Molina Clinical Policy
Speech Therapy: Policy No. 269
Last Approval: 12/13/2023
Next Review Due By: December 2024

DISCLAIMER

This Molina Clinical Policy (MCP) is intended to facilitate the Utilization Management process. Policies are not a supplementation or recommendation for treatment; Providers are solely responsible for the diagnosis, treatment and clinical recommendations for the Member. It expresses Molina's determination as to whether certain services or supplies are medically necessary, experimental, investigational, or cosmetic for purposes of determining appropriateness of payment. The conclusion that a particular service or supply is medically necessary does not constitute a representation or warranty that this service or supply is covered (e.g., will be paid for by Molina) for a particular Member. The Member's benefit plan determines coverage – each benefit plan defines which services are covered, which are excluded, and which are subject to dollar caps or other limits. Members and their Providers will need to consult the Member's benefit plan to determine if there are any exclusion(s) or other benefit limitations applicable to this service or supply. If there is a discrepancy between this policy and a Member's plan of benefits, the benefits plan will govern. In addition, coverage may be mandated by applicable legal requirements of a State, the Federal government or CMS for Medicare and Medicaid Members. CMS's Coverage Database can be found on the CMS website. The coverage directive(s) and criteria from an existing National Coverage Determination (NCD) or Local Coverage Determination (LCD) will supersede the contents of this MCP and provide the directive for all Medicare members. References included were accurate at the time of policy approval and publication.

OVERVIEW

Speech Language Pathology (SLP) services are defined by the American Speech Language Hearing Association (ASHA) as those necessary for the diagnosis and treatment of swallowing, speech-language, and cognitive-communication disorders that result in communication disabilities. Speech disorders include:

- 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)
- Feeding and swallowing (e.g., oral, pharyngeal, and dysphagia)

Speech-language pathologists (SLPs) specialize in the evaluation and treatment of communication and swallowing disorders and work with individuals who have physical or cognitive deficits/disorders resulting in difficulty communicating. Speech therapy services are classified as either rehabilitative or habilitative. Rehabilitative services aid in the restoration or enhancement of abilities that have been lost or impaired because of illness. Habilitative services are intended to maintain, develop, or improve skills that have not (but would normally have) developed or are at risk of being lost because of illness, injury, loss of a body part, or congenital abnormality (ASHA 2015).

State Resources

Early intervention is the process of providing services, education, and support to young children who are deemed to have an established condition, those who are evaluated and deemed to have a diagnosed physical or mental condition (with a high likelihood of resulting in a developmental delay), an existing delay, or a child who is at-risk of developing a delay or special need that may affect their development or impede their education.

Early Intervention Programs (EIPs) are typically the first option for children under the age of three who are eligible and who meet certain criteria. Each state offers education and related services through state-specific programs. Early intervention aims to mitigate the impact of a disability or delay. Services are intended to identify and meet a child's developmental needs in five domains: physical, cognitive, communicative, social or emotional, and adaptive. An EIP program is available within each state (refer to state-specific criteria).

COVERAGE POLICY

Please review all applicable State and Federal mandates and health plan regulations before applying the criteria below. Refer to requirements, criteria, and guidance provided by the State in which the Member is receiving treatment, as the State's documents will supersede this Molina Clinical Policy.

Initial Speech Language Therapy Criteria

Speech Language Therapy **may be covered and considered medically necessary** when the Member has at least **ONE** of the following diagnoses:

a. Autism spectrum disorder.
b. Developmental delay, neurogenic or psychogenic stuttering.
c. Language disorders (e.g., comprehension, expression, pragmatics, semantics, syntax).
d. Feeding and swallowing disorders (e.g., oral, pharyngeal, and esophageal stages).
e. Non-progressive central nervous system disorders (e.g., birth trauma, cerebral palsy, spina bifida, Down syndrome, traumatic brain injury [TBI], cerebrovascular accident [CVA], encephalitis, post-concussion syndrome).
f. Articulation disorder (e.g., apraxia, dysarthria).

In addition, Members must meet **ALL** the following:

1. The Provider has determined that the Member's condition can improve significantly with speech therapy within a reasonable and predictable period of time; **AND**

2. Services are delivered by a qualified Provider who holds the appropriate credentials in speech-language pathology; has pertinent training and experience; and is certified, licensed, or otherwise regulated by the State or Federal governments (e.g., Speech-Language Pathology [CCC-SLP]); **AND**

3. Services require the judgment, knowledge, and skills of a qualified provider of SLP services due to the complexity of the therapy and the medical condition of the Member; **AND**

4. Services must be provided in accordance with an ongoing, written plan of care that is reviewed with and approved by the treating Provider in accordance with applicable State laws and regulations. The plan of care should be of sufficient detail including, but not limited to:
   a. Prior functional level, or baseline condition.
   b. Results of assessments utilizing standard tools to determine the Member's level of function.
   c. Treatment plan including frequency and duration of therapy services as well as functional and measurable short- and long-term goals, Home Exercise Program (HEP) / strategy to transition care to Member and/or caregiver maintenance program.

