal reflux disease (GERD), allergies and thyroid problems. Medical intervention to stop smoking or to control stress is sometimes needed.

Many people receive behavioral intervention, or voice therapy, from a speech language pathologist (SLP). Voice therapy involves teaching good vocal hygiene, reducing/stopping vocal abusive behaviors and direct voice treatment to alter pitch, loudness or breath support for good voicing. Stress reduction techniques and relaxation exercises are often taught as well.

Swallowing therapy definitions:

Dysphagia

Dysphagia is a medical term for difficulty with swallowing. The degree of dysphagia can range from having problems swallowing certain foods or liquids, to the inability to swallow at all.

Dysphagia is usually caused by another health condition, such as:

- A condition affecting the nervous system, such as a stroke, Parkinson's disease, multiple sclerosis, head injury or dementia.
- Cancer, such as mouth cancer, throat cancer, esophageal cancer or brain tumors.
- Gastro-esophageal reflux disease (GERD), where stomach acid leaks back up into the esophagus, or other conditions that cause narrowing of the esophagus due to scarring

Dysphagia (at any age) is classified according to which phase of swallowing is affected. There may be impaired control of the tongue, which causes difficulty in initiating swallowing. With a pharyngeal dysfunction, food transport to the esophagus may be impaired. This may be caused by mechanical obstruction, motility disorder or impaired opening of the lower esophageal sphincter. Difficulty with swallowing may be referred to as dysphagia or a deglutition disorder. Pain in swallowing may accompany dysphagia and is called odynophagia. An inability to swallow is known as aphagia. Achalasia is a major exception to usual pattern of dysphagia in that swallowing of fluid tends to cause more difficulty than swallowing solids. In achalasia, there is idiopathic destruction of parasympathetic ganglia of the Auerbach submucosal plexus of the entire esophagus, which results in functional narrowing of the lower esophagus, and peristaltic failure throughout its length.

In infants, swallowing difficulty also includes difficulties with the sucking reflex. The sucking reflex initiates swallowing in the infant by stimulation of the lips and deeper parts of the oral cavity. The mandible, maxilla, upper gums, lips, palate and cheeks are necessary for compression of the nipple and expression of contents. Any defect of lips, tongue, palate,

mandible, maxilla or cheeks may create problems in an infant. Infants who do not learn sucking or chewing skills at the specific times in their development may have a difficult time mastering them later, leading to feeding problems. Oral dysphagia is commonly seen in children with neurodevelopmental disorders. These children will exhibit poor lingual and labial coordination.

The videofluorographic swallowing study (VFSS) is the gold standard for evaluating the mechanism of swallowing. VFSS is also known as a modified barium swallow. The study will demonstrate anatomic structures, the motions of these structures, and passage of the food through the oral cavity, pharynx and esophagus.

Additional diagnostic testing for swallowing disorders includes:

- Esophagoscopy: This test may be used to rule out neoplasm, particularly in patients who complain of thoracic dysphagia or odynophagia.
- Esophageal manometry and pH probe studies: These tests may be used when a motility disorder or gastric esophageal reflux disease is suspected.
- Electromyography: This test is indicated in patients with motor unit disorder such as polymyositis, myasthenia gravis or amyotrophic lateral sclerosis.
- Fiberoptic endoscopic examination of swallowing (FEES): This test is performed with a transnasal laryngoscope to assess pharyngeal swallowing. This test may be helpful when a VFSS is not feasible.
- Ultrasound imaging: This testing has been used to a limited extent on infants to assess the oral phase of swallowing. The technique is limited to infants since teeth will interfere with the sound signal. This method will permit studying of infants during breastfeeding since contrast media is not required.

Underlying medical conditions that may cause dysphagia at any age include but are not limited to:

- Neurological disorders and stroke
- Structural lesions
- Connective tissue disease
- Anatomic or congenital abnormalities
- Iatrogenic (symptom or illness brought on secondary to a medical procedure) causes such as surgical resection, radiation fibrosis, medications etc.

Swallowing/feeding therapy is considered a form of speech therapy and may be provided by a specialized speech or occupational therapist. The goals of swallowing therapy include reducing aspiration, improving the ability to eat and swallow, and optimizing the patient's nutritional status. Swallowing therapy involves the training of muscles for the oral, pharyngeal and esophageal stages of ingesting liquids or solids secondary to injury of these muscles. This training may include the teaching of specific movements or maneuvers to ensure safe swallowing. These maneuvers may include the head turn, chin tuck, effort full swallow, shaker exercises, supraglottic swallow maneuver and Mendelsohn maneuver. Patients and caregivers may also be trained in dietary therapy to determine what kind of foods, food volumes, and food consistencies allow the patient to swallow easily and safely.

Medical Policy Statement

The effectiveness of speech therapy (including swallowing and feeding therapy) has been established. It is a useful therapeutic option for patients meeting patient selection criteria.

Inclusionary and Exclusionary Guidelines (Clinically based guidelines that may support individual consideration and pre-authorization decisions)

A. Speech Therapy:

Rehabilitative Therapy

Inclusions (must meet all):

Short-term outpatient **speech therapy** is covered under all BCN certificates when:

- The speech therapy is ordered for the treatment of an organic medical condition resulting from illness, injury, surgery, or congenital abnormality, or for the immediate postoperative or convalescent state of the patient's illness, **AND**
- Based on a plan of care, the therapy sessions achieve a specific diagnosis-related goal for an individual who has a reasonable expectation of achieving measurable significant functional improvement in a reasonable and predictable period of time as a result of the therapy within 60 days, **AND** the therapy sessions provide specific, effective, and reasonable treatment for the individual's diagnosis and physical condition and require the judgment, knowledge, and skills of a qualified provider of SLP services due to the complexity and sophistication of the therapy and the medical condition of the individual.; **AND**
- The treatment is provided or supervised by a licensed or registered speech-language pathologist therapist that is properly contracted with BCN, **AND**
- Coverage is also available for treatment of an acute exacerbation of a chronic condition that is subject to significant improvement within 60 days.

