



Medicare Part C Medical Coverage Policy

Speech Language Pathology (SLP) Services

Origination: March 1, 1993

Review Date: November 20, 2019

Next Review: November, 2021

******This policy applies to all Blue Medicare HMO, Blue Medicare PPO, Blue Medicare Rx members, and members of any third-party Medicare plans supported by Blue Cross NC through administrative or operational services. ******

DESCRIPTION OF PROCEDURE

Speech language pathology (SLP) services are those services necessary for the diagnosis and treatment of speech and language disorders that result in communication disabilities and for the diagnosis and treatment of swallowing disorders, even if there is not a communication disability. The services are designed to improve or restore speech and language functioning (communication) following disease, injury or loss of a body part. Speech pathology also includes evaluation of swallowing.

DEFINITIONS:

A communication disorder is impairment in the ability to receive, send, process and comprehend concepts or verbal, nonverbal and graphic symbol systems. This may be evident in the processes of hearing, language or speech.

- A. A speech disorder is an impairment involving the articulation of sounds, fluency and or voice. Articulation issues are characterized by substitutions, omissions or distortions. Fluency disorders are characterized by abnormal production or speaking at an atypical rate, rhythm or repetitions. A voice disorder is characterized by lack of voice quality, loudness etc.
- B. A Language disorder encompasses impaired comprehension with spoken, written language or symbols.
 - a. Phonology is the sound system of a language and the rules that govern sound combinations.
 - b. Morphology governs the structure of words.
 - c. Syntax governs the order and combination of words to form sentences.
 - d. Semantics is the system that governs words and sentences.
 - e. