

Medicare Advantage Medical Policy



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Speech and Language Pathology Swallowing Rehabilitation – Medicare Advantage

Medicare Advantage Plan

☒ Medicare Plus BlueSM

☒ BCN AdvantageSM

UM Committee Approval Date: 7/16/2025

Effective Date: 8/16/2025

Description

Speech and language pathology (SLP) swallowing rehabilitation, also known as dysphagia rehabilitation, is a specialized area of practice that focuses on the assessment, diagnosis, and treatment of swallowing disorders (dysphagia) in individuals across the lifespan. Swallowing disorders can result from various medical conditions, such as stroke, traumatic brain injury, neurological diseases (e.g., Parkinson's disease, amyotrophic lateral sclerosis), cancer, and other conditions that affect the brain, nerves, and muscles involved in swallowing. 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.

Related Medical Coverage Policies

- Cognitive Rehabilitation
 - Autism Spectrum Disorder Services
 - Gender Affirming Services
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Policy Guidelines

Blue Cross Blue Shield of Michigan (BCBSM) and Blue Care Network of Michigan (BCN) adhere to guidance from the Centers for Medicare and Medicaid Services (CMS), including when performing organization determinations for Medicare Advantage plan members. CMS Medicare statutes, regulations, manuals, National Coverage Determinations (NCDs), Local Coverage Determinations (LCDs), Local Coverage Articles (LCAs) and other sub-regulatory guidance provide the clinical guidelines for coverage determinations, payment integrity functions, and all other uses by CMS regulations. When CMS Medicare guidance is silent, incomplete, or insufficient, CMS permits BCBSM/BCN to utilize "internal coverage criteria",

such as independent criteria, health plan policy research, LCD/LCAs outside the services area or research from independent medical research repositories (i.e., Hayes) for coverage policies 42 CFR § 422.101. BCBSM/BCN internal medical coverage policies are developed and based on current evidence in widely accepted treatment guidelines or clinical literature; in addition, they address how clinical benefits may or may not outweigh member harm.

Clinical review follows guidance provided in the BCBSM Medicare Advantage Coverage Determination Hierarchy policy, which may be found at <https://www.bcbsm.com/providers/mpradmin/> by entering the policy name.

Coverage Guidance

To ensure consistency with coverage guidance, the Medicare statutes, regulations, coverage manuals, NCD, LCD, and LCA should be reviewed and applied first. BCBSM/BCN internal coverage criteria should only be applied when CMS guidance is silent, incomplete, or insufficient for a code

Apart from durable medical equipment (DME), Medicare Administrative Contractor (MAC) jurisdiction for the purpose of clinical determination is based upon place of service. The place of service for laboratory testing is defined as the geographic location of the reference laboratory. Non-jurisdictional LCD/LCAs may not be utilized for a determination unless they have been specifically identified as internal coverage criteria by the policy. Alternatively, jurisdiction for DME MAC is determined by the member place of residence. Please see CMS Medicare Administrative Contractors (MAC) table for state MAC assignments below.

Code	Description	CMS Guidance	Additional Guidance
92507	Treatment of speech, language, voice, communication, and/or auditory processing disorder; individual	The Medicare Benefit Policy Manual, Chapter 15, "Covered Medical and Other Health Services," §§220 and 230.3.	BCBSM/BCN will follow CMS guidance as the primary source for coverage determinations. However, in instances where CMS guidance is silent, incomplete, or insufficient for a particular code, BCBSM/BCN internal coverage criteria will be applied to ensure consistent and informed decision-making. In such cases, please refer to the relevant BCBSM/BCN policy for guidance: <i>Speech and Language Pathology/Swallowing Rehabilitation</i> Policy attached below
92508	Group, two or more individuals	NCD 170.3 - Speech-Language Pathology Services for the Treatment of Dysphagia	
92521	Evaluation of speech fluency (e.g., stuttering, cluttering)	WPS None	
92522	Evaluation of speech sound production (e.g., articulation, phonological process, apraxia, dysarthria)	CGS L34046, A34046 - Speech-Language Pathology First Coast None	
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)	NGS L33580, A52866 - Speech-Language Pathology Noridian JE None Noridian JF None	

92524	Behavioral and qualitative analysis of voice and resonance	Novitas L35070, A54111 - Speech - Language Pathology (SLP) Services: Communication Disorders	
92526	Treatment of swallowing dysfunction and/or oral function for feeding		
92610	Evaluation of oral and pharyngeal swallowing function	Palmetto None	

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HCPSCS® codes, descriptions and materials are copyrighted by Centers for Medicare and Medicaid Services (CMS).

The above information is current as of the review date for this policy. However, the coverage issues and policies maintained by CMS are updated and/or revised periodically. Therefore, the most current CMS information may not be contained in this document.

Please refer to the Medicare Coverage Database website at <https://www.cms.gov/medicare-coverage-database/search.aspx> for the most current applicable NCD, LCD, LCA, and CMS Online Manual System Transmittals.

