

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

Original Issue Date (Created):	3/8/2004
Most Recent Review Date (Revised):	1/2/2019
Effective Date:	2/1/2019

[POLICY RATIONALE](#)
[DISCLAIMER](#)
[POLICY HISTORY](#)

[PRODUCT VARIATIONS](#)
[DEFINITIONS](#)
[CODING INFORMATION](#)

[DESCRIPTION/BACKGROUND](#)
[BENEFIT VARIATIONS](#)
[REFERENCES](#)

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);

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

- 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 1 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 speech apraxia 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 (ST) 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.
- Grammatical 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, Pervasive Developmental Disorders.)
- Neuromuscular electrical stimulation therapy for the treatment of dysphagia (e.g. VitalStim®).

MEDICAL POLICY

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

- 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-8.007 Cognitive Rehabilitation

MP-8.004 Occupational Therapy (Outpatient)

MP-2.304 Autism Spectrum Disorders

MP-8.001 Physical Medicine and Specialized Physical Medicine Treatments (Outpatient)

MP-8.011 Sensory Integration and Auditory Integration Therapy

MP-6.032 Speech Generating Devices

II. PRODUCT VARIATIONS

[TOP](#)

This policy is applicable to all programs and products administered by Capital BlueCross unless otherwise indicated below.

FEP PPO - The FEP program dictates that all drugs, devices or biological products approved by the U.S. Food and Drug Administration (FDA) may not be considered investigational. Therefore, FDA-approved drugs, devices or biological products may be assessed on the basis of medical necessity.

III. DESCRIPTION/BACKGROUND

[TOP](#)

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 (C) AP refers to the efficiency and effectiveness by which the central nervous system (CNS) utilizes auditory information. Narrowly defined, (C) AP refers to the perceptual processing of auditory information in the CNS and the neurobiologic activity that underlies that processing and gives rise to electrophysiologic auditory potentials. (C)AP includes the auditory mechanisms that underlie the following abilities or skills: sound localization and lateralization; auditory discrimination; auditory pattern recognition; temporal

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

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, (C) APD 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 (C) AP.

IV. RATIONALE

[TOP](#)

Central Auditory Processing

As indicated by American Speech-Language Hearing Association’s technical report indicates “At this time, there is no universally accepted method of screening for (C) APD. There remains a need for valid and efficient screening tools for this purpose. It is important to emphasize that screening tools should not be used for diagnostic purposes.”

The National Institute on Deafness and Communication Disorders notes that much research is still needed to understand CAPD problems, related disorders, and the best intervention for each child or adult. Researchers are currently studying a variety of approaches to treatment. At this time treatment and management are dependent upon the deficit that is displayed. No pharmacologic agent has shown to be effective specifically for (C) APD. Interventions for (C)APD focuses on improving the quality of the acoustic signal and the listening environment, improving auditory skills, and enhancing utilization of metacognitive and language resources.

British Society of Audiologists Practice Guidance also reports 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

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

some time and it is important that researchers and clinicians collaborate in their efforts.

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. In 1996, the American Speech Language Hearing Association published a task force report on CAP and noted that there was persistent controversy over CAP and its disorders and how it should be defined, identified, and ameliorated through intervention. These same concerns were echoed in a subsequent reports.

V. DEFINITIONS

[TOP](#)

(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. **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 PERCEPTUAL 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. **Tests** – Test of Central Auditory Processing with abnormal repetition of words spoken with and without background noise, Test of Auditory-Perceptual Skills-Revised (TAPS-R), Test of Auditory Processing and Reasoning, Clinical Evaluation of Language Fundamentals-3 (CLEF-3).

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. **Test** - Oral-motor exam.

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

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.

PHONOLOGIC DELAY is a disorder characterized by failure to use speech sounds that are appropriate for the individual's age and dialect. Symptoms typically include but are not limited to failure in sound production and use, substitutions of one sound for another, and omissions of sounds. **Test** - Goldman-Fristoe Test of Articulation.

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.

REDUCED PHONOLOGICAL AWARENESS describes problems in rhyming, isolation, deletion and blending of phonemes and graphemes. **Test** – Pattern Awareness Test (PAT)

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

VI. BENEFIT VARIATIONS

[TOP](#)

The existence of this medical policy does not mean that this service is a covered benefit under the member's contract. Benefit determinations should be based in all cases on the applicable contract language. Medical policies do not constitute a description of benefits. A member's individual or group customer benefits govern which services are covered, which are excluded, and which are subject to benefit limits and which require preauthorization. Members and providers should consult the member's benefit information or contact Capital BlueCross for benefit information.

VII. DISCLAIMER

[TOP](#)

Capital BlueCross'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. Capital BlueCross considers the information contained in this medical policy to be proprietary and it may only be disseminated as permitted by law.

VIII. CODING INFORMATION

[TOP](#)

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							

Current Procedural Terminology (CPT) copyrighted by American Medical Association. All Rights Reserved.

Covered when medically necessary:

CPT Codes®								
92507	92508	92526						

Current Procedural Terminology (CPT) copyrighted by American Medical Association. All Rights Reserved.

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

HCPCS Codes	Description
G0153	Services of a speech and language pathologist in home health or hospice settings, each 15 minutes
G0161	Services performed by a qualified speech-language pathologist, in the home health setting, in the establishment or delivery of a safe and effective speech-language pathology maintenance program, each 15 minutes
S9128	Speech therapy, in the home, per diem

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
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

[TOP](#)

American Academy of Pediatrics (AAP), Committee on Children with Disabilities Auditory integration training and facilitated communication for autism Pediatrics 1998; 102(2):431-433 Reaffirmed February 1, 2010.

American Speech-Language-Hearing Association Aphasia [Website]: <http://www.asha.org>. Accessed January 2, 2019.

American Speech-La Inguage-Hearing Association (2005) (Central) Auditory Processing Disorders [Working Group] Website: <http://find.asha.org/asha#q=central%20auditory&sort=relevancy>. Accessed January 2, 2019.

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

- American Speech-Language Hearing Association. Position Statement. (Central) Auditory Processing Disorders—The Role of the Audiologist. 2005. [Website]: <http://www.phon.ucl.ac.uk/courses/spsci/audper/ASHA%202005%20CAPD%20statement.pdf> Accessed January 2, 2019.
- American Speech-Language-Hearing Association Speech and language development [Website]: <https://www.asha.org/public/speech/development/>. Accessed January 2, 2019.
- American Speech-Language-Hearing Association Speech and language disorders [Website]: <http://www.asha.org/public/speech/disorders/> Accessed January 2, 2019.
- American Speech-Language-Hearing Association Swallowing disorders in adults Website]: <http://www.asha.org/public/speech/swallowing/SwallowingAdults.htm> Accessed January 2, 2019.
- American Speech-Language-Hearing Association Swallowing disorders in children [Website]: <http://www.asha.org/public/speech/swallowing/FeedSwallowChildren.htm> Accessed January 2, 2019.
- Carnaby-Mann, GD, Crary, MA Examining the evidence on neuromuscular electrical stimulation for swallowing: a meta-analysis Arch Otolaryngol Head Neck Surg. 2007; 133(6):564-571.
- Carter, J, M usher, K. Etiology of speech and language disorders in children. In: UpToDate Online Journal [serial online]: updated Mar 20, 2017 [Website] : www.uptodate.com . Accessed January 2, 2018.
- Children's Speech Care Center. Glossary of Speech and Language Related Terms. [Website]: <http://www.childspeech.net/glossary.html>. Accessed January 2, 2019.
- El Dib RP, Atallah AN. Evidence-based speech, language and hearing therapy and the Cochrane Library's systematic reviews. Sao Paulo Med J. 2006 Mar 2; 124(2):51-4.
- Jordan, Lori C; Hillis, Argye E Disorders of speech and language: aphasia, apraxia and dysarthria. Current Opinion in Neurology 19(6):580-585, December 2006.
- May-Benson TA, Koomar JA Systematic review of the research evidence examining the effectiveness of interventions sensory integrative approach for children. Am J Occupat Ther 2010; 64(3):403-14
- Moore, D, Ferguson, M. et al. Nature of Auditory Processing Disorder in Children. Pediatrics Vol. 126 No. 2 August 2010, [Website]: <https://www.ncbi.nlm.nih.gov/pubmed/20660546> Accessed January 2, 2019.
- National Dissemination Center for Children with Disabilities. [Website]: <https://www.nidcd.nih.gov/directory/national-dissemination-center-children-disabilities-nichcyl>. Accessed January 2, 2019.
- National Institute of Neurological Disorders and Stroke. Information on Aphasia. [Website]: <https://www.ninds.nih.gov/Disorders/All-Disorders?title=aphasia> Accessed January 2, 2019.
- National Institute on Deafness and other Communicative Disorders. Information on Aphasia. [Website]: <https://www.nidcd.nih.gov/health/aphasia>. Accessed January 4, 2017.
- National Institute on Deafness and other Communicative Disorders. Information on Apraxia. [Website]: <https://www.nidcd.nih.gov/health/apraxia-speech>. Accessed January 2, 2019.

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

Nelson HD, Nygren P, Walker M, Panoscha R. Screening for speech and language delay in preschool children: systematic evidence review for the US Preventive Services Task Force. Pediatrics. 2006; 117(2).

Prathanee B, Thinkhamrop B, Dechongkit S. Factors associated with specific language impairment and later language development during early life: a literature review. Clin Pediatr (Phila). 2007 Jan; 46(1):22-9. Review.

Smith Hammond, CA, Goldstein, LB. Cough and aspiration of food and liquids due to oral-pharyngeal dysphagia: ACCP evidence-based clinical practice guidelines. Chest. 2006; 129(1 Suppl): 154S-168S.

Stiegler LN Discovering communicative competencies in a nonspeaking child with autism. Lang Speech Hear Serv Sch. 2007 Oct; 38(4):400-13.

VitalStim. [Website]: <https://www.djoglobal.com/vitalstim>. Accessed January 2, 2019.

West C, et al. Interventions for apraxia of speech following stroke. The Cochrane Database of Systematic Reviews Issue 4 2005 Oct 19. Edited published in Issue 1, 2009

X. POLICY HISTORY

[TOP](#)

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
	CAC 4/26/2011 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. No change in policy statement, references updated.
	7/26/13 Admin coding review complete.
	CAC 9/24/13 Consensus. 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. No change to policy statements. References updated. Coding reviewed/unranged. Changed Medicare variation to reference (LCD): Vestibular and Audiologic Function Studies L32767.

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

	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.
	1/2/2019 Consensus. No change to policy statements. References updated.

[Top](#)

Health care benefit programs issued or administered by Capital BlueCross and/or its subsidiaries, Capital Advantage Insurance Company®, Capital Advantage Assurance Company® and Keystone Health Plan® Central. Independent licensees of the BlueCross BlueShield Association. Communications issued by Capital BlueCross in its capacity as administrator of programs and provider relations for all companies.