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Speech-Language Therapy (SLT)

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Disclaimer

Carefully check state regulations and/or the member contract.

Each benefit plan, summary plan description or contract defines which services are covered, which services are excluded, and which services are subject to dollar caps or other limitations, conditions or exclusions. Members and their providers have the responsibility for consulting the member's benefit plan, summary plan description or contract to determine if there are any exclusions or other benefit limitations applicable to this service or supply. **If there is a discrepancy between a Medical Policy and a member's benefit plan, summary plan description or contract, the benefit plan, summary plan description or contract will govern.**

Legislative Mandates

EXCEPTION: For Illinois only: Illinois Public Act 103-0458 [Insurance Code 215 ILCS 5/356z.61] (HB3809 Impaired Children) states all group or individual fully insured PPO, HMO, POS plans amended, delivered, issued, or renewed on or after January 1, 2025 shall provide coverage for therapy, diagnostic testing, and equipment necessary to increase quality of life for children who have been clinically or genetically diagnosed with any disease, syndrome, or disorder that includes low tone neuromuscular impairment, neurological impairment, or cognitive impairment.

EXCEPTION: For HCSC members residing in the state of Arkansas, § 23-79-130 relating to speech or hearing impairment, requires coverage for the necessary care and treatment of loss or impairment of speech or hearing. The phrase "loss or impairment of speech or hearing" shall include those communicative disorders generally treated by a speech pathologist or audiologist licensed by the Board of Examiners in Speech-Language Pathology and Audiology and which fall within the scope of his or her area of certification. Coverage shall not apply to hearing instruments or devices. This applies to the following: Fully Insured Group, Student, Small Group, Mid-Market, Large Group, HMO, EPO, PPO, POS. Unless indicated by the group, this mandate or coverage will not apply to ASO groups.

Coverage

For Montana, State Legislation Mandates may apply. Carefully check for Legislative Mandates that may apply for each plan.

This medical policy does NOT address Gender Reassignment Services (Transgender Services). This medical policy IS NOT TO BE USED for Gender Reassignment Services. Refer to SUR717.001, Gender Assignment Surgery and Gender Reassignment Surgery with Related Services.

Speech-Language Therapy

Speech-language therapy (SLT) services may be considered eligible for benefit coverage when SLT services are:

- Prescribed by a licensed physician or other qualified provider (see NOTE 1) to restore or improve the function in a member who has impaired physical function of phonation or swallowing, or communication disability related to expressive or receptive aphasia/paraphasia and/or speech language impairment. (see NOTE 2 for information regarding childhood ages with corresponding speech-language milestones and speech-language delay for children); AND
- Prescribed to achieve condition-specific corrective benefit for a member who has a reasonable expectation of achieving measurable improvement (see NOTE 2 for information regarding childhood ages with corresponding speech-language milestones and speech-language delay for children); AND
- Prescribed to provide specific, effective, and reasonable treatment for the patient's diagnosis and physical condition (see NOTE 2 for information regarding childhood ages with corresponding speech-language milestones and speech-language delay for children); AND
- Provided under a documented plan of care that is updated as the patient's condition changes and is recertified by a physician or other qualified provider (see NOTE 1) at least every 30 days, and includes:
 1. Specific long-term and short-term goals; AND
 2. Measurable objectives; AND
 3. Reasonable estimate of when goals will be reached; AND
 4. Specific treatment techniques and/or exercises to be used; AND
 5. Frequency and duration of treatment; AND
 6. Clearly document a reduction in the functional deficit over time as compared to normal or average function for members of the same or similar demographic; AND
- Services that require the judgment, knowledge, and skills of a qualified provider (see NOTE 1) of SLT services due to the complexity and sophistication of the therapy and the physical condition of the patient (see NOTE 2 for information regarding childhood ages with corresponding speech-language milestones and speech-language delay for children); AND
- Services that cannot be reasonably taught to and implemented by nonprofessional or lay caregivers; AND
- Services that are delivered by a qualified, licensed provider (see NOTE 1) of SLT services; AND

- Services that do not duplicate services provided by any other therapy, particularly occupational therapy.

NOTE 1:

- A qualified provider is one who is licensed where required and performs within the scope of licensure and laws where he/she practices, e.g., speech pathologist, speech-language pathologist, etc. In Montana, scope of licensure for speech therapists allows direct access, i.e., evaluation and treatment without a physician's referral. Therefore, the speech therapist might be the qualified provider who will evaluate the patient, administer the treatment, and prepare the written plan of care.
- In conjunction with delivering SLT services, the speech therapist is expected to provide training to the patient, family, and/or caregivers to facilitate their participation in and assumption of the SLT, continued improvement and maintenance program. Periodic assessment of improvement and modification of patient- or caregiver-implemented interventions may be appropriate.

NOTE 2:

- For additional information regarding childhood ages with corresponding speech-language milestones from the American Speech-Language-Hearing Association, the National Institutes of Health, the American Academy of Pediatrics, and the American Academy of Pediatric Dentistry, refer to the Description.
- Refer to the Description of information regarding speech and language delay for children from the American Academy of Family Physicians.

NOTE 3: For children, standardized testing scores may aid in the determination of a speech-language deficit. For example, a standard score of 70 or below, out of a 100-scale assessment, appears to indicate a severe impairment. Refer to the Description for more information.

SLT services are considered not medically necessary for ANY of the following:

- Speech dysfunction that is self-correcting, such as young children with natural dysfluency or developmental articulation errors not related to a specific medical condition;
- Maintenance therapy that will preserve the patient's present level of function and prevent regression of that function, including services intended to maintain function by using routine, repetitive, and reinforced procedures that are neither diagnostic nor therapeutic;
- Procedures that may be carried out effectively by the patient, family, care giver and/or teacher;
- Psychoneurotic or psychotic conditions;
- Group speech or computer-based therapies, as these therapies are not one-on-one, individualized treatment;
- Medical conditions causing communication difficulties that are not correctable (e.g., muscle disorders of face, mouth, lips or jaw [a tongue thrust], including orofacial myology or myofunctional treatment);

- Therapy with the only goal being instruction of and/or corroboration with other professional personnel in the patient’s SLT program or other community resources.

Aural Rehab/Auditory Rehab

Aural rehab/auditory rehab **is considered experimental, investigational, and/or unproven** in individuals with the following conditions:

- Tinnitus; and/or
- Hearing loss without a cochlear implant.

NOTE 4: Refer to SUR714.004 Cochlear Implant For Aural Rehabilitation.

Speech Volume Modulation System (e.g., SpeechVive™)

The use of a speech volume modulation system (e.g., SpeechVive) to improve vocal loudness and/or speech clarity in patients with hypophonia secondary to Parkinson’s disease (PD) is considered experimental, investigational and/or unproven.