CMS Medicare Administrative Contractors (MAC) Jurisdictions

Part A and Part B MAC Jurisdictions	
Wisconsin Physicians Service Insurance Corporation (WPS)	IA, IN, KS, MI, MO, NE
CGS Administrators, LLC	KY, OH
First Coast Service Options, Inc	FL, PR, US VI
National Government Services, Inc (NGS)	CT, IL, MA, ME, MN, NH, NY, RI, VT, WI,
Noridian Healthcare Solutions, LLC, Jurisdiction JE	CA, HI, NV, American Samoa, Guam, Northern Mariana Islands
Noridian Healthcare Solutions, LLC, Jurisdiction JF	AK, AZ, ID, MT, ND, OR, SD, UT, WA, WY
Novitas Solutions, Inc	AR, CO, DC, DE, LA, MD, MS, NJ, NM, OK, PA, TX,
Palmetto GBA	AL, GA, TN NC, SC, VA, WV
DME MAC Jurisdictions	
CGS Administrators, LLC, Jurisdictions JB and JC	AL, AR, CO, FL, GA, IL, IN, KY, LA, MI, MN, MS, NM, NC, OH, OK, Puerto Rico, SC, TN, TX, VA, Virgin Island, WI, WV
Noridian Healthcare Solutions, LLC, Jurisdictions JA and JD	AK, American Soamoa, AZ, CA, CT, DE, DC, Guam, HI, ID, IA, KS, MA, MD, ME, MO, MT, ND, NE, NH, NJ, NV, NY, Northern Mariana Islands, OR, PA, RI, SD, UT, VT, WA, WY

Important Reminder

BCBSM and BCN follow CMS Medicare coverage guidance to limit coverage to items and services that are reasonable and necessary for the diagnosis or treatment of an illness or injury or to improve the functioning of a malformed body member. Medicare Advantage Medical Policies list the criteria BCBSM and BCN use to decide which medical services are considered “reasonable and necessary” when Medicare coverage rules are not fully developed, or as otherwise may permitted by CMS Medicare regulations. Individual member benefit plan documents, such as the Evidence of Coverage and Annual Notice of Change, as

well as applicable laws govern benefit coverage, including any inclusion, exclusion, and/or other restrictions.

Medicare Advantage Medical policies are created when permitted by CMS Medicare regulations, reviewed regularly, and may be revised periodically. BCBSM/BCN Medical Policies are proprietary and should not be copied or disseminated without the express, prior written approval of BCBSM. All providers are required to review applicable BCBSM reimbursement policies prior to claim submission and bill for covered services in accordance with those policies. Additionally, providers contracted with BCBSM or BCN's Medicare Advantage network(s) should review the provider manual for any additional claim submission requirements. Providers not contracted with BCBSM or BCN's Medicare Advantage network may be required to submit documentation to BCBSM, BCN, or its delegated entity supporting billed claims, including but not limited to applicable medical records.

Note: U.S. Food and Drug Administration (FDA) approval for a specific indication or the issuance of a CPT code is not sufficient for a procedure to be considered medically reasonable and necessary. Similarly, the presence of a procedure/device code or payment amount for the service in the Medicare fee schedule does not necessarily indicate coverage. If a service is deemed not reasonable and necessary, to treat illness or injury for any reason (including lack of safety and efficacy because it is an experimental procedure, etc.), the procedure is considered not covered.

Disclaimer: This medical policy is not an authorization, certification, explanation of benefits, or a contract for the services, devices, or drugs that is referenced in the medical policy. Medical policies do not constitute medical advice and do not guarantee any results or outcomes or guarantee payment. The medical policy is not intended to replace independent medical judgment for the treatment of individuals. Treating physicians and health care providers are solely responsible for determining what care to provide to their patients. Identification of selected brand names of devices, tests and procedures in a medical coverage policy is for reference only and is not an endorsement of any one device, test, or procedure over another.

Pursuant to Section 1557 and Section 504, Blue Cross does not discriminate on the basis of race, color, national origin, age, disability, or sex (including sex characteristics, intersex traits; pregnancy or related conditions; sexual orientation; gender identity, and sex stereotypes). This includes our rules, benefit designs and medical policies.

BCBSM/BCN Medicare Advantage Policy History

Policy Effective Date	UM Committee Approval Date	Comments
07/17/2024	07/17/2024	Medicare Advantage policy established
08/16/2025	07/16/2025	MA policy foundational language updated. Adoption of JUMP policy updates.

Medical Policy



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Joint Medical Policies are a source for BCBSM and BCN medical policy information only. These documents are not to be used to determine benefits or reimbursement. Please reference the appropriate certificate or contract for benefit information. This policy may be updated and is therefore subject to change.

***Current Policy Effective Date: 9/1/25**
(See policy history boxes for previous effective dates)

Title: Speech and Language Pathology/Swallowing Rehabilitation

Description

Speech and language disorders are two major types of communication disorders. Speech impairment involves disorders of articulation, voice, or fluency. Language impairment involves disorders of comprehension and systems (oral, written, sign) used to convey language. Speech and language rehabilitation is focused on improving communication skills, voice quality, and safe swallowing techniques.

Background

Speech-language pathology services (SLP)

Speech-language pathology services are considered necessary for the diagnosis and treatment of swallowing, speech-language, and cognitive-communication disorders that result in communication disabilities. Speech-language pathologists treat disorders of speech sound production (e.g., articulation, apraxia, dysarthria), resonance (e.g., hypernasality, hyponasality), voice (e.g., phonation quality, pitch, respiration), fluency (e.g., stuttering), language (e.g., comprehension, expression, pragmatics, semantics, syntax), cognition (e.g., attention, memory, problem solving, executive functioning), and feeding and swallowing (e.g., oral, pharyngeal, and esophageal stages).

Rehabilitative 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, or loss of a body part and involve goals an individual can reach in a reasonable period of time.

Habilitative Services

Health care services and devices that help an individual keep, learn, or improve skills and functioning for daily living. Examples include therapy for a child who is not walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for individuals with disabilities in a variety of inpatient and/or outpatient settings.

Congenital Abnormality

A congenital abnormality, also known as a birth defect, is a condition that occurs during the development of an unborn child. A structural or functional anomaly that occurs during intrauterine life. Examples of congenital abnormalities may include, but are not limited to, cleft lip and palate, Down syndrome, cerebral palsy, hemifacial microsomia, and CHARGE syndrome (a rare genetic disorder that affects many parts of the body including the eyes, heart, ears and more).

Developmental Delay

A developmental delay may be seen when a child's progression through predictable developmental phases slows, stops, or reverses. Symptoms may include slower-than-normal development of motor, cognitive, social or emotional skills. Developmental delays occur when children do not reach expected milestones in key areas:

- Speech/Language: difficulty speaking, understanding, or using words;
- Motor Skills: trouble with movements (e.g., walking holding objects);
- Cognitive: challenges with learning, memory, or problem-solving;
- Social/Emotional: struggles with interacting, forming relationships, or showing emotions;
- Adaptive Skills: problems with self-care (e.g., feeding, dressing).

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 (at any age) is classified according to which phase of swallowing is affected. There may be the oral phase which involves impaired control of the tongue, leading to 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.

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.

Speech Therapy Definitions

Aural rehabilitation

Aural rehabilitation is beneficial for individuals with hearing loss who use hearing or assistive devices, cochlear implants or individuals without hearing aids or implants to improve communication skills.

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 may be 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

Childhood apraxia of speech occurs in children and is present from birth. If left untreated, it may impair development. It appears to affect more boys than girls. This speech disorder goes by several other names, including verbal apraxia, verbal dyspraxia, articulatory apraxia, and childhood apraxia of speech. Childhood apraxia of speech 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

Aphasia

Aphasia is an acquired neurogenic language disorder resulting from an injury to the brain, usually, the left hemisphere. Aphasia involves varying degrees of impairment. Depending on an individual's unique set of symptoms, impairments may result in loss of ability to use functional communication skills. A person with aphasia often has relatively intact nonlinguistic cognitive skills.

Mixed Expressive/Receptive Disorder

A mixed expressive-receptive language disorder (also called mixed language disorder) is a condition where an individual has difficulty both understanding (receptive language) and expressing (expressive language) thoughts and ideas verbally. This means they may struggle with comprehending spoken language and with forming their own sentences and communicating their needs and desires.

Fluency disorder

A fluency disorder is an interruption in the flow of speaking characterized by atypical rate, rhythm, and disfluencies (e.g., repetitions of sounds, syllables, words, and phrases; sound prolongations; and blocks), which may also be accompanied by excessive tension, speaking avoidance, struggle behaviors, and secondary mannerisms.

Speech and sound disorders: articulation and phonology

Speech sound disorders is an umbrella term referring to any difficulty or combination of difficulties with perception, motor production, or phonological representation of speech sounds and speech segments—including phonotactic rules governing permissible speech sound sequences in a language. Speech sound disorders can be organic or functional in nature. Organic speech sound disorders result from an underlying motor/neurological, structural, or sensory/perceptual cause. Functional speech sound disorders are idiopathic—they have no known cause.

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. 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.

Feeding/Swallowing Therapy Definitions

Feeding disorders

Feeding disorders are characterized by extreme food selectivity (beyond pickiness) by type, (exclude more than one food group from the child's diet); by texture (only eat smooth or crunchy foods); or by brand, shape or color. Some children develop feeding problems due to a medical condition such as reflux or a severe illness. Some have poor oral motor skills and have difficulty chewing and swallowing and this restricts their diet. Pediatric feeding disorders can lead to problems including weight loss, nutritional deficiency, need for nutritional supplements, or problems with daily functioning.

Condition Severity Grading

An individual's speech-related problems can be classified, in part, by severity. Severity is a function of multiple factors which can include, but are not limited to, the frequency, duration, and intensity to which the problem occurs. Severity grading helps to provide context to the problem or condition the individual is facing as part of a review for medical need of skilled care. However, it does not guarantee medical need or

authorization of care. In general, problems associated with a condition may be classified as mild, moderate or severe.