Conditions for which rehabilitative speech therapy may be covered include, but are not limited to:

- Intensive treatment of a physical disease, trauma, congenital anomalies, therapeutic surgical interventions (e.g., surgery to the neck or throat) or medical interventions (e.g., post radiation therapy).
- Treatment of apraxia or dyspraxia
- Rehabilitation following stroke or transient ischemic attacks
- Rehabilitation after cochlear implantation (aural rehabilitation)
- Speech therapy for the presurgical or nonsurgical treatment of vocal cord nodules or polyps.
- Speech therapy for a documented diagnosis of autism as part of a comprehensive treatment program for autism.*

**Note: Michigan mandates treatment coverage for the diagnosis and treatment of autism spectrum disorders, including therapeutic care (e.g., services provided by a licensed or certified speech*

therapist, occupational therapist, physical therapist, or social worker up to a specific maximum annual benefit as determined by the patient's age.

Exclusions for rehabilitative speech therapy (Please check individual certificates relating to exclusions for the diagnosis of developmental delay. If developmental delay is not specifically listed as an excluded condition in the certificate, then speech therapy may be considered for coverage for this diagnosis if criteria is met.):

- Speech therapy for developmental delay (*excluding* autism), including syntax, semantic or articulation disorders. This would include speech therapy for patients with underlying conditions such as cerebral palsy or developmental delay/intellectual disability.
- The therapy is for dysfunctions that are self-correcting, such as:
 - Language therapy for young children with natural dysfluency; or
 - Developmental articulation errors that are self-correcting.
- The expectation does not exist that the speech therapy will result in a practical improvement in the level of functioning within a reasonable and predictable period of time.
- Speech therapy is not covered if the services can be provided by any federal or state agency or local political subdivision, including school districts, when a Member is not liable for the costs in the absence of insurance.
- Maintenance of a current speech level.
- Summer speech therapy programs normally provided by the school system during the regular school year.
- Sensory, behavioral, cognitive or attention disorders
- Self-correcting conditions including hoarseness
- Treatment of stuttering or stammering
- Services that do not require the skills of a qualified provider of SLP services including, but not limited to, the following:
 - Treatments that maintain function using routine, repetitious, or reinforced procedures that are neither diagnostic nor therapeutic (for example, practicing word drills for developmental articulation errors);
 - Procedures that may be carried out effectively by the individual, family, or caregivers.
- Treatments that are not supported in peer-reviewed literature

Habilitative Therapy

Inclusions:

- The therapy is intended to **maintain, develop or improve** speech, language, or swallowing impairment skills which have not (but normally would have) developed or which are at risk of being lost as a result of illness*, injury, loss of a body part, or congenital abnormality; An individual would either not be expected to develop the function or would be expected to permanently lose the function without the habilitative service (not merely fluctuate); and
- An individual would either not be expected to develop the function or would be expected to permanently lose the function without the habilitative service (not merely fluctuate); and

- The therapy documentation objectively verifies that, at a minimum, functional status is maintained; and
- The services require the judgment, knowledge, and skills of a qualified, BCN-contracted provider of SLP services due to the complexity and sophistication of the therapy and the medical condition of the individual.

*Note: Illness includes a wide range of conditions. For purposes of clarity, illness includes but is not limited to autism spectrum disorder.

Exclusions:

- The therapy is not aimed at developing, improving or maintaining functions, which would normally develop.
- The therapy is aimed at a function which would be permanently lost as a result of illness, injury, loss of a body part, or congenital abnormality whether or not therapy was provided.
- The therapy is considered primarily educational.
- The expectation does not exist that the speech therapy will result in a practical improvement in the level of functioning within a reasonable and predictable period of time.
- Services that do not require the skills of a qualified provider of ST services including, but not limited to, the following:
 - Treatments that maintain function using routine, repetitious, or reinforced procedures that are neither diagnostic nor therapeutic (e.g., practicing word drills for developmental articulation errors);
 - Procedures that may be carried out effectively by the individual, family, or caregivers.
- Routine reevaluations –not meeting the above criteria.
- Treatments that are not supported in peer-reviewed literature.
- Duplicate Habilitative therapy

B. Swallowing therapy:

Inclusions:

- Infants who have a long-term history of being fed through a feeding tube and have never learned to swallow properly.
- Patients who are status post neurological injury (e.g., stroke, traumatic brain injury) or post-surgery and/or radiation who have been noted to have swallowing difficulties.
- Members with congenital (i.e. present at birth) anatomic defects that affect swallowing where functional improvement is predicted (e.g. cleft palate and cleft lip).
- Members with chronic conditions (e.g., Parkinson's disease, amyotrophic lateral sclerosis etc.) with **new onset** swallowing difficulties as evidenced by coughing and choking with meals, drooling, etc. may benefit from short-term swallowing therapy.