Policy Guidelines

CPT codes 92507, 92508 are not considered time-based codes; they are intended to be billed one time per session. The initial evaluation is usually completed in 1-3 sessions.

Description

Speech-language therapy (SLT) is the treatment of communication impairment and swallowing disorders. SLT therapy services facilitate the development and maintenance of human communication and swallowing through assessment, diagnosis, and rehabilitation. (1)

Background

Approximately 40 million Americans have a communication disorder. Roughly 3 million Americans stutter and about 5% of children have a noticeable speech disorder by the first grade. When looking at the prevalence incidence of disease-related communication disorders, roughly 2 million patients in the U.S. have aphasia; 89% diagnosed worldwide with Parkinson’s disease (PD) have a speech or voice disorder; and 300,000 to 600,000 are affected by dysphasia resulting from a neurological condition. (1, 3)

Speech is the verbal production of language, whereas language is the conceptual processing of communication. Language includes receptive language (understanding) and expressive language (the ability to convey information, feelings, thoughts, and ideas). Language is commonly thought of in its spoken form, but may also include a visual form, such as American Sign Language (ASL). (2)

Speech language pathology (SLP) provides clinical services and provides education, speech therapy services and research in the areas of communication and swallowing across the life span. SLPs assess, diagnose and 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). (1).

A communication disorder is an impairment in the ability to receive, send, process, and comprehend concepts of verbal, nonverbal, and graphic symbols. A communication disorder may be evident in the processes of hearing, language, and/or speech and may range in severity from mild to profound. It may be congenital or acquired. Individuals may demonstrate one or a combination of communication disorders. A communication disorder may result in a primary disability, or it may be secondary to other disabilities. SLT incorporates the processes of multiple disorders and the treatment of speech-language, swallowing, and cognitive-communication difficulties. Many disorders have a neurological basis such as head injury, PD, stroke, amyotrophic lateral sclerosis (ALS) and cerebral palsy. (1)

SLT covers a wide range of services which are tailored to each individual. SLT helps individuals gain the ability to communicate through speech and language. Speech therapists might use repetitive exercises and training as well as assistive devices for communication to assist with augmentive and assistive communication, or AAC, these devices produce speech or sound for those who are nonverbal. SLT therapy may be provided in schools, community programs, provider offices, clinics, hospitals, home care, rehabilitation centers, and nursing homes. Generally, this therapy is provided by SLPs who work with clients or patients who have the physical or cognitive impairment/deficit/disorder that results in difficult communication. This may include those adults and children who have previously learned how to read and write, then are diagnosed with a neurological impairment. SLPs may also provide services for patients with dysphagia (difficulty swallowing). (1, 2)

According to the American Speech-Language Hearing Association (ASHA) 2015 Speech-Language Pathology Medical Review Guidelines, the potential etiologies of communication and swallowing disorders may include the following (1):

- Neonatal problems (e.g., prematurity, low birth weight, substance exposure);
- Developmental disabilities (e.g., specific language impairment, dyslexia, and attention deficit/hyperactive disorder);
- Auditory problems (e.g., hearing loss or deafness, central auditory processing disorders);
- Oral anomalies (e.g., cleft lip/palate, dental malocclusion, macroglossia, oral-motor dysfunction);
- Respiratory compromise (e.g., bronchopulmonary dysplasia, chronic obstructive pulmonary disease);
- Pharyngeal anomalies (e.g., upper airway obstruction, velopharyngeal insufficiency/incompetence);

- Laryngeal anomalies (e.g., vocal fold pathology, tracheal stenosis, tracheostomy);
- Neurological disease/dysfunction (e.g., traumatic brain injury, cerebral palsy, cerebral vascular accident, dementia, PD, amyotrophic lateral sclerosis);
- Psychiatric disorder (e.g., psychosis, schizophrenia);
- Genetic disorders (e.g., Down syndrome, fragile X syndrome, Rett syndrome, velocardiofacial syndrome).

To assess speech-language development problems for children under the age of 5 years, providers may utilize the following Table 1 to compare the child’s speech-language pattern to development milestones, adapted from the American Speech-Language-Hearing Association (ASHA), the National Institutes of Health (NIH), the American Academy of Pediatrics (AAP), the American Academy of Pediatric Dentistry (AAPD) and the Centers for Disease Control and Prevention (CDC). (1, 4-8)

Table 1. Language Development Milestones from Birth to 5 Years of Age (1, 2, 4-8)

Child’s Age	Speech-Language Milestones
By the end of 12 months	<ul style="list-style-type: none"> • Try imitating speech sounds, • Say a few words, such as "dada," "mama", "hi" or "dog", • Understand simple instructions, such as “no” and "come here", • Recognize words for common items, such as "shoe", • Turn and look in the direction of sounds, • Waves “bye-bye.”
By the end of 18 months	<ul style="list-style-type: none"> • Recognize names of familiar people, objects and body parts, • Follow simple directions accompanied by gestures, • Says 3 or more words besides “mama” or “dada”.
2 years	<ul style="list-style-type: none"> • Use simple phrases, such as "more milk" (puts 2 words together), • Ask one- to two-word questions, such as "Go bye-bye?", • Follow simple commands and understand simple questions, • Speak about 50 or more words, • Speak well enough to be understood at least half the time by you or other primary caregivers, • Points to things in a book when you ask, like “Where is the bear?”, • Points to at least two body parts when you ask him to show you, • Uses more gestures than just waving and pointing, like blowing a kiss or nodding yes.
3 years	<ul style="list-style-type: none"> • Has a word for almost everything, • Uses two- or three-word phrases to talk about and ask for things, • Uses k, g, f, t, d, and n sounds, • Speaks in a way that is understood by family members and friends, • Names objects to ask for them or to direct attention to them. • Talks with you in conversation using at least two back-and-forth exchanges,

	<ul style="list-style-type: none"> • Asks “who,” “what,” “where,” or “why” questions, like “Where is mommy/daddy?”, • Says what action is happening in a picture or book when asked, like “running,” “eating,” or “playing”, • Says first name, when asked.
4 Years	<ul style="list-style-type: none"> • Hears you when you call from another room, • Hears the television or radio at the same sound level as other, family members, • Answers simple “Who?” “What?” “Where?” and “Why?” questions, • Talks about activities at daycare, preschool, or friends’ homes, • Uses sentences with four or more words, • Speaks easily without having to repeat syllables or words, • Says some words from a song, story, or nursery rhyme.
5 Years	<ul style="list-style-type: none"> • Pays attention to a short story and answers simple questions about it. For example, a cat was stuck in a tree and a firefighter saved it, • Hears and understands most of what is said at home and in school, • Uses sentences that give many details, • Tells stories that stay on topic, • Communicates easily with other children and adults, • Says most sounds correctly except for a few (l, s, r, v, z, ch, sh, and th), • Names some letters and numbers, • Uses adult grammar, • Keeps a conversation going with more than three back-and-forth • Exchanges, • Uses or recognizes simple rhymes (bat-cat, ball-tall).

