

# MEDICAL POLICY

<b>POLICY TITLE</b>	<b>SPEECH THERAPY (OUTPATIENT)</b>
<b>POLICY NUMBER</b>	<b>MP 8.002</b>

<b>CLINICAL BENEFIT</b>	<input type="checkbox"/> MINIMIZE SAFETY RISK OR CONCERN. <input checked="" type="checkbox"/> MINIMIZE HARMFUL OR INEFFECTIVE INTERVENTIONS. <input type="checkbox"/> ASSURE APPROPRIATE LEVEL OF CARE. <input type="checkbox"/> ASSURE APPROPRIATE DURATION OF SERVICE FOR INTERVENTIONS. <input checked="" type="checkbox"/> ASSURE THAT RECOMMENDED MEDICAL PREREQUISITES HAVE BEEN MET. <input type="checkbox"/> ASSURE APPROPRIATE SITE OF TREATMENT OR SERVICE.
<b>Effective Date:</b>	<b>1/1/2025</b>

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## 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, and improvement is regularly documented.

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).
- Developmental delay (See Policy Guidelines)
- 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 speech and language problems (See Policy guidelines):

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. Documentation should include:

- Patient's significant past history; and diagnoses that require speech therapy;
- Name of the attending physician and any related physician orders;

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- Therapy goals, both short and long term, and potential for achievement, including measurable objectives and a reasonable estimate of when goals may be reached;
- Any contraindications;
- Patient's awareness and understanding of diagnosis, prognosis, and treatment goals;
- Specific treatment type, including amount, frequency, and duration of activities; and
- When appropriate, the summary of treatment provided, and results achieved during previous periods of speech therapy services.

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:

- Attention deficit disorder/attention deficit hyperactivity disorder, unless individual has a concurrent diagnosis that is covered above.
- Behavioral problems (including impulsive behavior and impulsivity syndrome), unless individual has a concurrent diagnosis that is covered above.
- Neuromuscular electrical stimulation therapy for the treatment of dysphagia (e.g. VitalStim®).

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

**Note:** 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 Disorders).

### ***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**

## **POLICY GUIDELINES**

Specialist consultation is appropriate for children with screening abnormalities, parent concerns, or physician concerns, beginning with speech-language pathology and audiology evaluations. Watchful waiting is not recommended for late talkers, such as children with a vocabulary of fewer than 50 words at 24 months or older or without word combinations or children not meeting screening test thresholds. Delays in care may result in long-lasting adverse effects on communication development.

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The American Speech-Language-Hearing Association recommends early identification and treatment of speech and language delays to minimize these adverse effects on social development and school performance. Immediate referral should be considered for expressive or receptive language concerns or deficits noted after two years of age, speech and language milestone regression, and speech that remains incomprehensible after two years of age. Referral criteria are the same for monolingual and bilingual children.

The differential diagnosis for speech and language delays is broad. These delays can be classified as secondary to other conditions or as primary conditions without apparent underlying causes. Table PG1 outlines common primary and secondary causes of speech and language delays.

**Table PG1 Speech and Language Problems in Children**

<b>Disorder</b>	<b>Clinical Findings and comments</b>	<b>Treatment and Prognosis</b>
<b>Primary Causes</b>	Stuttering includes speech and fluency disturbances, such as sound repetitions and prolongations, broken words, speech pauses, circumlocutions, or excess physical tension with words.	Focuses on speaking more slowly, breathing regulation, feedback training, and muscle tension reduction
Childhood-onset fluency disorder (stuttering and cluttering)	First-degree relatives of people who stutter have a three times higher risk of stuttering than the general population; multiple genes have been isolated and associated with stuttering.  Cluttering is abnormally fast or irregular speech delivery rate, leading to unexpected sounds, phrases, patterns, or dysfluencies in speech.	
Language disorder	Reduced vocabulary, limited sentence structure, and impaired ability to carry conversation in spoken, written, or sign language or other comprehension or production deficits.  Not caused by hearing or other sensory loss, motor dysfunction, or another medical or neurologic condition  Highly heritable	Focuses on knowledge and use of language for all modalities of communication.  Likely to continue into adulthood; delays presenting after four years of age are predictive of long-term outcomes, whereas delays before four years of age are not.
Social (pragmatic) communication disorder	Social verbal and gestural difficulties, including appropriate use of eye contact,	Includes mediating social exchanges through instruction, modeling, role-

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	facial expressions, body language, and emotional expression.	play, and cognitive behavior therapies.
<b>Secondary causes</b>	Deficits in social-emotional reciprocity, nonverbal communicative behaviors, and understanding relationships; restricted, repetitive patterns of behavior, interests, or activities	Focuses on specific speech-language deficits, including motor function, semantics, social communication, and receptive and expressive language skills; augmentative and alternative communication methods may also be used.  Not a degenerative disorder; positive prognostic factors include absence of intellectual disability, language impairment, and additional mental health problems.
Autism Spectrum Disorder		
Cerebral Palsy	Movement disorder from perinatal brain damage, which causes subsequent intellectual and sensory deficits; speech and gestural difficulties are common.	Focuses on language skills, articulation, and proper breathing for speech and swallowing; augmentative and alternative communication methods may also be used.
Craniofacial disorders	Cleft lip/palate, dental malocclusion, macroglossia, or 22q11.2 deletion syndrome.	Requires multidisciplinary approach, including craniofacial, dental, audiologic, and speech-language services.
Global developmental delay	Failure to meet developmental milestones in several areas of intellectual function in children younger than five years.	Precursor to intellectual disability
Hearing loss after spoken language established	Often affects speech articulation and volume and leads to gap in vocabulary attainment. Conductive hearing loss is often due to outer and middle ear pathology (e.g., auditory canal obstruction, otitis media or externa, tympanic membrane rupture, tympanostomy	Involves addressing underlying cause, audiologic rehabilitation, and compensating for hearing loss with alternative communication

