MEDICAL POLICY

POLICY TITLE	SPEECH THERAPY (OUTPATIENT)
POLICY NUMBER	MP- 8.002

Effective Date:	8/1/2022

I. POLICY

Speech therapy services may be considered **medically necessary** when the services are reasonable and necessary for the treatment of the individual's illness or injury and an expectation exists that the therapy will result in a significant and measurable improvement in the individual's level of functioning within a reasonable period of time (i.e., approximately 3-4 months) and the improvement is documented at 3-4 month intervals.

Treatment should be provided by a speech therapist, speech pathologist, or speech clinician in accordance with a written plan of care as appropriate for the diagnosis. The plan of care should include:

- Patient's significant past history;
- Patient's diagnoses that require speech therapy;
- Name of the attending physician and any related physician orders;
- Therapy goals, both short and long term, and potential for achievement, including measureable objectives and a reasonable estimate of when goals may be reached;
- Any contraindications;
- Patient's awareness and understanding of diagnosis, prognosis, and treatment goals;
- When appropriate, the summary of treatment provided and results achieved during previous periods of speech therapy services; and
- Specifics of the type of treatment, including amount, frequency, and duration of activities.

Speech therapy may be considered **medically necessary** when it is directed to the active treatment of at least one of the following conditions:

- Autism spectrum disorders (see cross-reference).
- Childhood speech delay due to congenital hearing loss or disease (e.g. recurrent otitis media etc.).
- Congenital craniofacial anomalies (e.g., cleft palate and lip).
- Disease (e.g., post-cerebrovascular accident).
- Medical/biological voice dysfunctions with vocal cord lesions or movement abnormalities.
- Previous therapeutic interventions (e.g., esophageal training following laryngectomy)
- Swallowing disorders (e.g., dysphagia), regardless of the presence of a communication disability.
- Trauma (e.g., subdural hematoma influencing the speech center).

- Pediatric or developmental disorders or delays that are documented as resulting in speech less than the 20th percentile (more than one standard deviation less than the norm) or a 15% age delay on standardized testing. Scaled score norms are usually 10 with a standard deviation of +/- 3 or standard scores of 100 with a standard deviation of 15. These disorders or delays include the following:
  - Childhood stuttering and stammering severe or present for more than 6 months, under nine years of age; or
  - Childhood apraxia of speech that is not part of a global developmental delay; or
  - Disarticulation, articulation disorder; or
  - Dysarthria; or
  - Expressive language disorder or delay; or
  - Phonological disorder; or
  - Receptive language disorder or delay

Outpatient speech therapy services may be considered **medically necessary** as outlined in the guidelines set forth in this policy and further described in the Centers for Medicare and Medicaid Services (CMS), Publication 100-02, Medicare Benefit Policy Manual, Chapter 15, Section 220 (as may be amended from time to time).

Speech therapy services are considered **not medically necessary** for the following conditions:

- Attention deficit disorder/attention deficit hyperactivity disorder.
- Auditory conceptual dysfunction or conceptual handicap (see definitions).
- Behavioral problems (including impulsive behavior and impulsivity syndrome).
- Developmental listening delay.
- Grammatic delays treated by services that are primarily educational in nature (e.g. use of pronouns, plural/singular words, syntax, semantics, etc.).
- Individuals with an intellectual disability, except when disorders such as aphasia or dysarthria are present.
- Mild delays that are likely amenable to normal parental and classroom training, corresponding to standardized test results approximately above the 20th percentile or less than 15% age delay.
- Maintenance therapy services except for individuals whose benefits are subject to the terms mandated in the Pennsylvania Act 62 of 2008, Section 635.2, Autism Spectrum Disorders Coverage. (See MP 2.304, Autism Spectrum Disorder).
- Neuromuscular electrical stimulation therapy for the treatment of dysphagia (e.g. VitalStim®).
- Pediatric symbolic dysfunction (i.e. pediatric agnosia).
- Pragmatic or social communication disorder or delay, including but not limited to conversational turn-taking or topic maintenance, color identification, etc.
- Psychosocial speech delay.
- Severe global delay evidenced by delay in multiple areas of comprehension, expression, and organization of speech, and/or speech motor abnormality.