To determine the etiology of a possible communication deficit for adults and children, the ASHA recommends that the comprehensive speech and language pathology assessment includes these components: (9)

- Case history, including medical status, education, socioeconomic, cultural, and linguistic backgrounds and information from teachers and other related service providers.
- Patient/client/student and family interview.
- Review of auditory, visual, motor, and cognitive status.
- Standardized and/or non-standardized measures of specific aspects of speech, spoken and non-spoken language, cognitive-communication, and swallowing function, including observations and analysis of work samples.
- Identification of potential for effective intervention strategies and compensations.
- Selection of standardized measures for speech, language, cognitive-communication, and/or swallowing assessment with consideration for documented ecological validity and cultural sensitivity.

- Follow-up services to monitor communication and swallowing status and ensure appropriate intervention and support for individuals with identified speech, language, cognitive-communication, and/or swallowing disorders.

For standardized testing, different tests use different terms to describe levels or degrees of language or speech problems. As a rule of thumb, on a scale where 100 is the average. The following generally indicates interpretation of test scoring: (10)

- A standard score of 70 or below suggests a severe impairment-
- A standard score of 71-77 suggests a moderate impairment.
- A standard score of 78-85 suggests a mild impairment.
- A standard score of 86 -114 suggests no impairment: treatment is not needed and should not be provided.

There are no grading standards or consistent test scoring for non-standardized testing.

For children, the assessment may have more elements to be reviewed in ascertaining the type of speech and language problem the child is experiencing, with consideration made for the age and linguistic development of the child. According to the ASHA, the additional factors should include the following: (11)

- Relevant case history, including birth and medical history:
 - Family history of speech, language, reading, or academic difficulties,
 - Family's concerns about the child's language (and speech),
 - Languages and/or dialects used in the home, including:
 - Age of introduction of a second language, as appropriate,
 - Circumstances in which each language is used,
 - Teachers' concerns regarding the impact of child's language difficulties in the classroom;
- Hearing screening, if not available from prior screening;
- Oral mechanism examination;
- Spoken language testing, including:
 - Phonology, including phonological awareness,
 - Semantics,
 - Morphology,
 - Syntax,
 - Pragmatics, including discourse-level language skills (conversation, narrative, expository).

In the American Family Physician Journal, the American Academy of Family Physicians (AAFP) published information on speech and language delay in children. (2) There are many conditions that fall under divided primary and secondary speech and language problems, all based upon the presenting signs/symptoms and following a speech and language evaluation, as outlined below in Table 2.

Table 2. Speech and Language Problems in Children (2)

Disorder	Clinical Findings	Treatment and Prognosis
Primary (Not Attributable to Another Condition)		
Developmental speech and language delay	<ul style="list-style-type: none"> • Speech is delayed. • Children have normal comprehension, intelligence, hearing, emotional relationships, and articulation skills. 	<ul style="list-style-type: none"> • SLT interventions are effective. Parent-provided therapy under the guidance of a clinician is as effective as clinician-provided therapy. Interventions lasting longer than 8 weeks may be more effective than those lasting less than 8 weeks. • Prognosis is excellent. Children typically have normal speech by the age of school entry.
Expressive language disorder	<ul style="list-style-type: none"> • Speech is delayed. • Children have normal comprehension, intelligence, hearing, emotional relationships, and articulation skills. • Expressive language disorder is difficult to distinguish at an early age from the more common developmental speech and language delay. 	<ul style="list-style-type: none"> • Active intervention is necessary because this disorder is not self-correcting. • SLT interventions are effective. Parent-provided therapy under the guidance of a clinician is as effective as clinician-provided therapy. Interventions lasting longer than 8 weeks may be more effective than those lasting less than 8 weeks.
Receptive language disorder	<ul style="list-style-type: none"> • Speech is delayed, and sparse, agrammatic, and indistinct in articulation. • Children may not look at or point to objects or persons named by parents (demonstrating a deficit in comprehension). • Children have normal responses to nonverbal auditory stimuli. 	<ul style="list-style-type: none"> • The effect of SLT is much smaller than it is for other groups. Parent-provided therapy under the guidance of a clinician is as effective as clinician-provided therapy. Interventions lasting longer than 8 weeks may be more effective than those lasting less than 8 weeks. • It is rare for these children to develop normal oral language capacity.
Secondary (Attributable to Another Condition)		
Autism spectrum disorder	<ul style="list-style-type: none"> • Children have a variety of speech abnormalities, including speech delay (especially with concurrent intellectual disability), echolalia (repeating phrases) without generation of their own novel phrases, difficulty 	<ul style="list-style-type: none"> • Children should be referred for developmental evaluation. • Children benefit from intensive, early intervention that focuses on increasing communication. • Language training programs have been shown to help children communicate.

	<p>initiating and sustaining conversations, pronoun reversal, and speech and language regression.</p> <ul style="list-style-type: none"> • Children have impaired communication, impaired social interaction, and repetitive behaviors/circumscribed interests. 	
Cerebral palsy	<ul style="list-style-type: none"> • Speech delay in children with cerebral palsy may be due to difficulty with coordination or spasticity of tongue muscles, hearing loss, coexisting intellectual disability, or a defect in the cerebral cortex. 	<ul style="list-style-type: none"> • SLT services can include introducing augmentative and alternative communication systems, such as symbol charts or speech synthesizers, enhancing natural forms of communication, and training communication partners.
Childhood apraxia of speech	<ul style="list-style-type: none"> • Apraxia of speech is a physical problem in which children have difficulty making sounds in the right order, making it hard for their speech to be understood by others. • Children communicate with gestures but have difficulty with speech (demonstrating motivation to communicate, but lack of speech ability). 	<ul style="list-style-type: none"> • Many different SLT techniques have been used.
Dysarthria	<ul style="list-style-type: none"> • Dysarthria is a physical problem in which children can have speech difficulties ranging from mild, with slightly slurred articulation and low-pitched voice, to profound, with an inability to produce any recognizable words. • Children communicate with gestures but have difficulty with speech (demonstrating motivation to communicate, but lack of speech ability). 	<ul style="list-style-type: none"> • Small, observational studies have suggested that for some children, SLT might be associated with positive changes in intelligibility and clarity of speech.