The results of formal assessments can help to categorize the severity of an individual's problem. Formal assessments are recommended when appropriate. There are multiple assessments that utilize normal bell-curve standard deviation ranges. Formal assessments can be helpful in tracking severity and how it changes in a standard, repeatable, fashion. The typical bell curve deviation severity ranges are as follows:

- Mild: -1 to 1.5 Standard deviations (SD) below the mean
- Moderate: -1.5 to -2 SD below the mean
- Severe: -2 or more SD below the mean

Duplicative Therapy Services

Services provided to an individual under two or more different disciplines, or providers, for the same body-part or diagnosis with the same or similar plan of care for treatment are considered duplicate services. This is not the same as interdisciplinary or multidisciplinary care where an individual may receive care from different disciplines but each with different plans of care, goals and treatments.

Regulatory Status

N/A

Medical Policy Statement

Speech and language pathology services (including e.g., voice therapy, swallowing, and feeding therapy) have been established. These services are a useful therapeutic option for individuals when criteria are met.

Inclusionary and Exclusionary Guidelines

Speech and Language Pathology Rehabilitative Therapy

Inclusions (must meet all):

Outpatient speech and language rehabilitation is covered when:

- The speech therapy is ordered for the treatment of an organic medical condition resulting from illness, injury, surgery, 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. **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 speech-language pathologist that is properly contracted with BCBSM,
- Coverage is also available for treatment of an acute exacerbation of a chronic condition that is subject to significant improvement.

Conditions for which rehabilitative speech and language pathology services may be covered include, but are not limited to:

- Intensive treatment of a physical disease, trauma, therapeutic surgical interventions (e.g., surgery to the neck or throat) or medical interventions (e.g., post radiation therapy that impact voice, speech, language, fluency, swallowing or cognition).
- Treatment of apraxia or dyspraxia of speech
- Treatment of mixed expressive/receptive language disorders
- Rehabilitation following stroke or transient ischemic attacks
- Rehabilitation post cochlear implantation (aural, speech, language, and voice rehabilitation)
- Voice therapy for the pre-surgical or nonsurgical treatment of vocal cord nodules or polyps, vocal cord paresis/paralysis and muscle tension dysphonia
- Speech and language 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 and Language Pathologist).
- Speech and language therapy for developmental conditions, including syntactic, semantic or articulation disorders when it is determined that the condition is severe AND not likely to be "self-correcting."

The following criteria help to identify severe developmental conditions.

Severity Criteria for Developmental Conditions

The child's communicative abilities are scored within the severe range on a standardized test of communicative dysfunction. The typical bell curve deviation severity ranges are as follows:

- Mild: -1 to 1.5 Standard deviations (SD) below the mean
- Moderate: -1.5 to -2 SD below the mean
- Severe: -2 or more SD below the mean

OR

1. The child is essentially nonverbal and has a communication deficit that is too severe for standardized testing.
2. The child tests at more than one year behind norms for receptive language skills on a standardized test of communicative dysfunction.
3. The child tests at more than one year behind for expressive language skills on a standardized test of communicative dysfunction.
4. The child tests at more than one year behind norms for articulation proficiency on a standardized test of communicative dysfunction.

If a child's severity status changes as a consequence of treatment while therapy is in progress, coverage will continue for the remainder of the 60 calendar days or sixty treatments, depending on the member's benefit.

The medical chart must demonstrate specific treatment goals based on the original and ongoing assessment of the child's speech or language disorder. Measurement of progress to goals must be documented. Periodic re-evaluation using a standardized tool must be completed. The medical record(s) must be supplied upon request.

Exclusions:

- Long standing conditions where functional, sustained improvement is unlikely with or without therapy.
- Therapy for conditions that are self-correcting with no history of a medical problem such as:
 - Language therapy for very young children
 - Mild developmental articulation errors that are self-correcting.
 - Developmental disorders not felt to be severe.
- 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 can be provided by a federal or state agency or local political subdivision, including school districts, when the member is not liable for the costs in the absence of insurance.
- Summer speech therapy programs normally provided by the school system during the regular school year.
- Self-correcting conditions including hoarseness when no medical problem is identified
- 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.
- Voice therapy associated with gender affirming services.

Habilitative Therapy

Please check individual certificates relating to exclusions for the diagnosis of developmental disorders. If developmental disorders are not specifically listed as excluded conditions in the certificate or contract, then speech therapy may be considered for coverage for this diagnosis if the above criteria under rehabilitative therapy severity criteria are met.

Inclusions:

- The therapy is intended to keep, learn or improve speech, voice, 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*, 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

- 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 SLP 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 aimed at developing, improving, or maintaining functions, which would normally develop with no intervention.
- 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, OR an assessment of progress to goals does not demonstrate “maintenance” of status or capabilities.
- Services that do not require the skills of a qualified provider of SLP 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.
- Long standing chronic conditions.

Swallowing therapy

Inclusions:

- Infants who have a 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, post-surgery) and/or radiation who have been noted to have swallowing difficulties.
- Patients with congenital (i.e., present at birth) abnormalities that affect swallowing where functional improvement is predicted (e.g., craniofacial impairments such as cleft palate and cleft lip).
- Patients 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:

- BCBS 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.