Exclusions for swallowing therapy:

- BCN does not cover swallowing/feeding therapy for food aversions because this is considered a behavioral problem. Treatment for behavioral problems is not covered under the speech/swallowing therapy benefit. Neuromuscular stimulation to the muscles of the throat to stimulate inactive swallowing muscles commonly found in

patients with dysphagia (known as Vital Stimulation or VitalStim therapy) and similar non-specific electrical stimulation methods for the treatment of dysphagia

- Deep pharyngeal neuromuscular stimulation (DPNS). DPNS is a systematized therapeutic program which directly stimulates the pharyngeal musculature with specifically progressive and accountable techniques. DPNS can be used alone or in conjunction with VitalStim.
- Any therapy involving digital stimulation of the mouth, tongue or pharynx in patients not having a specifically diagnosed neuromuscular disorder specifically and adversely effecting swallowing.
- Swallowing therapy for deviant swallow or tongue thrust

CPT/HCPCS Level II Codes (*Note: The inclusion of a code in this list is not a guarantee of coverage. Please refer to the medical policy statement to determine the status of a given procedure*)

Established codes:

92507	92521	92522	92523	92524	92526	92610
G8996	G8997	G8998				

Other codes (investigational, not medically necessary, not a benefit, etc.):

92508

Rationale

Speech therapy is considered a useful therapeutic option to correct speech impairment or communication disorders resulting from disease, trauma, physical anomaly or previous therapeutic processes.

Speech and language pathologists also assist patients who have swallowing and feeding disorders. Children and adults with feeding or swallowing disorders due to an underlying medical condition may be assisted with feeding therapy. The goals of swallowing/feeding therapy include reducing aspiration, improving the ability to eat and swallow thereby optimizing the patient's nutritional status.

Apraxia

Apraxia of speech (AOS) was first defined almost 40 years ago by Darley as an articulatory disorder, resulting from impairment as a result of brain damage, of the capacity to program the positioning of speech musculature and the sequencing of muscle movements for the volitional production of phonemes. There is no associated significant weakness, slowness or incoordination in reflex and automatic acts to explain the incapacity. There may be prosodic alterations (i.e., abnormal intonation) associated with the articulatory problem, perhaps in compensation for it. There is a lack of well-controlled, randomized clinical trials to support the use of speech therapy for the treatment of speech apraxia.

An article by Ogar, et al., (1) states: “Within the literature on apraxia of speech (AOS), the site (or sites) of lesion, nature of defining speech characteristics and most effective treatment strategies remain somewhat elusive. Though AOS is now a widely accepted term, there is still debate as to which symptoms are most pathognomonic of this motor speech disorder, as many of the behaviors in AOS are also common symptoms in other speech and language disorders.

Clear and uniform diagnostic criteria will help clinicians and theorists better describe the features of AOS and will help address the question of whether there are different types of AOS, one associated with damage to the frontal lobe and another with temporoparietal lesions. The different location of lesions could impair the complex processes of speech articulation at different phases of the process and might require different types of intervention.

Using modern acoustic, physiologic and neuroimaging techniques may help refine the understanding of motor speech disorders in general and the neuroanatomical and cognitive bases of AOS in particular.

Most available treatments for AOS have limited data to support their efficacy.³⁰ Over the last few decades, a variety of treatment approaches have been studied, with no one approach proving to be effective for all patients. Given that AOS is generally believed to primarily disturb articulation and prosody (the rhythm of spoken language, including stress and intonation), many programs have focused on remediating these specific deficits.

An article by Wambaugh provided an overview of investigations of treatments for AOS. The treatment summary indicates that most available AOS treatments have limited data to support their use.³⁰ There are numerous individual case studies to be found in the medical literature, but there is a notable lack of replication of treatment findings in most of these studies.

A 2009 Cochrane review on *Childhood Apraxia of Speech* states, “The review demonstrates a critical lack of well controlled treatment studies addressing treatment efficacy for Childhood Apraxia of Speech (CAS), making it impossible for conclusions to be drawn about which interventions are most effective for treating CAS in children or adolescents.”²¹

Significant gains have been demonstrated since Darley’s original diagnosis almost 40 years ago, and many clients’ communication skills with AOS have improved greatly through speech therapy. However, many questions remain. These questions will continue to challenge researchers and clinicians to determine the best way of managing AOS for the benefit of our patients.

Voice Therapy

The vocal cords consist of two pairs of bands or folds of mucous membrane in the throat that project into the larynx. Sound is produced when the lower folds vibrate when air is passed up from the lungs through them.

Vocal *nodules* are small, benign, submucosal callous growths on the vocal cords. They usually form in pairs, one on each vocal fold. They form at the area that receives the most pressure when the folds come together to vibrate. Vocal *polyps* are benign extramucosal growths that are similar to vocal nodules but are usually softer. They most usually form on only one vocal

cord. Patients with either condition usually have voices that sound hoarse, low-pitched and slightly breathy. These conditions are diagnosed with a physical examination along as well as laryngoscopy or fiberoptic laryngoscopy.

Vocal cord *paralysis* occurs when one or both of the vocal cords fail to properly open or close. Vocal polyps and nodules can be treated by surgical removal of the lesions or voice therapy that may include exercises to strengthen the vocal cords or improve breath control during speech.

Electrical Stimulation for Dysphagia

Electrical stimulation has been proposed as a treatment for dysphagia. This may involve either direct electrical stimulation of the oral structure, or transcutaneous stimulation of the throat musculature. It appears the goal of the therapy is to stimulate and re-educate the neuromuscular pathways involved in swallowing.