<p>Hearing loss after spoken language established.</p>	<ul style="list-style-type: none"> • Refer to SUR714.004 Cochlear implant for aural rehabilitation. • Speech and language are often gradually affected, with a decline in the precision of speech articulation and a lack of progress in vocabulary acquisition. • Parents may report that the child does not seem to be listening or describe the child speaking better than listening. 	<ul style="list-style-type: none"> • Refer to SUR714.004 Cochlear implant for aural rehabilitation. • Children with hearing loss should be referred to an audiologist. The audiologist, as part of an interdisciplinary team of professionals, will perform an evaluation and suggest the most appropriate intervention program. • Early family-centered intervention promotes language (spoken and/or signed) and cognitive development. Children identified with hearing loss who begin services early may be able to develop language (spoken and/or signed) on par with their hearing peers.
<p>Hearing loss before onset of speech</p>	<ul style="list-style-type: none"> • Speech is delayed. • Children may have distortions of speech sounds and prosodic patterns (intonation, rate, rhythm, and loudness of speech). • Children may not look at or point to objects or persons named by parents (demonstrating a deficit in comprehension). • Children have normal visual communication skills. 	<ul style="list-style-type: none"> • Children with hearing loss should be referred to an audiologist. The audiologist, as part of an interdisciplinary team of professionals, will perform an evaluation and suggest the most appropriate intervention program. • Early family-centered intervention promotes language (spoken and/or signed) and cognitive development. • Children identified with hearing loss who begin services early may be able to develop language (spoken and/or signed) on par with their hearing peers.
<p>Intellectual disability</p>	<ul style="list-style-type: none"> • Speech is delayed. • Use of gestures is delayed, and there is a generalized delay in all aspects of developmental milestones. • Children may not look at or point to objects or persons named by parents (demonstrating a deficit in comprehension). 	<ul style="list-style-type: none"> • Children should be referred for developmental evaluation. This may include referral to a tertiary-level child development center that can provide interdisciplinary evaluations (including SLT and audiology).

<p>Selective mutism</p>	<ul style="list-style-type: none"> • Children with selective mutism show a consistent failure to speak in specific social situations (in which there is an expectation for speaking [e.g., at school]) despite speaking in other situations. 	<ul style="list-style-type: none"> • Children should be referred to a SLP for evaluation, and to a therapist for behavioral and cognitive behavior therapies, which appear to be effective. • Combined intervention including behavioral modification, family participation, school involvement, and in severe cases, treatment with specific medications is promising.
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SLT: speech-language therapy; SLP: speech-language pathologist.

SLT can also assist individuals with swallowing disorders (dysphagia). A swallowing evaluation may be performed to assess oral, pharyngeal, and/or upper digestive structures and function. The SLT evaluation can determine the oropharyngeal and respiratory status, identify functional and structural impairments, and assess the ability to eat safely to sustain adequate nutrition and hydration. SLT may provide additional interventions to support individuals with dysphagia in order to promote adequate hydration and nutrition, minimize pulmonary complications, and facilitate coordinated movements of their oral/pharyngeal and respiratory system. (1)

Generally, the type of SLT services include (1):

- Habilitative services and therapies are designed to develop new skills and maximize functioning.
- Rehabilitative services help restore or improve abilities lost or impaired as a result of illness, disease, injury, or disability.
- Maintenance program services are intended to maintain functional status or to prevent or slow further deterioration in function.

Glossary of Terms:

- Anomic aphasia (also known as anomia or nominal aphasia): Impairment of language marked by difficulty or inability in finding the proper word and especially the name of objects. Anomic aphasia typically results from an injury to the brain (e.g., stroke). Patients with anomic aphasia have intact repetition, intact comprehension, and fluent speech, but have difficulty naming. (12)
- Aphasia or dysphasia: Loss or impairment of the power to use or comprehend words usually resulting from brain damage (e.g., stroke, head injury, or infection) or disease. (13, 14)
- Aphonia: The loss of voice and of all but whispered speech. (15)
- Apraxia of speech (also known as acquired apraxia of speech, verbal apraxia or childhood apraxia of speech): A neurological disorder that affects the brain pathways involved in planning the sequence of movements involved in producing speech. The brain knows what it wants to say but cannot properly plan and sequence the required speech sound movements. (18)

- Broca's (expressive) aphasia: Results from injury to speech and language brain areas such as the left hemisphere inferior frontal gyrus, among others. Such damage is often a result of stroke but may also occur due to brain trauma. Patients have difficulty producing grammatical sentences and their speech is limited mainly to short utterances of less than four words. Producing the right sounds or finding the right words is often a laborious process. (19)
- Dysphagia: Impaired swallowing is a swallowing disorder involving the oral cavity, pharynx, esophagus, or gastroesophageal junction. Consequences of dysphagia include malnutrition and dehydration, aspiration pneumonia, compromised general health, chronic lung disease, choking, and even death. (20)
- Dysphonia: A defective use of the voice (16) characterized by altered vocal quality, pitch, loudness, or vocal effort. (17)
- Fluency: Refers to the continuity, smoothness, rate, and effort in speech production. (21)
- Fluency disorder: An interruption in the flow of speaking characterized by atypical rate, rhythm, and repetitions in sounds, syllables, words, and phrases. (21)
- Habilitative services: Health care services that are short-term and help a person to acquire or attain an age-appropriate bodily function necessary to participate in activities of daily living. (1)
- Intonation: The rise and fall of pitch in the voice while speaking. (12)
- Morphology: Units of language, including words and parts of speech. (22)
- Phonology: Language-based sounds: in particular, phonemes, which are the units that make up words. (22)
- Pragmatics: How the context of language contributes to meaning. (22)
- Rehabilitative services: Health care services rendered for the purpose of restoring function lost due to illness, injury or surgical procedures. (1)
- Semantics: The study of meanings in language. (22)
- Stuttering: Frequent repetition of words or parts of words that disrupts the smooth flow of speech. (22)
- Syntax: Sentence formation and structure. (22)
- Voice Disorders: Group of problems involving abnormal pitch, loudness, or quality of the sound produced by the larynx (voice box). (22)
- Wernicke's aphasia (also known as receptive or fluent aphasia): Disorder in which someone can speak but can't understand language in its written or spoken form; caused by damage to the medial temporal lobe of the brain. (22)

Aural Rehab/Auditory Rehab

Aural rehabilitation, also referred to as auditory rehabilitation, is an assessment used to evaluate the impact of hearing loss on communication functioning along with the identification of speech communication impairments. Treatment goals focus on identifying the impact of hearing loss and/or auditory symptoms on communication with others. Treatment focuses on comprehension and production of language (oral, signed or written), speech and voice production, multimodal training (e.g., visual, auditory-visual, and tactile), communication strategies and education. (1)

Speech Volume Modulation System (e.g., SpeechVive™)

The SpeechVive device is a portable device designed to improve vocal loudness and/or speech clarity in patients with hypophonia (abnormally weak voice), a common speech impairment in patients diagnosed with PD. The device is worn behind the ear like a hearing aid and contains an accelerometer that detects when the individual speaks. The SpeechVive device works by playing a background (babble) noise in the ear only when the patient speaks, eliciting louder speech through the Lombard Effect. The Lombard Effect is a phenomenon where speakers naturally speak louder under conditions of background noise. (23, 24)

Regulatory Status

SLT is not subject to regulation by the U.S. Food and Drug Administration (FDA).