AND

5. Rehab potential based on prior level of function with expectation for clinical or functional improvement (potential refers to probability that therapy goals and Member outcomes are realistic and attainable based on assessment of Member's prior level of function, severity of illness, and extent of impairment).

Speech therapy is considered not medically necessary when it is a duplicate therapy for Members receiving speech therapy through an individual education program.

Re-Evaluation for Speech Therapy

A re-evaluation for speech therapy is indicated when there are new significant clinical findings, including failure to respond to SLP interventions, and/or the need for closure or a break. Re-evaluation is a more comprehensive assessment that includes all the components of the initial evaluation. **Two (2) evaluations per 365 days are allowed.**

Food Aversion in Children and Adolescents

Symptoms of feeding disorders may include extreme food selectivity, food refusal, failure to thrive, oral aversion, and recurrent emesis. Anatomical or functional disorders that make feeding difficult or uncomfortable for the child may result in a learned aversion to eating even after the underlying disorder is corrected. Children with developmental disabilities are more likely to develop feeding-related difficulties such as gastroesophageal reflux, oral motor dysfunction and aversive feeding disorder.

Speech Therapy for the treatment of food aversion(s) **may be covered and considered medically necessary** when the Member meets at least **ONE** of the following:

1. Weight loss, poor growth, or failure to thrive/achieve expected weight gain.
   a. Failure to Thrive / Weight Loss: Unresponsive to standard age-appropriate interventions over four weeks with clinical signs and symptoms of nutritional risk from failure to thrive as indicated by the following for neonates, infants, and children < 18 years of age:
      - Weight for height or BMI for age ≤ 10 percent; **OR**
      - Crossed (downward) at least 2 percentile lines of weight for age on the growth chart.
2. Nutritional deficiency; **OR**
3. Impaired psychosocial functioning; **OR**
4. Oral motor dysfunction (problems swallowing due to central nervous system [CNS] or neuromuscular disorders.

In addition, **ALL** of the following criteria must be met:

5. Services are delivered by a qualified Provider who holds the appropriate credentials in speech-language pathology; has pertinent training and experience; and is certified, licensed, or otherwise regulated by the State or Federal governments (e.g., Speech-Language Pathology [CCC-SLP]); **AND**

6. Services require the judgment, knowledge, and skills of a qualified provider of SLP services due to the complexity of the therapy and the medical condition of the Member; **AND**

7. Services must be provided in accordance with an ongoing, written plan of care that is reviewed with and approved by the treating physician in accordance with applicable state laws and regulations. The plan of care should be of sufficient detail and include:
   a. Sufficient information to determine medical necessity of treatment;
   b. The speech therapy evaluation;
   c. Specific and measurable short-and long-term goals and reasonable estimate of when they will be reached.

   AND
8. Frequency and duration of treatment, and techniques/ exercises to be used in treatment; **AND**

9. Services are considered medically necessary if there is a reasonable expectation that speech therapy will achieve a measurable improvement in the Member's condition in a reasonable and predictable period of time.

Continued Therapy

Continued therapy for food aversion **may be considered covered and medically necessary** when the following are met:

1. Member still meets definition of failure to thrive or nutritional deficiency; **AND**
2. Has shown improvement in oral intake (quantity and/ or variety); **AND/OR**
3. Has shown improvement in weight and/or nutritional status; **AND**
4. Member and/or caregiver committed to program participation including adherence to carryover exercises.

Limitations and Exclusions

All other treatment requests that do not meet the above criteria are **considered not medically necessary or experimental, investigational and/or unproven.** This includes **ALL** of the following:

1. Developmental speech or language delays/disorders one standard deviation or less below the mean in areas of receptive, expressive, pragmatic, or total language score.
2. Self-correcting dysfunctions such as language therapy for normal non-fluency. (Children ages 2-5 years may experience normal non-fluency and speech therapy may not be authorized for this condition).
3. Computer-based learning programs for speech training such as Fast ForWord.
4. Duplicate therapies of the same treatment from two different rehabilitative providers (e.g., occupational or physical therapy in conjunction with speech therapy).
5. Education services, testing and school performance tests (e.g., SIPT, praxis testing).
6. Facilitated Communication (FC), auditory integration training (AIT), and sensory integration (SI) therapy.
7. Long term rehabilitative services when significant therapeutic improvement (when there is a therapeutic plateau) is not expected.