According to an article by Smith-Hammond and Goldstein, “Electrical stimulation of the submandibular and thyrolaryngeal muscles during swallow with aspiration and stimulation of the recurrent laryngeal nerve via an implanted electrode around the recurrent laryngeal nerve represent new approaches to treatment for patients with severe dysphagia.²⁷ The results of preliminary investigations are promising. However, further studies are needed.”

An article by Steele indicates, “In recent years, there has been a proliferation of interest in the use of electric stimulation for the treatment of swallowing disorders.²⁸ This review explores both the rationale and existing evidence for electric stimulation approaches to swallowing rehabilitation. Although this is an exciting area of research which holds promise for future clinically relevant technology and/or therapy, a critical analysis of the existing literature will be presented to support the argument that implementation of electric stimulation in clinical swallowing rehabilitation settings still remains premature.”

There is insufficient evidence in published, peer-reviewed medical literature to establish electrical stimulation as effective in the treatment of dysphagia or other swallowing disorders. There is a need for well-designed, randomized, controlled clinical trials to demonstrate the effectiveness and clinical efficacy of electrical stimulation for this condition.

Government Regulations

National:

NCD for Speech-Language Pathology services for the treatment of dysphagia (170.3) Effective 10/2/2006.

Benefit Category

Outpatient Speech Language Pathology Services

Note: This may not be an exhaustive list of all applicable Medicare benefit categories for this item or service.

Item/Service Description

Dysphagia is a swallowing disorder that may be due to various neurological, structural, and cognitive deficits. Dysphagia may be the result of head trauma, cerebrovascular accident, neuromuscular degenerative diseases, head and neck cancer, and encephalopathies. While dysphagia can afflict any age group, it most often appears among the elderly.

Patients who are motivated, moderately alert, and have some degree of deglutition and swallowing functions are appropriate candidates for dysphagia therapy. Elements of the therapy program can include thermal stimulation to heighten the sensitivity of the swallowing reflex, exercises to improve oral-motor control, training in laryngeal adduction and compensatory swallowing techniques, and positioning and dietary modifications. Design all programs to ensure swallowing safety of the patient during oral feedings and maintain adequate nutrition.

Indications and Limitations of Coverage

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

Cross Reference

The Medicare Benefit Policy Manual, Chapter 15, "Covered Medical and Other Health Services," §§220 and 230.3.

Local:

CGS Administrators LLC- Local Coverage Determination (LCD)-for Speech – Language Pathology (L32794), last updated July 2013. Archived on 7/15/13

Speech-language pathology services are those services provided within the scope of practice of speech-language pathologists and necessary for the diagnosis and treatment of speech and language disorders, which result in communication disabilities and for the diagnosis and treatment of swallowing disorders (dysphagia), regardless of the presence of a communication disability.

A qualified speech-language pathologist for program coverage purposes meets one of the following requirements:

- The education and experience requirements for a Certificate of Clinical Competence in (speech-language pathology) granted by the American Speech-Language Hearing Association; or
- Meets the educational requirements for certification and is in the process of accumulating the supervised experience required for certification. (CMS Publication 100-02, Medicare Benefit Policy Manual, Chapter 15, Section 230.3(B))

An SLP normally has a master's degree and a Certificate of Clinical Competence (CCC-SLP) or all the requirements leading to a Certificate of Clinical Competence, that is, he or she is in their clinical fellowship year (CFY-SLP).

Under the Medicare Program, an independently practicing speech pathologist may now bill the Medicare program directly. However, the services of speech-language pathologists may continue to be billed by providers such as rehabilitation agencies, HHAs, CORFs, hospices, outpatient departments of hospitals, and suppliers such as physicians, non-physician

practitioners (NPPs), physical and occupational therapists in private practice. When these services are billed by physicians or NPPs, they are covered when billed under the “incident to” provision. “Incident to” services or supplies are defined as those furnished as an integral, although incidental, part of the physician’s or NPPs personal professional services in the course of diagnosis or treatment of an injury or illness. These services must be related directly and specifically to a written treatment regimen established by the physician/NPP, after any needed consultation with a qualified speech pathologist, or by the speech pathologist providing such services.

Indications:

Speech-language pathology services must be reasonable and necessary.

To be considered reasonable and necessary, the following conditions must be met: (CMS Publication 100-02, Medicare Benefit Policy Manual, Chapter 15, Section 220.2(B))

- The services shall be considered under accepted standards of medical practice to be a specific and effective treatment for the patient’s condition. Acceptable practices for therapy services are found in:
 - Medicare manuals (such as the Medicare manual and Publications 100-03 and 100-04),
 - Contractors Local Coverage Determinations (LCDs and NCDs are available on the Medicare Coverage Database: <http://www.cms.gov/mcd> and
 - Guidelines and literature of the professions of physical therapy, occupational therapy and speech-language pathology.
- The services shall be of such a level of complexity and sophistication or the condition of the patient shall be such that the services required can be safely and effectively performed only by a qualified therapist, or in the case of physical therapy and occupational therapy by or under the supervision of a qualified therapist. Services that do not require the performance or supervision of a therapist are not skilled and are not considered reasonable or necessary therapy services, even if they are performed or supervised by a qualified professional.
- If the contractor determines the services furnished were of a type that could have been safely and effectively performed only by or under the supervision of such a qualified professional, it shall presume that such services were properly supervised when required. However, this presumption is rebuttable, and, if in the course of processing claims it finds that services are not being furnished under proper supervision, it shall deny the claim and bring this matter to the attention of the Division of Survey and Certification of the Regional Office.
- While a beneficiary’s particular medical condition is a valid factor in deciding if skilled therapy services are needed, a beneficiary’s diagnosis or prognosis should never be the sole factor in deciding that a service is or is not skilled. The key issue is whether the skills of a qualified therapist are needed to treat the illness or injury, or whether the services can be carried out by non-skilled personnel. See item C for descriptions of skilled (rehabilitative) services.
- There must be an expectation that the patient’s condition will improve significantly in a reasonable (and generally predictable) period of time, or the services must be necessary for the establishment of a safe and effective maintenance program required in connection with a specific disease state. In the case of a progressive degenerative disease, service may be intermittently necessary to determine the need for assistive equipment and/or establish a program to maximize function (see item D for descriptions of maintenance services); and