- BCBS does not separately cover 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 unless included in a standard program of dysphagia rehabilitation.
- BCBS does not cover deep pharyngeal neuromuscular stimulation (DPNS).
- 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	92508	92521	92522	92523	92524
92526	92610				

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

N/A

Note: Individual policy criteria determine the coverage status of the CPT/HCPCS code(s) on this policy. Codes listed in this policy may have different coverage positions (such as established or experimental/investigational) in other medical policies.

Rationale

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.¹

An article by Ogar et al (2005) 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."²

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.³ 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.³ 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."⁴

Vocal Rehabilitation

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.⁵

Sahin et al (2018) investigated the role of voice therapy (VT) and factors that may affect the response to VT in the treatment of vocal fold polyps, especially as a complement to phonosurgery. Retrospective review of patients with vocal fold polyp undergoing surgery and/or VT in a tertiary medical center. The demographic data, phoniatric history, videolaryngostroboscopic findings, polyp characteristics, VHI-10 and GRB scores, and voice analysis data were recorded before and after the treatment. The patients were grouped as those who had undergone endolaryngeal microsurgery only (Group S), those who had first received VT then undergone surgery due to inadequate VT outcome (Group VTpS), and those who had only undergone VT with a follow-up plan (Group VT). Data were reviewed from 211 (108 M, 103 F) patients with a mean age of 41.3 ± 11 years. The improvement in all voice-related variables observed in the S and VTpS groups was significantly greater compared to the VT group despite the degree of improvement achieved in this group. At the end of the

treatment period, improvements in G-R-B, VHI-10 and stroboscopy scores were significantly greater in the VTpS group than in the S and VT groups. The authors concluded that VT could improve voice quality during the treatment of vocal fold polyps.⁷

In 2019, Agarwal et al. compared the short-term outcomes of treatment with voice therapy alone (VT), surgery alone (SUR) or voice therapy and surgery (VTS). A retrospective study was performed for patients diagnosed with VFP (International Classification of Diseases between January 2010 and April 2016). Inclusion criteria were age greater than 18 years and charted evidence of treatment with voice therapy, surgery, or both. Exclusion criteria were history of laryngeal cancer or radiation above the clavicles. Outcomes measured included chart records of lesion absence, persistence or recurrence, and differences between pretreatment and post-treatment Voice Handicap Index-10 and GRBAS (G/grade, R/roughness, B/breathiness, A/asthenia, S/strain) scores. One hundred twenty patients with VFPs were identified (SUR = 23, 19.2%, VT = 29, 24.2%, VTS = 68, 56.7%). Mean follow-up was 5.5 months. There were no recurrences in 115 patients (95.8%). There was significant improvement from pre- to post-treatment VHI-10 scores in the SUR (mean improvement = 12.5, standard deviation [SD] = 12.7) and VTS (mean improvement = 12.3, SD = 10.3) groups compared to the VT (mean improvement = 2.84, SD = 11.9) group ($P = .009$). Pre- and post-treatment GRBAS scores did not significantly change in any group.⁶

White (2019) wrote on the management of benign vocal fold lesions. Benign vocal fold lesions (BVFLs) cause dysphonia by preventing full vocal fold closure, interrupting vibratory characteristics and increasing compensatory muscle tension. Management includes phonosurgery, voice therapy, pharmacological treatment or more commonly a combination of these interventions. This review highlights variation in the management of BVFLs. There is evidence that phonosurgery is a well-tolerated and effective intervention for BVFLs. Primary voice therapy can frequently prevent surgery in vocal fold nodules and some types of polyps. Used as an adjunct to phonosurgery, preoperative and postoperative voice therapy can improve patient-reported outcomes and acoustic parameters of the voice. However, heterogeneity of studies and poor descriptions of intervention components prevent a robust analysis of the impact of voice therapy.⁸

Swallow Therapy

According to Wilkinson et al (2021), dysphagia is common but may be underreported. Specific symptoms, rather than their perceived location, should guide the initial evaluation and imaging. Obstructive symptoms that seem to originate in the throat or neck may actually be caused by distal esophageal lesions. Oropharyngeal dysphagia manifests as difficulty initiating swallowing, coughing, choking, or aspiration, and it is most commonly caused by chronic neurologic conditions such as stroke, Parkinson disease, or dementia. Symptoms should be thoroughly evaluated because of the risk of aspiration. Patients with esophageal dysphagia may report a sensation of food getting stuck after swallowing. This condition is most commonly caused by gastroesophageal reflux disease and functional esophageal disorders. Eosinophilic esophagitis is triggered by food allergens and is increasingly prevalent; esophageal biopsies should be performed to make the diagnosis. Esophageal motility disorders such as achalasia are relatively rare and may be over diagnosed. Opioid-induced esophageal dysfunction is becoming more common. Esophagogastroduodenoscopy is recommended for the initial evaluation of esophageal dysphagia, with barium esophagography as an adjunct. Esophageal cancer and other serious conditions have a low prevalence, and testing in low-risk patients may be deferred while a four-week trial of acid-suppressing therapy is undertaken. Many frail

older adults with progressive neurologic disease have significant but unrecognized dysphagia, which significantly increases their risk of aspiration pneumonia and malnourishment. In these patients, the diagnosis of dysphagia should prompt a discussion about goals of care before potentially harmful interventions are considered. Speech-language pathologists and other specialists, in collaboration with family physicians, can provide structured assessments and make appropriate recommendations for safe swallowing, palliative care, or rehabilitation.⁹