Central auditory processing disorder (CAPD) testing or treatment is considered **investigational.** There is insufficient evidence to support a conclusion concerning the health outcomes or benefits associated with this procedure.

Cross-references:

MP 2.304 Autism Spectrum Disorders
MP 6.032 Speech Generating Devices
MP 8.001 Physical Medicine and Specialized Physical Medicine Treatments (Outpatient)
MP 8.004 Occupational Therapy (Outpatient)
MP 8.007 Cognitive Rehabilitation
MP 8.011 Sensory Integration and Auditory Integration Therapy

II. PRODUCT VARIATIONS

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This policy is only applicable to certain programs and products administered by Capital Blue Cross please see additional information below, and subject to benefit variations as discussed in Section VI below.

FEP PPO – Refer to FEP Medical Policy Manual. The FEP Medical Policy manual can be found at: https://www.fepblue.org/benefit-plans/medical-policies-and-utilization-management-guidelines/medical-policies

III. DESCRIPTION/BACKGROUND

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Speech therapy includes those services necessary in the diagnosis and treatment of speech and language disorders which result in communication disabilities, and services required in the diagnosis and treatment of swallowing disorders, regardless of the presence of a communication disability.

Central auditory processing (CAP), also seen as (central) auditory processing or auditory processing, refers to the efficiency and effectiveness by which the central nervous system (CNS) utilizes auditory information. Narrowly defined, CAP refers to the perceptual processing of auditory information in the central auditory nervous system (CANS) and the neurobiological activity that underlies that processing and gives rise to electrophysiologic auditory potentials. CAP includes the auditory mechanisms that underlie the following abilities or skills: sound localization and lateralization; auditory discrimination; auditory pattern recognition; temporal aspects of audition, including temporal integration, temporal discrimination (e.g., temporal gap detection), temporal ordering, and temporal masking; auditory performance in competing acoustic signals (including dichotic listening); and auditory performance with degraded acoustic signals

Central auditory processing disorder (CAPD) refers to difficulties in the perceptual processing of auditory information in the CNS as demonstrated by poor performance in one or more of the above skills. Although abilities such as phonological awareness, attention to and memory for auditory information, auditory synthesis, comprehension and interpretation of auditorily presented information, and similar skills may be reliant on or associated with intact central auditory function,

they are considered higher order cognitive communicative and/or language-related functions and, thus, are not included in the definition of CAP.

IV. RATIONALE

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Central Auditory Processing

As indicated in a technical report published by the American Speech-Language Hearing Association (ASHA), "There is no universally accepted method for screening for CAPD. There remains a need for valid and efficient screening tools".

UpToDate (2021) states, "Evaluation for a central auditory processing disorder in school-age children is based upon the assumption that an auditory-specific perceptual deficit is the foundation of learning problems such as reading and language disabilities. However, the diagnosis, management, and even the existence of a modality-specific dysfunction are controversial".

British Society of Audiologists Practice Guidance (2011) states the following:

> At this time there is no 'gold standard' for diagnosing APD. Without such a 'gold standard', the best methods for identifying and managing APD remain elusive. Data specifically addressing the efficacy of interventions for APD are lacking and many of the recommendations commonly made are based on theory or inferred from approaches validated in other populations, e.g. specific language impairment and dyslexia.
>
> Researchers are demanding empirical evidence before endorsing diagnostic criteria and intervention strategies whilst clinicians, seeing individuals with 'suspected APD', are demanding guidelines for best practice at this time. The translation of evidence into practical recommendations is likely to take some time and it is important that researchers and clinicians collaborate in their efforts.

British Society of Audiology Position Statement and Practice Guidance (2018). Auditory Processing Disorder (APD)

> It was noted that "there continues to be no universally accepted diagnostic criteria or test batteries for APD" and that "developmental APD may contribute to childhood learning difficulties, but its status as a distinct learning disability is controversial. Other more commonly used and agreed disorders (e.g. language impairment, dyslexia, attention deficit/hyperactivity disorder, autism spectrum disorder) should take diagnostic precedence".

In general, an overview of the literature reveals numerous articles describing various tests of central auditory processing. It would appear that the concept of such testing is widely accepted among the medical and audiology community. This acceptance challenges the determination that tests of CAP would still be considered investigational; however, an evidence-based approach to

their evaluation is limited due to the multiple different batteries of tests that have been explored, the lack of a gold standard test for comparison, the heterogeneous nature of patients that have been tested (based both on age and symptoms), and the uncertain impact on the overall health of the patient.