- The amount, frequency, and duration of the services must be reasonable under accepted standards of practice. The contractor shall consult local professionals or the state or national therapy associations in the development of any utilization guidelines.
- The services of a maintenance program themselves are not covered. However, the development of a functional treatment plan for patient maintenance including evaluation, plan of treatment, and staff and family training, is covered, but it must require the skills of an SLP, and be a distinct and separate service which can only be done safely by a SLP.
- Reevaluation may be covered if necessary because of a change in the beneficiary's condition.

Evaluation of Language Disorders:

The order or referral for the evaluation and any specific testing in areas of concern should be designated by the referring physician in consultation with an SLP. The physician's certification of the need for care (e.g., approval of the plan of care) may substitute for the order. The documentation of the evaluation or re-evaluation by the SLP should demonstrate that an actual hands-on assessment occurred to support the medical necessity for reimbursement of the evaluation or re-evaluation. The documentation should differentiate between evaluation or re-evaluation and screening. Screening assessments are 13neurogenic and should not be billed. The initial screening assessments of patients or regular routine reassessments of patients are not covered. Evaluations in the absence of signs and symptoms are not covered.

The evaluation should include the beneficiary's history and the onset or exacerbation date of the current disorder. The history in conjunction with the current symptoms must establish support for additional treatment. Prior level of functioning should be documented, as well as current baseline abilities, to establish the basis for the therapeutic interventions. Evaluations must include the plan, goals (realistic, long-term, functional, communication goals) duration of therapy, frequency of therapy, and definition of the type of service. Diagnostic and assessment testing services to ascertain the type, causal factor(s) and severity of speech and language disorders, should be identified during the evaluation.

Re-evaluations are usually focused on the current treatment and might not be as extensive as initial evaluations. Continuous assessment of the patient's progress is a component of ongoing therapy services and is not payable as a re-evaluation. A re-evaluation is not a routine, recurring service but is focused on evaluation of progress toward current goals, making a professional judgment about continued care, modifying goals and/or treatment or terminating services. A formal re-evaluation is covered only if the documentation supports the need for further tests and measurements after the initial evaluation. Indications for a re-evaluation include new clinical findings, a significant change in the patient's condition, or failure to respond to the therapeutic interventions outlined in the plan of care.

A re-evaluation may be appropriate prior to planned discharge for the purposes of determining whether goals have been met, or for the use of the physician or the treatment setting at which treatment will be continued.

A re-evaluation is focused on evaluation of progress toward current goals and making a professional judgment about continued care, modifying goals and/or treatment or terminating services. Reevaluation requires the same professional skills as evaluation. The minutes for re-evaluation are documented in the same manner as the minutes for evaluation. Current

Procedural Terminology does not define a re-evaluation code for speech-language pathology; use the evaluation code. (CMS Publication 100-02, Medicare Benefit Policy Manual, Chapter 15, Section 220.3.C)

Documentation is expected to support the ability of the beneficiary to learn and retain instruction. Absence of such documentation may result in a denial of services. If the patient has questionable cognitive skills, a brief cognitive-communication assessment should be performed in order to establish the patient's learning ability. The brief cognitive assessment may also determine the need for more comprehensive cognitive performance testing.

For additional information on Medicare requirements for PT, OT, and Speech-Language Pathology evaluation and re-evaluation of services see CMS Publication 100-02, *Medicare Benefit Policy Manual*, Chapter 15, Section 220.

Skilled Procedures and Modalities:

After the evaluation and establishment of the plan of treatment, therapeutic interventions are expected to improve the beneficiary's functional abilities. Skilled procedures include:

- Design of a treatment program addressing the beneficiary's disorder. Continued assessment and analysis during the implementation of the services is expected at regular intervals.
- Establishment of compensatory skills for communication (e.g., air injection techniques or word finding strategies).
- Establishment of a hierarchy of speech-language tasks and cueing that directs a beneficiary toward communication goals.
- Analysis of actual progress toward goals.
- Establishment of treatment goals specific to speech dysfunction and designed to specifically address each problem identified in initial assessment.
- The selection and initial training of a device for augmentative or alternative communication systems.
- Patient and family training to augment restorative treatment or to establish a maintenance program. Education of staff and family must begin at the time of evaluation.

There should be an expectation of measurable functional improvement.

Documentation is expected to support the ability of the beneficiary to learn and retain instruction. Absence of such documentation may result in a denial of services. If the patient has questionable cognitive skills, a brief cognitive-communication assessment should be performed in order to establish the patient's learning ability. The brief cognitive assessment may also determine the need for more comprehensive cognitive performance testing.

Aural Rehabilitation:

Coverage for speech reading is only allowed with documentation that supports a loss of hearing sensitivity that cannot be corrected with a hearing aid or amplification. Documentation should also support visual acuity of the beneficiary sufficient to participate in aural rehabilitation.