According to Lawlor and Choi (2020), awareness of swallowing dysfunction in the pediatric population is growing. As many as 50% of parents report that their otherwise healthy children have a feeding problem. Dysphagia is increasingly common in the pediatric population, especially as advances in health care improve the survival of extremely premature infants and children with complex congenital abnormality. Symptoms of dysphagia and aspiration prompt referral to otolaryngologists. Dysfunction can exist at any of the 4 phases of the physiologic swallow. Dysphagia manifests differently in children at each age in their development. Dysphagia can present in otherwise healthy children but is more common in patients with a history of prematurity, neuromuscular disorders, cardiopulmonary disorders, anatomic anomalies of the upper aerodigestive tract, and gastrointestinal tract disorders. Workup involves clinical feeding evaluations, imaging studies, and endoscopic evaluations. Appropriate management depends on the cause of dysphagia. The causes of dysphagia in children are varied and often multifactorial. Evaluation by a multidisciplinary team can facilitate accurate diagnosis and guide management.¹⁰

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.¹¹ 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.¹² 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.”

Summary of Evidence

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.

Supplemental Information

PRACTICE GUIDELINES AND POSITION STATEMENTS

American Speech-Language-Hearing Association (ASHA)

According to ASHA (1997-2023), treatment should focus on getting the muscles to move correctly to produce sounds again. Saying sounds over and over and using the correct mouth movements will assist with this goal. In severe cases, the individual may need to find other ways to communicate. These may include simple hand gestures, writing, pointing to letters or pictures, or using a computer (e.g., augmentative and alternative communication).¹³

Government Regulations

National:

NCD for Speech-Language Pathology services for the treatment of dysphagia (170.3) Effective 10/2/2006.¹⁴ Rev. 11426. 05/20/22.

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.

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, or encephalopathies. While dysphagia can affect any age group, it most often appears among the elderly. Speech-language pathology services are covered under Medicare for the treatment of dysphagia, regardless of the presence of a communication disability. 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.

Cross Reference

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

Medicare Benefit Policy Manual, Chapter 15, Section 220. Rev. 11865., 02-16-23.

ACTIVE PARTICIPATION of the clinician in treatment means that the clinician personally furnishes in its entirety at least 1 billable service on at least 1 day of treatment. ASSESSMENT is separate from evaluation, and is included in services or procedures, (it is not separately payable). The term assessment as used in Medicare manuals related to therapy services is distinguished from language in Current Procedural Terminology (CPT) codes that specify assessment, e.g., 97755, Assistive Technology Assessment, which may be payable). Assessments shall be provided only by clinicians because assessment requires professional skill to gather data by observation and patient inquiry and may include limited objective testing and measurement to make clinical judgments regarding the patient's condition(s). Assessment

determines, e.g., changes in the patient's status since the last visit/treatment day and whether the planned procedure or service should be modified. Based on these assessment data, the professional may make judgments about progress toward goals and/or determine that a more complete evaluation or re-evaluation (see definitions below) is indicated. Routine weekly assessments of expected progression in accordance with the plan are not payable as re-evaluations.

CERTIFICATION is the physician's/nonphysician practitioner's (NPP) approval of the plan of care. Certification requires a dated signature on the plan of care or some other document that indicates approval of the plan of care. The CLINICIAN is a term used in this manual and in Pub 100-04, chapter 5, section 10 or section 20, to refer to only a physician, nonphysician practitioner or a therapist (but not to an assistant, aide or any other personnel) providing a service within their scope of practice and consistent with state and local law. Clinicians make clinical judgments and are responsible for all services they are permitted to supervise. Services that require the skills of a therapist, may be appropriately furnished by clinicians, that is, by or under the supervision of qualified physicians/NPPs when their scope of practice, state and local laws allow it, and their personal professional training is judged by Medicare contractors as sufficient to provide to the beneficiary skills equivalent to a therapist for that service.