The SpeechVive is classified as Class I, 510(k) exempt device and is registered with the FDA. FDA product code KTH. (24)

Rationale

The policy was created in 1992 and is based on peer reviewed scientific literature using the PubMed database, Centers for Medicare and Medicaid Services (CMS) and professional guidelines. The following is a summary of the key literature through October 26, 2023.

Each benefit plan, summary plan description or individual contract defines which speech therapy services are covered, which services are excluded, and which services are subject to dollar caps or other limitations, conditions, or exclusions. If there is a discrepancy between this medical policy and a member's benefit plan, summary plan description or contract, the benefit plan, summary plan description or contract will govern.

SPEECH-LANGUAGE THERAPY

A search of peer reviewed literature identified few clinical trials that address the efficacy of specific speech therapy modalities or assess the effect of individual modalities in the treatment of specific conditions. The application of speech therapy is generally based on empirical experience and professional guidelines.

In 2012, Brady et al. (25) evaluated the effectiveness of SLT for aphasia following stroke. Investigators searched the Cochrane Stroke Group Trials Register, MEDLINE, and CINAHL. In an effort to identify further published, unpublished and ongoing trials, researchers' hand-searched the International Journal of Language and Communication Disorders and reference lists of relevant articles and contacted academic institutions and other researchers. There were no language restrictions. Randomized controlled trials (RCTs) comparing SLT (a formal intervention that aims to improve language and communication abilities, activity and participation) with (i) no SLT; (ii) social support or stimulation (an intervention that provides social support and communication stimulation but does not include targeted therapeutic interventions); and (iii)

another SLT intervention (which differed in duration, intensity, frequency, intervention methodology or theoretical approach). Investigators independently extracted the data and assessed the quality of included trials. They also sought missing data from investigators. Researchers included 39 RCTs (51 randomized comparisons) involving 2,518 participants in this review; 19 randomized comparisons (1,414 participants) compared SLT with no SLT where SLT resulted in significant benefits to patients' functional communication (standardized mean difference (SMD) 0.30, 95 % CI: 0.08 to 0.52, $p = 0.008$), receptive and expressive language; 7 randomized comparisons (432 participants) compared SLT with social support and stimulation but found no evidence of a difference in functional communication; 25 randomized comparisons (910 participants) compared 2 approaches to SLT. There was no indication of a difference in functional communication. Generally, the trials randomized small numbers of participants across a range of characteristics (age, time since stroke and severity profiles), interventions and outcomes. The authors concluded that this review provided some evidence of the effectiveness of SLT for people with aphasia following stroke in terms of improved functional communication, receptive and expressive language. However, some trials were poorly reported. The potential benefits of intensive SLT over conventional SLT were confounded by a significantly higher dropout from intensive SLT. More participants also withdrew from social support than SLT interventions. They stated that there was insufficient evidence to draw any conclusion regarding the effectiveness of any one specific SLT approach over another.

In 2009, the Canadian Agency for Drugs and Technologies in Health (CADTH) released a meta-analysis and technology report, reviewing the clinical effectiveness for SLT for preschoolers, and evidence for the optimal frequency of therapy sessions prior to decision-making. (26) Literature search included 25 RCTs reporting SLT for ≤ 5 years of age. Of the RCTs reviewed, 1 was of good quality. The RCT cited therapies included individual and group therapies and treatment lengths and frequency varied. Overall, for clinical effectiveness of quality of life (QoL) for preschoolers, the RCTs demonstrated improvement in many outcome measures; but conclusions and generalizability are limited. Regarding frequency of SLT sessions for preschoolers, no studies were identified. The reviewer's conclusion, "Limited data suggested favorable outcomes of SLT in preschool-aged children. The studies identified reported that speech and language outcomes significantly improved following intervention programs. The RCTs included were less than 100 patients although additional studies are needed on long-term outcomes and QoL."

The 1 good quality RCT, noted above by CADTH, was published by Buschmann et al. in 2008. (27) The RCT evaluated the effectiveness of a parent-based language intervention group program for 2-year-old children with specific expressive language delay (SELD). Of the 61 children presenting with SELD, 58 were randomly assigned to the intervention group ($n=29$) or a 12-month waiting group without any intervention ($n=29$). The intervention used was the Heidelberg Parent-based Language Intervention (HPLI). The HPLI, a structured program developed for use with a group of 5-10 parents, was based on an interactive model of language intervention with focused on optimized parental input. The program consisted with seven 2 hour sessions and one 3-hour session 6 months later. Forty-seven children were included in the analysis. Children were assessed at 6 months and 12 months following the intervention. After

12 months, 75% of the children in the intervention group showed normal expressive language abilities, as compared to the waiting group. Only 8% of the children in the intervention group versus 26% in the waiting group met the criteria for specific language impairment (t score $<$ or $=$ 35).

Stuttering is one specific speech disorder affecting children and adults. According to UpToDate, the treatment plan for a child with this type of speech disorder is tailored to his or her individual needs. (28) In 1996, Craig et al., presented a paper with the results of a controlled trial of child stuttering treatment. (29) Three treatments were investigated, which included intensive smooth speech, intensive electromyography (EMG) feedback, and home-based smooth speech. The children or adolescents were assessed across 3 speaking contexts on measures of percentages syllables stuttered (% SS) and syllables spoken per minute (SSM). The outcomes were assessed at 12 months of therapy. Repeated measures analysis of variance demonstrated significant differences between the control group and all 3 treatment groups across time on conversations in various settings. Although individuals in the stuttering control group did not change across time, the individuals in the treatment group experienced decreased stuttering to very low levels post-treatment (less than 1% syllables stuttered on average), with a mean improvement in stuttering frequency of at least 85% to 90% across all assessment contexts. Stuttering did not increase significantly up to 3 months and 1-year post-treatment in the experimental groups, although levels did rise across time (less than 3% syllables stuttered on average). Speech results showed increasing naturalness across time as rated by the clinician and parent. This was not the case for the controls. The results suggest that all 3 treatments for children aged 9-14 who stutter were very successful in the long term for over 70% of the group, though the EMG feedback and home-based treatments were superior when percentages falling below a cutoff point (2% SS) were used to discriminate between groups.