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	tubes) Sensorineural hearing loss is due to damage to inner ear or neural pathways (e.g., from congenital infections, meningitis, ototoxic medications, tumors, or trauma)	modalities (e.g., sign language), hearing aids (for conductive or sensorineural hearing loss), or cochlear implants with intensive audiologic rehabilitation for profound hearing loss.  Early detection and intervention are critical to minimizing sequelae of hearing loss.  Hearing loss at birth or within first few months of life has the most profound effect on language development
Hearing loss before onset of speech	Speech expression and comprehension are delayed	Same as above
Intellectual developmental disorder	Deficits in intellectual functions and adaptive functioning in comparison with peers that is first noted during developmental period Child often has associated difficulties with social judgment; self-management of behavior, emotions, or relationships; and communication skills Known causes include genetic syndromes (e.g., Down syndrome, fragile X syndrome, Williams syndrome, Rett syndrome)	Lifelong, but generally nonprogressive except in certain genetic disorders (e.g., Rett syndrome) or epilepsy disorders (e.g., Lennox-Gastaut syndrome)
Myofunctional disorder (tongue thrust)	Tongue thrusting at rest or during swallowing, lip incompetency, and sucking habits	Structural assessment and diagnostic procedures guide management
Vocal cord dysfunction	Inappropriate vocal cord movement that affects respiratory function and voice production; often presents with chronic cough, episodes of breathing difficulty, throat or chest tightness, and sensation of choking; often misdiagnosed as asthma, allergies, gastroesophageal reflux disease, or upper airway obstruction	Focuses on behavior interventions to improve symptoms and reduce recurrences, such as relaxed-throat breathing, breathing exercises, and chronic cough suppression strategies.

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**Note:** This table is not an exhaustive list of conditions affecting speech and language in children.

### 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.

Childhood speech and language concerns are commonly encountered in the primary care setting. Family physicians are integral in the identification and initial evaluation of children with speech and language delays. Parental concerns and observations and milestone assessment aid in the identification of speech and language abnormalities. Concerning presentations at 24 months or older include speaking fewer than 50 words, incomprehensible speech, and notable speech and language deficits on age-specific testing. Validated screening tools that rely on parental reporting can serve as practical adjuncts during clinic evaluation. Early referral for additional evaluation can mitigate the development of long-term communication disorders and adverse effects on social and academic development. All children who have concerns for speech and language delays should be referred to speech language pathology and audiology for diagnostic and management purposes. Parents and caretakers may also self-refer to early intervention programs for evaluation and management of speech and language concerns in children younger than three years.

Early intervention programs are government-funded multi-disciplinary programs designated to support families with young children and infants with developmental delays. These self-referral programs offer speech and language therapy, occupational therapy, and physical therapy services to children younger than three years. Services are free of charge or priced according to income. Parents and guardians of children younger than three years can directly contact state-run early intervention programs through information found on the CDC website.

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

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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 (2023) states, "Evaluation for a central auditory processing disorder (sometimes referred to as auditory processing disorder) in school-age children is based on the assumption that an auditory-specific perceptual deficit can be the basis for learning problems such as reading and language disabilities. However, the diagnosis, management, and even the existence of auditory processing disorders are controversial. Some authorities suggest that it may exist as a primary deficit, whereas others believe that it may be secondary to cognitive deficits. The absence of a coherent theory renders diagnosis and management exceedingly difficult".

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.



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### 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.)



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**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' 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:**

Procedure Codes								
92620	92621							

**Covered when medically necessary:**

Procedure Codes								
G0153	G0161	S9128	92507	92508	92521	92522	92523	92524
92526	96105	96110	96112					

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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
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

## IX. REFERENCES

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### X. POLICY HISTORY

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<b>MP 8.002</b>	<b>11/16/2020 Consensus Review.</b> No change to policy statement. Reviewed references and rationale.
	<b>08/04/2021 Consensus Review.</b> No change to policy statement. References updated.
	<b>09/01/2021 Administrative Update.</b> New codes F78.A1 and F78.A9 added. Effective 10/1/21
	<b>03/10/2022 Consensus Review.</b> No change to policy statement. FEP and references updated. No changes to coding.
	<b>09/28/2023 Minor Review.</b> Updates to both covered and noncovered conditions. Added policy guideline section with table of language disorders. Updated background. Added CPT codes. Removed ICD10 from non-covered table. New references.
	<b>08/09/2024 Consensus Review.</b> No change to policy stance. New references. Added CPT code 96112.

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