COMPLEXITIES are complicating factors that may influence treatment, e.g., they may influence the type, frequency, intensity and/or duration of treatment. Complexities may be represented by diagnoses (ICD codes), by patient factors such as age, severity, acuity, multiple conditions, and motivation, or by the patient's social circumstances such as the support of a significant other or the availability of transportation to therapy. A DATE may be in any form (written, stamped or electronic). The date may be added to the record in any manner and at any time, as long as the dates are accurate. If they are different, refer to both the date a service was performed and the date the entry to the record was made. For example, if a physician certifies a plan and fails to date it, staff may add "Received Date" in writing or with a stamp. The received date is valid for certification/re-certification purposes. Also, if the physician faxes the referral, certification, or re-certification and forgets to date it, the date that prints out on the fax is valid. If services provided on one date are documented on another date, both dates should be documented. The EPISODE of Outpatient Therapy – For the purposes of therapy policy, an outpatient therapy episode is defined as the period of time, in calendar days, from the first day the patient is under the care of the clinician (e.g., for evaluation or treatment) for the current condition(s) being treated by one therapy discipline (PT, or OT, or SLP) until the last date of service for that discipline in that setting. During the episode, the beneficiary may be treated for more than one condition; including conditions with an onset after the episode has begun. For example, a beneficiary receiving PT for a hip fracture who, after the initial treatment session, develops low back pain would also be treated under a PT plan of care for rehabilitation of low back pain. That plan may be modified from the initial plan, or it may be a separate plan specific to the low back pain, but treatment for both conditions concurrently would be considered the same episode of PT treatment. If that same patient developed a swallowing problem during intubation for the hip surgery, the first day of treatment by the SLP would be a new episode of SLP care.

EVALUATION is a separately payable comprehensive service provided by a clinician, as defined above, that requires professional skills to make clinical judgments about conditions for which services are indicated based on objective measurements and subjective evaluations of

patient performance and functional abilities. Evaluation is warranted e.g., for a new diagnosis or when a condition is treated in a new setting. These evaluative judgments are essential to development of the plan of care, including goals and the selection of interventions.

FUNCTIONAL REPORTING, which is required on claims for all outpatient therapy services pursuant to 42CFR410.59, 410.60, and 410.62, uses nonpayable G-codes and related modifiers to convey information about the patient's functional status at specified points during therapy. (See Pub 100-04, chapter 5, section 10.6) NOTE: Functional reporting requirements are no longer applicable for claims for dates of service on and after January 1, 2019. See the NOTE at the beginning of Section 220.4 for more information about the discontinuation of functional reporting requirements.

RE-EVALUATION provides additional objective information not included in other documentation. Re-evaluation is separately payable and is periodically indicated during an episode of care when the professional assessment of a clinician indicates a significant improvement, or decline, or change in the patient's condition or functional status that was not anticipated in the plan of care. Although some state regulations and state practice acts require re-evaluation at specific times, for Medicare payment, reevaluations must also meet Medicare coverage guidelines. The decision to provide a reevaluation shall be made by a clinician.

INTERVAL of certified treatment (certification interval) consists of 90 calendar days or less, based on an individual's needs. A physician/NPP may certify a plan of care for an interval length that is less than 90 days. There may be more than one certification interval in an episode of care. The certification interval is different from a Progress Report period.

MAINTENANCE PROGRAM (MP) means a program established by a therapist that consists of activities and/or mechanisms that will assist a beneficiary in maximizing or maintaining the progress he or she has made during therapy or to prevent or slow further deterioration due to a disease or illness.

NONPHYSICIAN PRACTITIONERS (NPP) means physician assistants, clinical nurse specialists, and nurse practitioners, who may, if state and local laws permit it, and when appropriate rules are followed, provide, certify or supervise therapy services. PHYSICIAN with respect to outpatient rehabilitation therapy services means a Doctor of Medicine, osteopathy (including an osteopathic practitioner), podiatric medicine, or optometry (for low vision rehabilitation only). Chiropractors and doctors of dental surgery or dental medicine are not considered physicians for therapy services and may neither refer patients for rehabilitation therapy services nor establish therapy plans of care. PATIENT, client, resident, and beneficiary are terms used interchangeably to indicate enrolled recipients of Medicare covered services. PROVIDERS of services are defined in §1861(u) of the Act, 42CFR400.202 and 42CFR485 Subpart H as participating hospitals, critical access hospitals (CAH), skilled nursing facilities (SNF), comprehensive outpatient rehabilitation facilities (CORF), home health agencies (HHA), hospices, participating clinics, rehabilitation agencies or outpatient rehabilitation facilities (ORF). Providers are also defined as public health agencies with agreements only to furnish outpatient therapy services, or community mental health centers with agreements only to furnish partial hospitalization services. To qualify as providers of services, these providers must meet certain conditions enumerated in the law and enter into an agreement with the Secretary in which they agree not to charge any beneficiary for covered services for which the program will pay and to refund any erroneous collections made. Note that the word

PROVIDER in sections 220 and 230 is not used to mean a person who provides a service but is used as in the statute to mean a facility or agency such as rehabilitation agency or home health agency.