UpToDate cited the follow-up study of the same 3 groups stated earlier by Craig et al., in 1998. (28, 30) The children and adolescents were now age 11 to 18 years. The authors reported on treatment effectiveness 4 years post-treatment. Results demonstrate that treatment gains were maintained in the long term, with rates of stuttering similar to the 1-year post-outcomes. There were no significant differences among the 3 treatments in long-term effectiveness. This controlled study substantiates the claim that the treatments investigated will more than likely have substantial long-term benefits for the fluency and personality of children and adolescents who stutter. Longer follow-up periods of this same controlled trial and similar trials have not been identified.

Swallowing disorders (dysphagia) in children and infants are complex and may have multiple causes. Underlying medical conditions that may cause dysphagia in this patient population may include, but are not limited to the following conditions (31, 32):

- Neurological disorders (e.g., cerebral palsy);
- Disorders affecting suck-swallow-breathing coordination (e.g., bronchopulmonary dysplasia);
- Structural lesions (e.g., neoplasm);

- Connective tissue disease (e.g., muscular dystrophy);
- Iatrogenic causes (e.g., surgical resection, medications);
- Anatomic or congenital abnormalities (e.g., cleft lip and/or palate).

There are limited published clinical trials that assess the specific treatments for dysphagia and the effect of the treatments. Coverage for speech therapy in individuals are supported by professional guidelines and position statements.

Non-Correctable Communication Disorders

No RCTs or other comparative studies evaluating the treatment of non-correctable medical conditions causing communication difficulties, including orofacialmyology or myofunctional treatments, were identified therefore are considered not medically necessary.

Group Therapy and/or Computer Based Therapy

Computer-based therapy programs have been developed to improve reading and language skills. The use of speech software or computer-based programs, repetitive training devices/exercises or school-based programs are considered training in nature and are not considered medically appropriate, as they do not involve the formal interaction of one-to-one supervision with a speech-language pathologist. Group speech therapy and/or computer-based therapy may be excluded as a non-covered benefit per the terms of the member's benefit plan.

Duplicate Therapy

When individuals receive multiple therapies (i.e., both occupational and speech therapy), the therapies should provide different treatments and not duplicate the same treatment. (33) They must also have separate treatment plans and goals. Duplicate therapy is considered not medically necessary.

Non-Skilled Services

Certain types of treatment do not generally require the skills of a qualified provider of speech therapy services, such as treatments that maintain function by using routine, repetitions, and reinforced procedures that are neither diagnostic nor therapeutic (e.g., practicing word drills for developmental articulation errors) or procedures that may be carried out effectively by the patient, family, or caregivers. These services are considered not medically necessary.

Maintenance Program

A maintenance therapy program consists of activities (i.e., drills, techniques, and exercises) that preserve the patient's present level of function and prevent regression of that function. (34) Maintenance begins when the therapeutic goals of a treatment plan have been achieved and when no further functional progress is expected to occur. Maintenance programs do not require the professional skills of a licensed SLP, therefore are not considered medically necessary. Such services include but are not limited to the following:

- Services related to the general welfare of the beneficiary such as exercises to promote fitness and flexibility, training or conditioning, and holistic treatments,

- Repetitive services that are performed to maintain function, maintain gait, maintain strength and endurance that do not require the professional skills of a licensed therapy provider,
- Therapy after the beneficiary has achieved goals outlined in the Plan of Care or where there is no meaningful progress, or
- Exercises and range of motion exercises not related to the restoration of a specific loss of function.

Professional Guidelines and Position Statements

American Academy of Family Practice (AAFP)

In 2011, the AAFP published Key Recommendations for Practice for both evaluation and SLT for children. (2) Their recommendations for treatment include the following in Table 3:

Table 3. Key Recommendations for Speech-Language Therapy for Children (2)

Clinical Recommendation	Evidence Rating	Resource
SLT is effective for primary expressive language disorders. The effect of SLT for children with receptive language disorder appears to be much smaller than it is for other groups.	A	Cochrane review
For children receiving SLT, parent-provided therapy under the guidance of a clinician is as effective as clinician-provided therapy.	A	Cochrane review
SLT interventions lasting longer than eight weeks may be more effective than those lasting less than eight weeks.	B	Cochrane review

A: consistent, good-quality patient-oriented evidence;

B: inconsistent or limited-quality patient-oriented evidence;

SLT: speech-language therapy.

American Speech-Language Hearing Association (ASLHA)

SLT services may consist of multiple interventions performed by licensed practitioners trained specifically in the treatment of speech, language, and hearing. (1) These services must meet certain criteria and be performed by a qualified provider in accordance with the requirements outlined by the ASLHA as well as any state licensure guidelines regarding their scope of practice.

In 2015, the ASLHA published Speech-Language Pathology Medical Review Guidelines. (1) The ASLHA stated their purpose of the guidelines for speech-language pathology was to serve as a resource for health plans to use in all facets of claims review and policy development. The guidelines provide an overview of the profession of speech-language pathology including speech-language pathologist qualifications, standard practices, descriptions of services, documentation of services, and treatment efficacy data. (1) The ASLHA also offers comprehensive evidence-based guidance and online resources for specific diagnosis. (35)

Per ASLHA, (1) individuals of all ages are eligible for speech-language pathology services when their ability to communicate and/or swallow effectively is reduced or impaired or when there is reason to believe (e.g., risk factors) that treatment would prevent the development of a speech, language, communication, or feeding and swallowing disorder; reduce the degree of impairment; lead to improved functional communication skills and/or functional feeding and swallowing abilities; or prevent the decline of communication and/or swallowing abilities. In children a diagnosis of a developmental impairment indicates an abnormal state of function, therefore, speech-language services may be appropriate for this patient as they are for an adult who has suffered a stroke and lost speech and language function.

SLP may also provide voice treatment to individuals with voice disorders, a laryngeal speech, and/or laryngeal disorder affecting respiration in order to achieve improved voice production, coordination of respiration and laryngeal valving, and/or acquisition of a laryngeal speech sufficient to allow for functional oral communication. Voice treatment can resolve a voice disorder when medical intervention (i.e., surgery) is not warranted and may reduce the need for laryngeal surgery or other medical intervention, when indicated, if initiated before any medical interventions. (1)

American College of Chest Physicians (ACCP)

The American College of Chest Physicians (ACCP) published evidenced-based clinical practice guidelines regarding cough and aspiration of food and liquids due to oral-pharyngeal dysphagia (36). The guidelines note that the treatment of dysphagic patients by a multidisciplinary team, including early evaluation by a speech-language pathologist, is associated with improved outcomes. The ACCP also notes that, “Effective clinical interventions such as the use of compensatory swallowing strategies and the alteration of food consistencies can be based on the results of instrumental swallowing studies.”