Speech reading is considered medically necessary when determined by a licensed audiologist that the use of a hearing aid or other amplification would not significantly improve the beneficiary's understanding of speech. Speech reading training is not medically necessary for beneficiaries who refuse to wear a hearing aid. Routine screening for hearing acuity or

evaluations aimed at the use of hearing aids is not a covered service.

Determination of the medical necessity for the speech reading will be based on the following criteria:

- Documentation of basic hearing evaluation and audiogram;
- Documentation identifying type and extent of hearing loss;
- Documentation of adequate cognitive and memory skills;
- Documentation that visual acuity, with glasses if applicable, is sufficient to allow the beneficiary to participate in the therapy;
- Documentation of the beneficiary's motivation to participate in therapy in order to improve understanding of speech.

Group Therapy:

Group therapy sessions must meet the individualized plan of treatment requirement and are not subject to reimbursement if these criteria are not met. Group therapy coverage for speech reading can be covered (if medically justified) if the following criteria are met:

- Services are rendered under an individualized plan of care
- The group has no more than four group members
- Group therapy does not represent the entire plan of treatment

Laryngoscopy, flexible or rigid fiberoptic, with stroboscopy

This procedure may be used for assessing voice production and vocal function. It may be performed by qualified speech-language pathologists.

Speech-language pathologists should have evidence that they meet the ASHA (American Speech-Language—Hearing Association) training requirements as outlined in the ASHA's *Training Guidelines for Laryngeal Videoscopy/Stroboscopy*.

Limitations:

Following are some examples of interventions which would generally be considered non-skilled and therefore not covered under Medicare:

- Non-diagnostic, non-therapeutic, routine, repetitive and reinforcing procedures (e.g., the practicing of word drills without skilled feedback).
- Procedures which are repetitive and/or that reinforce previously learned material which the beneficiary, staff or family may be instructed to repeat.
- Procedures which may be effectively carried out with the beneficiary by any non-professional (family or restorative aide) after instruction is completed.
- Services rendered by a SLP assistant or aide.
- Provision of practice for use of augmentative or alternative communication systems after being taught their use.
- Although speech-language pathologists may perform laryngoscopy for the assessment of voice production and vocal function, laryngoscopy for medical diagnostic purposes must be performed by a physician.

Generally, group therapy sessions, except as specified above, are not covered. Group therapy sessions in social organizations such as the stroke club or lost cord club are not covered. See the "Indications" section above for information on when group therapy might be covered.

Speech-language pathology services provided for chronic disorders of memory and orientation are covered services when significant functional progress is demonstrated at early stages of the disorder. When functional progress plateaus, the development of a maintenance program, including training of caregivers and family members is covered

Preparation of memory aids such as memory books, memory boards, or communication books may be covered. Supervision of the use of such aids is not covered as these services do not require the skills of a qualified therapist.

All SLP services provided by anyone other than an SLP who is licensed or otherwise authorized by the State in which they practice, including a speech-language pathology assistant or aide, are not covered.

The following disorders are typically non-covered for the geriatric Medicare beneficiary:

- Fluency disorder
- Conceptual handicap
- Dysprosody
- Stuttering and cluttering (except stuttering caused by acquired brain damage)
- Myofunctional disorders, e.g., tongue thrust

Speech-language pathology is considered medically appropriate treatment for individuals with mental retardation when comorbid disorders such as aphasia or dysarthria are exhibited.

Speech therapy interventions to instruct the beneficiary in English phrases, who has a primary language other than English, are not covered. However, when the primary language of the beneficiary is other than English, speech therapy interventions in the patient's primary language will be covered within the parameters of this LCD.

(The above Medicare information is current as of the review date for this policy. However, the coverage issues and policies maintained by the Centers for Medicare & Medicare Services [CMS, formerly HCFA] are updated and/or revised periodically. Therefore, the most current CMS information may not be contained in this document. For the most current information, the reader should contact an official Medicare source.)

Related Policies

- Physical and Occupational Therapy (BCN only)
- Coma Stimulation
- Cognitive Rehabilitation
- Neuromuscular Electrical Stimulation
- Cochlear Implants