QUALIFIED PROFESSIONAL means a physical therapist, occupational therapist, speech-language pathologist, physician, nurse practitioner, clinical nurse specialist, or physician's assistant, who is licensed or certified by the state to furnish therapy services, and who also may appropriately furnish therapy services under Medicare policies. Qualified professional may also include a physical therapist assistant (PTA) or an occupational therapy assistant (OTA) when furnishing services under the supervision of a qualified therapist, who is working within the state scope of practice in the state in which the services are furnished. Assistants are limited in the services they may furnish (see section 230.1 and 230.2) and may not supervise other therapy caregivers. QUALIFIED PERSONNEL means staff (auxiliary personnel) who have been educated and trained as therapists and qualify to furnish therapy services only under direct supervision incident to a physician or NPP. See §230.5 of this chapter. Qualified personnel may or may not be licensed as therapists but meet all of the requirements for therapists with the exception of licensure. SIGNATURE means a legible identifier of any type acceptable according to policies in Pub. 100-08, Medicare Program Integrity Manual, chapter 3, §3.3.2.4 concerning signatures. SUPERVISION LEVELS for outpatient rehabilitation therapy services are the same as those for diagnostic tests defined in 42CFR410.32. Depending on the setting, the levels include personal supervision (in the room), direct supervision (in the office suite), and general supervision (physician/NPP is available but not necessarily on the premises).

SUPPLIERS of therapy services include individual practitioners such as physicians, NPPs, physical therapists and occupational therapists who have Medicare provider numbers. Regulatory references on physical therapists in private practice (PTPPs) and occupational therapists in private practice (OTPPs) are at 42CFR410.60 (C)(1), 485.701- 729, and 486.150-163.

THERAPIST refers only to qualified physical therapists, occupational therapists and speech-language pathologists, as defined in §230. Qualifications that define therapists are in §§230.1, 230.2, and 230.3. Skills of a therapist are defined by the scope of practice for therapists in the state). THERAPY (or outpatient rehabilitation services) includes only outpatient physical therapy (PT), occupational therapy (OT) and speech-language pathology (SLP) services paid using the Medicare Physician Fee Schedule or the same services when provided in hospitals that are exempt from the hospital Outpatient Prospective Payment System and paid on a reasonable cost basis, including critical access hospitals. Therapy services referred to in this chapter are those skilled services furnished according to the standards and conditions in CMS manuals, (e.g., in this chapter and in Pub. 100-04, Medicare Claims Processing Manual, chapter 5), within their scope of practice by qualified professionals or qualified personnel, as defined in this section, represented by procedures found in the American Medical Association's "Current Procedural Terminology (CPT)." A list of CPT (HCPCS) codes is provided in Pub. 100-04, chapter 5, §20, and in Local Coverage Determinations developed by contractors.

TREATMENT DAY means a single calendar day on which treatment, evaluation and/or reevaluation is provided. There could be multiple visits, treatment sessions/encounters on a treatment day.

VISITS OR TREATMENT SESSIONS begin at the time the patient enters the treatment area (of a building, office, or clinic) and continue until all services (e.g., activities, procedures, services) have been completed for that session and the patient leaves that area to participate in a non-therapy activity. It is likely that not all minutes in the visits/treatment sessions are billable (e.g., rest periods). There may be two treatment sessions in a day, for example, in the morning and afternoon. When there are two visits/ treatment sessions in a day, plans of care indicate treatment amount of twice a day.

Local:

No LCD is available for these services.

(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

- Cognitive Rehabilitation
- Cochlear Implants
- Pediatric Feeding Programs
- Autism Spectrum Disorder Services
- Augmentative Alternative Communication Devices-BCN policy
- Speech and Swallow Therapy—BCN policy retired
- Gender Affirming Services

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The articles reviewed in this research include those obtained in an Internet based literature search for relevant medical references through March 2025, the date the research was completed.

Joint BCBSM/BCN Medical Policy History

Policy Effective Date	BCBSM Signature Date	BCN Signature Date	Comments
7/1/23	4/26/23		Joint policy established, BCN policy retired, IMP on speech language pathology incorporated into this policy. Vendor managed: EviCore BCN and BCNA. (ds)
7/1/24	4/16/24		Routine maintenance, no change in policy status. Vendor managed: EviCore BCN and BCNA. (ds)
4/15/25	N/A		Policy tabled. Vendor managed: EviCore BCN & BCNA (ds)
9/1/25	6/17/25		• Added definitions for: ○ Congenital abnormality ○ Developmental delay ○ Mixed expressive/receptive language disorder ○ Condition severity grading (from EviCore) ○ Duplicative therapy services • Removed congenital “anomalies” and replaced with “abnormalities” • Removed congenital abnormality from the Rehabilitative section and placed under habilitative • Other minor changes in language made throughout policy for clarification purposes Vendor: EviCore BCN & BCNA (ds)

Next Review Date: 1st Qtr., 2026

Pre-Consolidation Medical Policy History

Original Policy Date	Comments
BCN:	Revised:
BCBSM:	Revised:

BLUE CARE NETWORK BENEFIT COVERAGE
POLICY: SPEECH AND LANGUAGE PATHOLOGY/SWALLOWING REHABILITATION

I. Coverage Determination:

Commercial HMO (includes Self-Funded groups unless otherwise specified)	Covered per policy
BCNA (Medicare Advantage)	Covered per NCD guidelines
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.
- Coverage is based on each member's certificate and is not guaranteed. Please consult the individual member's certificate for details. Additional information regarding coverage or benefits may also be obtained through customer or provider inquiry services at BCN.
- 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 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.