U.S. Preventive Services Task Force (USPSTF)

In 2015, the USPSTF revised their recommendation related to screening for speech and language delay in children 5 years of age and younger in the primary care setting which states: (37) “The USPSTF concludes that the evidence is insufficient to assess the balance of benefits and harms of screening for speech and language delay and disorders in children aged 5 years or younger. Level I recommendation.”

The USPSTF stated that potential harms may include the time, effort and anxiety related to additional testing after a positive screen as well as the potential detriments associated with diagnostic labeling. However, the USPSTF found no studies that address these harms.

Summary of Evidence: Speech-Language Therapy

For individuals who have signs and/or symptoms suggestive of speech and language conditions or disorders, and who have been diagnosed following an evaluation or assessment, the evidence of speech-language therapy (SLT) primarily includes empirical experience. The few clinical trials, small case series studies, anecdotal experiences, comparative and retrospective reviews have historically been used to support the utilization of SLT for adults and children.

Several systematic reviews or meta-analyses have been completed, yielding only 1 good quality, randomized controlled trial (RCT). More commonly found were, no RCTs identified during those reviews assessing SLT. Well-controlled treatment clinical trials and RCTs are needed to confirm the observed data. However, the empirical evidence is sufficient to determine that the therapy results in a meaningful improvement for net health outcomes in specific situations.

Aural Rehab/Auditory Rehab

Hearing Loss without a Cochlear Implant

In 2017, Michaud and Duchesne stated that few systematic reviews have been conducted regarding aural rehabilitation for adults with hearing loss, with none specifically targeting the older adult population. (38) Researchers stated that with prevalence rates of hearing loss being highest in older adults, examining the effects of aural rehabilitation on this population is needed. They evaluated the effects of aural rehabilitation on QoL in an older adult population presenting with hearing loss. Studies with adults presenting with hearing loss, greater than or equal to 50 years of age, with or without hearing aids, receiving interventions such as auditory training, speech-reading, communication strategies training, speech tracking, counseling, or a combination of approaches, and measuring outcomes related to QoL, in an individual or group format, with or without significant others and with no limitations as to year of publication were selected for analysis. These investigators performed searches in 6 databases, as well as results from gray literature and cross-referencing of articles, and retrieved 386 articles. Of the 145 assessed as full-text articles for eligibility, 8 studies met inclusion criteria. A component-based risk of bias assessment, as recommended by the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) statement was adopted. No effect sizes were found in group interventions measuring outcomes related to QoL, such as mental and emotional functions, environmental factors, participation restrictions, and activity limitations. An intervention effect regarding participation was found for a self-administered home training program, but an effect size was unavailable. Small-to-medium effect sizes were found in 1 of 2 individual communication training programs, for which outcomes related to QoL, such as emotional functions, activities, participation, and environmental factors were measured. The results of the component-based risk of bias assessment indicated that the quality of reporting was poor, thus compromising the internal validity of included primary studies. The authors concluded that these findings indicated that the combined body of evidence in support of aural rehabilitation for older adults with hearing loss was insufficient to draw any firm conclusions; they identified a need for more rigorous research to guide clinical decision-making.

Aural Rehabilitation for Tinnitus

In 2019, Searchfield and associates stated that tinnitus is a common otoneurological complaint often accompanying hearing loss. (39) In this perspective on rehabilitation, investigators described a framework for sound therapy and aural rehabilitation of tinnitus based on the ecological model of tinnitus. A thematic network analysis-based approach was used to relate aural rehabilitation methods to the ecological model of tinnitus and the client oriented scale of improvement in tinnitus. Aural rehabilitation methods were mapped to concepts of context, presence of sound, and reaction to sound. A global theme was adaptation to sound. The framework was the result of an iterative and cumulative research program exploring tinnitus as the outcome of the relationship between individual psychoacoustics and psycho-social factors

including context of perception. The authors concluded that the intent of this framework was to help guide audiologists managing tinnitus. The framework has been useful in the authors' clinic as illustrated by a case study although they stated that the benefits of this approach relative to standard care needs to be independently ascertained.

Summary of Evidence: Aural Rehab/Auditory Rehab

For individuals with hearing loss without cochlear implants and/or individuals with tinnitus the evidence is insufficient to draw any firm conclusions on the long term impact of aural/auditory rehab on health outcomes. Additional long term studies are warranted to guide clinical decision-making and to determine the long term benefits of this approach.

SPEECH VOLUME MODULATION SYSTEM (e.g., SpeechVive™)

Stathopoulos et al. (2014) investigated whether speakers with hypophonia, secondary to Parkinson's disease (PD), would increase their vocal intensity when speaking in a noisy environment (Lombard Effect). (40) The other objective was to examine the underlying laryngeal and respiratory strategies used to increase vocal intensity. Thirty-three participants with PD were included for study. Each participant was fitted with the SpeechVive™ device that played multi-talker babble noise into one ear during speech. Using acoustic, aerodynamic and respiratory kinematic techniques, the simultaneous laryngeal and respiratory mechanisms used to regulate vocal intensity were examined. Significant group results showed that most speakers with PD (26/33) were successful at increasing their vocal intensity when speaking in the condition of multi-talker babble noise. They were able to support their increased vocal intensity and subglottal pressure with combined strategies from both the laryngeal and respiratory mechanisms. Individual speaker analysis indicated that the particular laryngeal and respiratory interactions differed among speakers. Researchers concluded that The SpeechVive™ device elicited higher vocal intensities from patients with PD. The present positive results of eliciting higher vocal intensity in a one-session application gives strong evidence to plan a full treatment study.

Richardson et al. (2014) investigated the effect of increased vocal intensity on interarticulator timing in individuals with PD. (41) Ten individuals with mild to moderate hypophonia, secondary to PD, were selected for study. Over an 8-week treatment period, multi-talker babble noise was presented monaurally to the individuals with PD during everyday communication contexts to elicit increased vocal intensity (Lombard effect). Outcome measures included sound pressure level (SPL), voice onset time (VOT), VOT ratio, percent voicing, and speech intelligibility. Group and individual participant responses to the treatment are reported and discussed. Speakers with PD were shown to significantly increase SPL in response to treatment. Six of the 10 speakers showed improved temporal coordination between the laryngeal and supralaryngeal mechanisms (interarticulator timing) in response to treatment. Four of the 10 speakers, however, showed reduced laryngeal–supralaryngeal timing at the end of treatment. Group speech intelligibility scores were significantly higher post-treatment as compared to pre-treatment. Researchers concluded that voice treatment during everyday communication resulted in improved temporal coordination across the laryngeal and supralaryngeal mechanisms for the majority of speakers with PD and made them easier to

understand. Further investigations are planned to explore individual differences in response to treatment. The identification of speaker-specific voicing and devoicing strategies is consistent with the heterogeneous nature of PD.