References

1. Ogar J, Slama H., et al. "Apraxia of Speech: An overview. Neurocase. Volume 11. 2005. Pp. 427-432
2. Alexandra, John, et al., "Comparing outcomes of voice therapy: a benchmarking study using the therapy outcome measure," Journal of Voice, Volume 19, Number 1, 2004, pp. 114-1223.
3. Altman, Kenneth W., MD, PhD, FACS, "Vocal fold masses," Otolaryngol Clin N Am, Volume 40, 2007, pp. 1091-1108.
4. Ashley, Juliet, MS, CCC-SLP, et al., "Speech, language, and swallowing disorders in the older adult," Clinics in Geriatric Medicine, Volume 22, Number 2, May 2006, pp. 291-310.
5. Beukelman, D. R., et al., "AAC for adults with acquired neurological conditions: a review," Augment Altern Commun, Volume 23, Number 3, September 2007, pp. 230-242. Blue Cross Blue Shield Association, "Speech Therapy," Medical Policy Reference Manual, # 8.03.04, original policy date 07/31/96, Issue 4:2003, Last review date 12/17/03, no review scheduled.
6. Bos-Clark, M. and P. Carding, "Effectiveness of voice therapy I functional dysphonias: where are we now?" Curr Opin Otolaryngol Head Neck Surg, February 16, 2011, Epub ahead of print.
7. Centers for Medicare and Medicaid Services (CMS), "Outpatient Physical Therapy, Occupational Therapy and Speech-Language Pathology," National Coverage Provision, HYSMED-001, Effective Date 01/01/2006.
8. Centers for Medicare and Medicaid Services (CMS), Program Memorandum Intermediaries/Carriers, "NCD for Speech Pathology Services for the Treatment of Dysphagia: Beneficiary Notice of Implementation of Outpatient Therapy Service Limitations," Transmittal AB-03-085, September 16, 2004, Publication Number 100.3, Manual Section Number 170.3, original effective date 8/28/89, current effective date 10/1/08, < <http://www.cms.gov/medicare-coverage-database/details/ncd-details.aspx?NCDId=192&ncdver=2&CoverageSelection=Both&ArticleType=All&PolicyType=Final&s=Michigan&Keyword=Speech-Language+Pathology&KeywordLookUp=Title&KeywordSearchType=And&bc=gAAAACAA AAAA&> > (accessed June 2023).
9. Cohen, Seth M., MD and Garrett, C. Gaelyn, MD, "Utility of voice therapy in the management of vocal fold polyps and cysts," Otolaryngology-Head and Neck Surgery," Volume 135, 2007, pp.742-746.
10. Franco, Ramon A., MD and Jennifer G. Andrus, MD, "Common diagnoses and treatments in professional voice users," Otolaryngol Clin N Am, Volume 40, 2007, pp. 1025–1061.
11. Gray, Steven D., MD, et al., "Voice disorders in children," Pediatric Clinics of North America, Volume 43, Issue 6, December 1996, pp. 1-23.
12. Hicks, Marcy, MS, et al., "Vocal cord dysfunction/paradoxical vocal fold motion," Prim Care Clin Office Pract, Volume 35, 2008, pp. 81-103.
13. Holmberg, Eva B., et al., "Efficacy of a behaviorally based voice therapy protocol for vocal nodules," Journal of Voice," Volume 15, Number 3, 2001, pp. 395-412.
14. Johns, M. M., "Update on the etiology, diagnosis and treatment of vocal fold nodules, polyps and cysts," Curr Opin Otolaryngol Head Neck Surg, Volume 11, Number 6, December 2003, pp. 456-461.

15. Knollman-Porter, Kelly., "Acquired apraxia of speech: a review," *Top Stroke Rehabil*, Volume 15, Number 5, September-October 2008, pp. 484-493.
16. Lind, Christopher D., MD, "Dysphagia: evaluation and treatment," *Gastroenterology Clinics*, Volume 32, Number 2, June 2003, pp. 553-575.
17. McMurray, J. Scott, MD, FAAP, FACS, "Disorders of phonation in children," *Pediatr Clin N Am*, Volume 50, 2003, pp. 363-380.
18. Michigan Department of Health and Human Services, *Medicaid Provider Manual*, Section 7.28 and 7.3 Therapies, Last updated April 2017.
19. Miller, Susan, PhD, "Voice therapy for vocal cord paralysis," *Otolaryngol Clin N Am*, Volume 37, 2004, pp. 105-119.
20. Mizuno, Katsumi, MD and Aki Ueda BS, "The maturation and coordination of sucking, swallowing, and respiration in preterm infants," *Journal of Pediatrics*, Volume 142, Number 1, January 2003, (no page numbers listed).
21. Morgan, A. T. and Vogel, A. P., "A Cochrane review of treatment for childhood apraxia of speech," *Eur J Phys Rehabil Med*, Volume 45, Number 1, March 2009. Pp. 103-110.
22. Pannbacker, Mary, "Treatment of vocal nodules: options and outcomes," *American Journal of Speech-Language Pathology*, Volume 8, August 1999, pp. 209-217.
23. Pederson, M., et al., "Dysphonia: Medical treatment and a medical voice hygiene advice approach. A prospective randomized pilot study," *European Archives of Oto-Rhino-Laryngology*, Volume 261, Number 6, pp. 312-315.
24. Roy, Nelson, et al., "An evaluation of the effects of two treatment approaches for teachers with voice disorders: a prospective, randomized clinical trial," *Journal of Speech, Language and Hearing Research*, Volume 44, April 2001, pp. 286-296.
25. Schneider, Sarah L., MS, CCC-SLP and Robert T. Sataloff, MD, DMA, "Voice therapy for the professional voice," *Otolaryngol Clin N Am*, Volume 40, 2007, pp. 1133-1149.
26. Slama, Ogar J., et al., "Apraxia of speech: an overview," *Neurocase*, Volume 11, Number 6, December 2005, pp. 427-432.
27. Smith Hammond, C. A., and Goldstein, L. B., "Cough and aspiration of food and liquids due to oral-pharyngeal dysphagia: ACCP evidence-based clinical practice guidelines," *Chest*, Volume 129, Number 1 Suppl, January 2006, pp. 154S-168S.
28. Steele, C. M., et al., "Electric stimulation approaches to the restoration and rehabilitation of swallowing: a review," *Neurol Res*, Volume 29, Number 1, January 29, 2007, pp. 9-15.
29. Sullivan, P., "Verdict still out on electrical stimulation: More research needed on "e-stim" techniques," *The ASHA Leader*, p. 3, (2004, April 13), accessed March 16, 2011, available at <https://leader.pubs.asha.org/doi/10.1044/leader.FTR8.09072004.2> Accessed June 13, 2022.
30. Wambaugh, J. L., "A summary of treatments for apraxia of speech and review of replicated approaches," *Semin Speech Lang*, Volume 23, Number 4, November 2002, pp. 293-308.
31. Yun, Y. S., et al., "The effect of vocal hygiene education for patients with vocal polyp," *Otolaryngol Head Neck Surg*, Volume 137, Number 4, 2007, pp. 569-575.
32. WPS LCD L28531, available at [http://www.cms.gov/medicare-coverage-database/details/lcd-details.aspx?LCDId=28531&ContrId=267&ver=36&ContrVer=1&CtrctrSelected=267*1&Ctrctr=267&name=Wisconsin+Physicians+Service+Insurance+Corporation+\(08202%2c+MAC+-+Part+B\)&s=27&DocType=All&bc=AggAAAIAAAAAA%3d%3d&](http://www.cms.gov/medicare-coverage-database/details/lcd-details.aspx?LCDId=28531&ContrId=267&ver=36&ContrVer=1&CtrctrSelected=267*1&Ctrctr=267&name=Wisconsin+Physicians+Service+Insurance+Corporation+(08202%2c+MAC+-+Part+B)&s=27&DocType=All&bc=AggAAAIAAAAAA%3d%3d&) (4/30/14)(3/7/13). LCD retired effective 3/10/14.