V. DEFINITIONS

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(Including diagnoses with their associated tests, if applicable)

APHASIA is a total or partial loss of the ability to use or understand language; usually caused by stroke, brain disease, or injury.

APRAXIA OF SPEECH refers to a disorder of the nervous system that affects the ability to sequence and say sounds, syllables, and words. The two main types are acquired and childhood. **Tests**: Oral Motor Examination, Melody of Speech Assessment, Articulation Evaluation.

AUDITORY CONCEPTUAL DYSFUNCTION OR CONCEPTUAL HANDICAP is an impairment in the primary sensory-cognitive function that is basic to reading and spelling. Inability to make precise judgments as to how syllables and words match or differ.

AUDITORY PROCESSING DISORDER is also known as an auditory perceptual problem, central auditory dysfunction, or central auditory processing disorder. It is a condition wherein a person does not process speech/language correctly. They may have difficulties knowing where sound has occurred and identifying the source of the sound or in distinguishing one sound from another.

DYSARTHRIA is a motor speech disorder that is due to a paralysis, weakness, altered muscle tone, or incoordination of the speech muscles. Speech is slow, weak, imprecise, or uncoordinated.

DYSARTICULATION OR ARTICULATION DISORDERS are disorders of the quality of speech characterized by the substitution, omission, distortion, and addition of phonemes. **Tests** - Goldman-Fristoe Test of Articulation, Patterned Articulation Test (PAT).

DYSPHAGIA is difficulty with swallowing.

EXPRESSIVE LANGUAGE DISORDER OR DELAY is a delay in vocabulary, tenses, word recall, or production of sentences with developmentally appropriate length or complexity. **Tests** - Clinical Evaluation of Language Fundamentals-3 (CLEF-3) Expressive language subtests, Testing of Language Development Primary for under 3 year old, Preschool Language Scale-4 (PLS-4) for 1-4 year olds, Expressive 1 Word Vocabulary Test for 1-6 year olds.

GRAMMATIC DELAY is delay in use of pronouns, plural – singular, syntax, semantics, etc.

MAINTENANCE PROGRAM is a therapy program that consists of activities that preserve the patient's present level of function and prevents regression of that function. Maintenance begins when the

therapeutic goals of a treatment plan have been achieved or when no further progress is apparent or expected to occur.

PHONEME is the smallest sound unit which, in terms of the phonetic sequences of sound, controls meaning.

PHONOLOGICAL DISORDERS focus on predictable, rule-based errors (e.g., fronting, stopping, and final consonant deletion) that affect more than one sound.

PSYCHOSOCIAL SPEECH DELAY refers to speech delay resulting from psychosocial deprivation, (i.e. the absence of appropriate stimuli in the physical or social environment which are necessary for the emotional, social, and intellectual development of the individual.)

RECEPTIVE LANGUAGE DISORDER OR DELAY is a difficulty understanding words, sentences, or age appropriate extended discourse. **Tests** - Clinical Evaluation of Language Fundamentals-3 (CLEF-3) Receptive language subtests, Preschool Language Scale-4 (PLS-4), Testing of Language Development Primary, Receptive 1 Word Vocabulary Test for 1-6 year olds.

VI. BENEFIT VARIATIONS

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The existence of this medical policy does not mean that this service is a covered benefit under the member's health benefit plan. Benefit determinations should be based in all cases on the applicable health benefit plan language. Medical policies do not constitute a description of benefits. A member's health benefit plan governs which services are covered, which are excluded, which are subject to benefit limits and which require preauthorization. There are different benefit plan designs in each product administered by Capital Blue Cross. Members and providers should consult the member's health benefit plan for information or contact Capital Blue Cross for benefit information.

VII. DISCLAIMER

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Capital Blue Cross's medical policies are developed to assist in administering a member's benefits, do not constitute medical advice, and are subject to change. Treating providers are solely responsible for medical advice and treatment of members. Members should discuss any medical policy related to their coverage or condition with their provider and consult their benefit information to determine if the service is covered. If there is a discrepancy between this medical policy and a member's benefit information, the benefit information will govern. If a provider or a member has a question concerning the application of this medical policy to a specific member's plan of benefits, please contact Capital Blue Cross' Provider Services or Member Services. Capital Blue Cross considers the information contained in this medical policy to be proprietary and it may only be disseminated as permitted by law.