8. Maintenance therapy in which no additional functional progress is being made or unless a change in status occurs that would require a re-evaluation.
9. Therapy to improve or enhance school, recreational, or job performance.
10. Therapy when intended to improve communication skills beyond premorbid levels (e.g., beyond the functional communication status prior to the onset of a new diagnosis or change in medical status).
11. Therapy is being provided to meet developmental milestones and/or is provided by the Member's school district or other State benefit.
12. Therapy that does not require the skills of a qualified provider of speech therapy services, such as treatments which maintain function and are neither diagnostic nor therapeutic, or procedures that may be carried out efficiently by the patient, family, or caregivers in the home.
13. Therapy that is considered primarily for the enhancement of educational purposes when services are provided by public or private educational agencies (e.g., developmental delay).
14. If required services are provided by another public agency, including the Member's school district.

DOCUMENTATION REQUIREMENTS. Molina Healthcare reserves the right to require that additional documentation be made available as part of its coverage determination; quality improvement; and fraud; waste and abuse prevention processes. Documentation required may include, but is not limited to, patient records, test results and credentials of the provider ordering or performing a drug or service. Molina Healthcare may deny reimbursement or take additional appropriate action if the documentation provided does not support the initial determination that the drugs or services were medically necessary, not investigational, or experimental, and otherwise within the scope of benefits afforded to the member, and/or the documentation demonstrates a pattern of billing or other practice that is inappropriate or excessive.

SUMMARY OF MEDICAL EVIDENCE

There is robust published peer-reviewed literature on the effectiveness of speech therapy for a wide range of conditions. The published evidence consists of systematic reviews, randomized controlled trials, controlled clinical trials and retrospective comparison studies that compare speech and language therapy to placebo, no intervention and other communication interventions for speech problems. However, there are no universal guidelines on the number of speech therapy treatments for any diagnosis, nor is there consistent evidence based on any diagnosis on which to base a treatment decision.

Diaféria et al. (2022) conducted a randomized controlled clinical trial to evaluate the impact of the ATAXIA–Myofunctional Orofacial and Vocal Therapy (A-MOVT) program on the quality of life (QOL) of patient with spinocerebellar ataxia type 3 (SCA3). Forty-eight participants (33 females and 15 males) were divided into either the intervention group (STG) or the control group (CG). Participants in the STG underwent therapy once a week with a total of 12 session and the CG participants were patients on the waiting list for speech therapy. Inclusion criteria for the study included diagnosis of SCA3, between 18 and 70 years of age, and complaints related to voice or swallowing. Exclusion criteria included inability to follow instructions, other neurological disorders, severe clinical or psychiatric diseases, and previous participation in speech therapy programs. Outcomes were measured using the World Health Organization's Quality of Life (WHOQOL-BREF) assessment, Living with Dysarthria (LwD), Quality of Life in Swallowing Disorders (SWAL-QOL), and Food Assessment Tool (EAT-10). The LwD QOL data for STG showed a significant score reduction postintervention, but CG scores increased ($p < 0.001$). The SWAL-QOL scores showed a significant improvement in the communication domain in the STG at 3 months of intervention ($p = 0.007$) while lower scores were identified in the CG group at 3 months ($p = 0.007$). EAT-10 score revealed a reduction in swallowing symptoms ($p = 0.018$) and showed significant improvement in the EAT-10 scores in the STG at the end of 3-months ($p = 0.024$). LwD showed higher total scores and individual subscale scores for the STG when compared to the CG ($p < 0.050$ for all comparisons). There were no significant changes found in the WHOQOL-BREF scores. Limitations of this study include small sample size and short duration of the rehabilitation program. These study results showed the positive impact speech therapy rehabilitation programs have on QOL of individuals living with SCA3.

Stahl et al. (2018) performed a randomized, parallel-group, blinded assessment-controlled trial to assess the appropriate quantity of speech-language therapy (SLT) in the rehabilitation of chronic post-stroke aphasia. Thirty patients were included in the study with an average age of 60.1 years with an average of 65.2 months post-onset of stroke. Patients were assigned either highly intensive practice where they received 4 hours of SLT daily or moderately intensive practice with 2 hours of SLT daily. Inclusion criteria for the study included diagnosis of aphasia confirmed by the Aachen Aphasia Test (AAT), chronic stage of aphasia confirmed by symptoms at least 1-year post-onset of stroke, German as native language and right handedness according to the Edinburg Handedness Inventory. Exclusion criteria included aphasia due to traumatic brain injury or other neurodegenerative disease, severe non-verbal cognitive deficits,

severe uncorrected vision or hearing disorders, or intensive SLT in the previous 2 years. Outcomes in the study were scored with the AAT measured by the Token Test, repetition, naming and comprehension and the Action Communication Test (ACT). AAT scores showed significant progress in each of the two training intervals. Progress did not depend on the intensity level applied. ACT scores showed only patients with moderately intensive practice continued to make progress which patients with highly intensive practice did not. This study demonstrated a 2-week increase in treatment duration a 2-hour daily dosage of SLT contributes to recovery from chronic post-stroke aphasia.