33. National Coverage Determination (NCD) for SPEECH-Language Pathology SERVICES for the Treatment of Dysphagia (170.3), available at <http://www.cms.gov/medicare-coverage-database/details/ncd-details.aspx?NCDId=192&ncdver=2&CoverageSelection=Both&ArticleType=All&PolicyType=Final&s=Michigan&KeyWord=speech+services&KeyWordLookUp=Title&KeyWordSearchType=And&bc=gAAAABAAAAAAAAAA%3d%3d&>. Accessed June 2023.

The articles reviewed in this research include those obtained in an Internet based literature search for relevant medical references through June 2023, the date the research was completed.

BCN Medical Policy History

Date	Rationale
1990	BCN policy established
3/14/01	Routine maintenance
6/30/04	Routine maintenance
10/3/05	Routine maintenance
10/3/06	Routine maintenance; added information regarding feeding and swallowing therapy
11/9/07	Routine maintenance
1/13/09	Routine maintenance
2/17/10	Routine maintenance
5/18/11	• Updated Blue Cross Complete section indicating that there are no diagnosis restrictions for speech or swallowing therapy. • Addressed the issue of speech therapy for verbal apraxia (considered non-covered). • Added criteria stating that speech therapy is covered for the presurgical or nonsurgical treatment of vocal cord nodules or polyps. • Reinforced BCN position of non-coverage for voice therapy when done in the absence of vocal cord nodules or polyps. • Added information regarding electrical stimulation for the treatment of dysphagia; considered experimental and investigational for this condition.
2/15/12	Added “occupational therapists” as appropriate providers of swallowing disorder therapies, in addition to speech-language pathologists.
3/20/13	Routine update. Updated description and inclusionary/exclusionary guidelines for both speech and swallowing therapies.
5/21/14	Routine update. Added information re: coverage of therapy services for autism spectrum disorder. Updated CPT codes and MDCH information.
9/16/15	Routine update.
8/17/16	Routine policy maintenance. Updated Medicaid/Medicare coverage.
8/23/17	Routine policy maintenance. No change in policy status.
7/18/18	Routine policy maintenance. No change in policy status.
7/17/19	Removed Medicaid section. Routine policy maintenance, no change in policy status.
7/9/20	Routine policy maintenance. No change in policy status.

7/15/21	Routine policy maintenance, no change in policy status.
7/7/22	Routine policy maintenance, no change in policy status.
7/13/23	This policy was replaced by JUMP policy—Speech and Language Pathology/Swallowing Rehabilitation, effective 7/1/23. Vendor managed: N/A. (ds)

Next Review: Policy replaced, no further review.

MEDICAL POLICY TITLE: SPEECH/SWALLOWING THERAPY BCN BENEFIT ADMINISTRATION

I. Coverage Determination

Commercial HMO (includes Self-Funded groups unless otherwise specified)	Covered, criteria apply. See inclusionary/exclusionary guidelines. NOTE: Michigan mandates the coverage of the diagnosis and treatment of autism spectrum disorders, such as therapeutic care (including services provided by a licensed or certified speech therapist, occupational therapist, physical therapist, or social worker) up to a specific maximum annual benefit as determined by the patient's age. NOTE: For U of M Premier groups only: Speech therapy for life-style activities (e.g., "voice therapy" for singers, etc.) may be covered when medically necessary and condition is subject to improvement within benefit limitations.
BCNA (Medicare Advantage)	Covered services include, but aren't limited to, the following: physical therapy, occupational therapy, and speech and language therapy. Authorization rules may apply. Call Customer Service for details. NOTE: Medicare covers speech therapy for the diagnosis of verbal apraxia.
BCN65 (Medicare Complementary)	Coinsurance covered if primary Medicare covers the service.

II. Administrative Guidelines

- The member's contract must be active at the time the service is rendered.
- The service must be authorized by the member's PCP except for Self-Referral Option (SRO) members seeking Tier 2 coverage.
- Services must be performed by a BCN-contracted provider, if available, except for Self-Referral Option (SRO) members seeking Tier 2 coverage.
- Payment is based on BCN payment rules, individual certificate benefits and certificate riders.
- Appropriate copayments will apply. Refer to certificate and applicable riders for detailed information.
- CPT - HCPCS codes are used for descriptive purposes only and are not a guarantee of coverage.