VIII. CODING INFORMATION

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Note: This list of codes may not be all-inclusive, and codes are subject to change at any time. The identification of a code in this section does not denote coverage as coverage is determined by the terms of member benefit information. In addition, not all covered services are eligible for separate reimbursement.

Investigational; therefore, not covered:

CPT Codes®								
92620	92621							

Covered when medically necessary:

Procedure Codes								
92507	92508	92526	G0153	G0161	S9128			

The following ICD-10-CM Diagnosis Codes are considered not medically necessary; therefore, not covered:

ICD-10-CM Diagnosis Codes	Description
F63.89	Other impulse disorders
F70	Mild intellectual disabilities
F71	Moderate intellectual disabilities
F72	Severe intellectual disabilities
F73	Profound intellectual disabilities
F78	Other intellectual disabilities
F78.A1	SYNGAP1-related intellectual disability
F78.A9	Other genetic related intellectual disability
F80.82	Social pragmatic communication disorder
F80.89	Other developmental disorders of speech and language
F81.89	Other developmental disorders of scholastic skills
F88	Other disorders of psychological development
F90.0	Attention-deficit hyperactivity disorder, predominantly inattentive type
F90.1	Attention-deficit hyperactivity disorder, predominantly hyperactive type
F90.2	Attention-deficit hyperactivity disorder, combined type
F90.8	Attention-deficit hyperactivity disorder, other type
R48.1	Agnosia

IX. REFERENCES

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X. POLICY HISTORY

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MP 8.002	**CAC 5/24/04**
	CAC 10/25/05
	CAC 10/31/06
	CAC 1/29/08
	CAC 11/25/08
	7/1/09 Added cross-reference for Pervasive Developmental Disorders
	CAC 11/24/09 Consensus review. No change in policy statement references updated.
	4/21/10 Revised exclusion language for central auditory processing
	7/19/10 Revised Medicare variation
	CAC 11/30/10 Consensus review.
	CAC 4/26/11 Minor Revision. Central Auditory processing changed from not medically necessary to investigational. Sensory integration therapy information extracted and separate policy for this therapy developed. See MP-8.011 Sensory Integration Therapy
	CAC 6/26/12 Consensus review. No change in policy statement references updated.
	7/26/13 Admin coding review complete.
	CAC 9/24/13 Consensus review. No change to policy statements.
	CAC 5/20/14 Minor. Removed Auditory processing delay from list of not medically necessary conditions. Is listed as investigational. References reviewed and updated. Added rationale section for central auditory processing. Codes reviewed.
	CAC 6/2/15 Consensus review. No change to policy statements. References updated. Coding reviewed/unchanged. Changed Medicare variation to reference (LCD): Vestibular and Audiologic Function Studies L32767.
	11/2/15 Administrative change. LCD numbers changed from L32767 to L35007, L27537 to L34891, and L27531 to L35070 due to Novitas update to ICD-10.
	CAC 11/29/16 Consensus review. No change to policy statements. References updated. Coding reviewed. Variation section reformatted. Coding reviewed.
	2/1/17 Administrative update: Coding updated.
	4/5/17 Administrative update. For the treatment of pediatric developmental disorders or delays - removed requirement for re-evaluation every 3-4 months by the Plan's medical director.
	1/1/18 Admin Update: Medicare variations removed from Commercial Policies
	1/4/18 Minor review. Removed the terms "phonologic delay" and "reduced phonological awareness" which were replaced with "phonological disorder". Treatment of phonological disorders are considered medically necessary. Coding reviewed.

	1/2/19 Consensus review. No change to policy statements. References updated.
	12/4/19 Consensus review. No changes to the policy statement. Updated definitions, rationale, and references.
	11/16/20 Consensus review. No change to policy statement. Reviewed references and rationale.
	8/4/21 Consensus review. No change to policy statement. References updated.
	9/1/21 Administrative update. New codes F78.A1 and F78.A9 added. Effective 10/1/21
	3/10/22 Consensus review. No change to policy statement. FEP and references updated. No changes to coding.

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