Osman et al. (2023) conducted a systematic review to assess effects of early initiation of speech therapy on children diagnosed with autism spectrum disorder (ASD). The review consisted of 12 articles with 501 participants (78% male and 22% female). Inclusion criteria included participants that received speech therapy as intervention for autism and children that had been clinically diagnosed with ASD. Articles were excluded if they were not aligned with targeted research goals, gray literature, and articles without full text or missing abstracts. Through the systematic review improvements in cognitive ability, communication, and social skills were reported. One study reported improved eye contact, verbal reciprocity, and better self-expression from participants. Another study reported a decrease in anxiety level among children with ASD. Limitations of the review included a small number of articles reviewed, the ratio of randomized to nonrandomized studies, and a short follow-up period.

National and Specialty Organizations

The **American Speech Language Hearing Association (ASHA)** published *Speech-Language Pathology Medical Review Guidelines* to provide an overview of standard practices, descriptions of services, documentation of services, medical necessity of services, and treatment data. The guidelines provide an overview of the prevalence and incidence of communication and swallowing disorders. The ASHA outlines medical necessity of speech-language pathology services and indications for treatment. Information in the publication is updated on an as-needed basis.

CODING & BILLING INFORMATION

CPT (Current Procedural Terminology) Codes

CPT	Description
92507	Treatment of speech, language, voice, communication, and/or auditory processing disorder; individual
92508	Treatment of speech, language, voice, communication, and/or auditory processing disorder; group, 2 or more individuals
92521	Evaluation of speech fluency (e.g., stuttering, cluttering)
92522	Evaluation of speech sound production (e.g., articulation, phonological process, apraxia, dysarthria);
92523	Evaluation of speech sound production (e.g., articulation, phonological process, apraxia, dysarthria); with evaluation of language comprehension and expression (e.g., receptive and expressive language)

HCPCS (Healthcare Common Procedure Coding System Codes

HCPCS	Description
G0153	Services performed by a qualified speech-language pathologist in the home health or hospice setting, 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
S9152	Speech therapy, re-evaluation

CODING DISCLAIMER. Codes listed in this policy are for reference purposes only and may not be all-inclusive. Deleted codes and codes which are not effective at the time the service is rendered may not be eligible for reimbursement. Listing of a service or device code in this policy does not guarantee coverage. Coverage is determined by the benefit document. Molina adheres to Current Procedural Terminology (CPT®), a registered trademark of the American Medical Association (AMA). All CPT codes and descriptions are copyrighted by the AMA; this information is included for informational purposes only. Providers and facilities are expected to utilize industry standard coding practices for all submissions. When improper billing and coding is not followed, Molina has the right to reject/deny the claim and recover claim payment(s). Due to changing industry practices, Molina reserves the right to revise this policy as needed.

APPROVAL HISTORY

12/13/2023	Policy reviewed, no changes to criteria. Updated Summary of Medical Evidence and References.
12/14/2022	Policy reviewed, no changes to criteria. Updated Summary of Medical Evidence and References.
12/08/2021	Policy reviewed, reorganized Coverage Policy section, updated Summary of Medical Evidence and References. IRO peer review by a board-certified speech pathologist.
04/05/2021	Policy reviewed, no changes to criteria. References updated.
04/23/2020	Policy reviewed, no changes to criteria. References updated.
06/19/2019	Policy reviewed, no changes to criteria. References updated.
03/08/2018	Policy reviewed, no changes to criteria. References updated.

REFERENCES

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2. Centers for Medicare and Medicaid Services (CMS). Medicare coverage database. National Coverage Determination (NCD) No. 170.3 - for Speech-Language Pathology Services for the Treatment of Dysphagia. Effective October 1, 2006. Accessed October 2, 2023. https://www.cms.gov/medicare-coverage-database/search.aspx
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6. Stahl B, Mohr B, Büscher V, Dreyer FR, Lucchese G, Pulvermüller F. Efficacy of intensive aphasia therapy in patients with chronic stroke: a randomised controlled trial. J Neurol Neurosurg Psychiatry. 2018 Jun;89(6):586-592. doi: 10.1136/jnnp-2017-315962. Epub 2017 Dec 22. PMID: 29273692; PMCID: PMC6031278.

APPENDIX

Reserved for State specific information. *Information includes, but is not limited to, State contract language, Medicaid criteria and other mandated criteria.*

Washington
For Medicaid, therapy past (NAN) visits would be subject to Limitation Extension review.