In 2021, ECRI reviewed clinical evidence related to the safety and efficacy of SpeechVive when used to correct hypophonia in patients with PD. (24) ECRI determined that the evidence is “inconclusive” as there are too few data related to outcomes. ECRI acknowledged evidence limitations in available studies as they are at high risk of bias due to small sample size and lack of parallel controls. ECRI recommended additional large, multicenter studies are warranted.

Summary of Evidence: Speech Volume Modulation System (e.g., SpeechVive™)

For individuals with hypophonia secondary to Parkinson’s disease who utilize a speech volume modulation system (e.g., SpeechVive) to improve vocal loudness and/or speech clarity, the evidence to date is limited to uncontrolled, short-term studies with small sample sizes. Although initial results from these limited studies was promising, at this time the evidence is considered insufficient to determine the effects of the technology on health outcomes.

Coding

Procedure codes on Medical Policy documents are included **only** as a general reference tool for each policy. **They may not be all-inclusive.**

The presence or absence of procedure, service, supply, or device codes in a Medical Policy document has no relevance for determination of benefit coverage for members or reimbursement for providers. **Only the written coverage position in a Medical Policy should be used for such determinations.**

Benefit coverage determinations based on written Medical Policy coverage positions must include review of the member’s benefit contract or Summary Plan Description (SPD) for defined coverage vs. non-coverage, benefit exclusions, and benefit limitations such as dollar or duration caps.

CPT Codes	92507, 92508, 92521, 92522, 92523, 92524, 92526, 92610, 92630, 92633
HCPCS Codes	E3000, G0153, G0161, S9128, [Deleted 1/2024: K1009]

*Current Procedural Terminology (CPT®) ©2023 American Medical Association: Chicago, IL.

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Centers for Medicare and Medicaid Services (CMS)

The information contained in this section is for informational purposes only. HCSC makes no representation as to the accuracy of this information. It is not to be used for claims adjudication for HCSC Plans.

The Centers for Medicare and Medicaid Services (CMS) does not have a national Medicare coverage position. Coverage may be subject to local carrier discretion.

A national coverage position for Medicare may have been developed since this medical policy document was written. See Medicare's National Coverage at <<https://www.cms.hhs.gov>>.

Policy History/Revision

Date	Description of Change
09/15/2024	Reviewed. No changes.
04/15/2024	Document updated with literature review. The following changes were made in Coverage: 1) Modified language from “due to illness/disease, trauma, surgery, congenital anomalies, or prior therapeutic intervention” to “speech language impairment” 2) Removed “in a reasonable and predictable period of time (usually 4-6 months, but not less than 8 weeks) 3) Removed the entire 5th bullet which includes a list of conditions under developmental delay 4) Added aural rehab/auditory rehab is considered experimental, investigational, and/or unproven in individuals with the following conditions: Tinnitus; and/or Hearing loss without a cochlear implant 5) Added NOTE 4 that refers to SUR714.004 for information on coverage of aural rehab. 6) Combined notes 1 and 2 specific to provider information AND notes 3 and 4 specific to children although no change to the intent and/or language in the notes. Added references 3, 8, 9, 12-22, 25, 31-36, 38, 39; others updated; some removed.
01/01/2023	Reviewed. No changes.
01/15/2022	Document updated with literature review. Coverage unchanged. Added references 11, 12, 33; others updated.
10/01/2020	Document updated with literature review. The following change was made to Coverage: Added “The use of a speech volume modulation system (e.g., SpeechVive) to improve vocal loudness and/or speech clarity in patients with hypophonia secondary to Parkinson’s disease (PD) is considered experimental, investigational and/or unproven”. Added references 31 and 32.

09/15/2019	Document updated with literature review. Coverage unchanged. The following 3 NOTES were added: NOTE 3: For additional information regarding childhood ages with corresponding speech-language milestones from the American Speech-Language-Hearing Association, the National Institutes of Health, the American Academy of Pediatrics, and the American Academy of Pediatric Dentistry, refer to the Description; NOTE 4: Refer to the Description of information regarding speech and language delay for children from the American Academy of Family Physicians; and NOTE 5: For children, standardized testing scores may aid in the determination of a speech-language deficit. For example, a standard score of 70 or below, out of a 100-scale assessment, appears to indicate a severe impairment. Refer to the Description for more information. The following references were added: 3-10, 13-17, and 25-29; none removed. The title changed from Speech Therapy.
04/15/2018	Document updated with literature review. The following was added to the medically necessary coverage statement: "illness" and "surgery" under prescribed by a licensed physician or other qualified provider to restore or improve the function in a member. The following was added to not medically necessary coverage statement: 1) Under development delay, for stammering or stuttering, "e.g., a congenital abnormality of the teeth, tongue, jaw, palate"; 2) Group speech or computer-based therapies, as these therapies are not one-to-one individualized treatment; and, 3) medical conditions causing communication difficulties that are not correctable (e.g., muscle disorders of face, mouth, lips or jaw [a tongue thrust], including orofacialmyology or myofunctional treatment).
04/15/2016	Reviewed. No changes.
03/15/2015	Document updated with literature review. The following changes were made to Coverage: 1) The bullet "Prescribed by a licensed physician or other qualified provider* to restore or improve the function in a member who has impaired physical function of phonation or swallowing, or communication disability related to expressive or receptive aphasia/paraphasia, due to disease, trauma, congenital anomalies, or prior therapeutic intervention" was modified by the addition of "or communication disability related to expressive or receptive aphasia/paraphasia"; 2) Everywhere that stated the need for a physician's referral, prescription, or certification was modified to include "or other qualified provider".
09/15/2014	Reviewed. No changes.
10/01/2013	Literature reviewed. No changes.
03/15/2008	Policy reviewed without literature review; new review date only
07/01/2007	Codes Revised/Added/Deleted
01/15/2006	Revised/Updated Entire Document
03/01/2000	Revised/Updated Entire Document
11/01/1999	Codes Revised/Added/Deleted

04/01/1994	Codes Revised/Added/Deleted
10/01/1993	Codes Revised/Added/Deleted
10/01/1992	New medical document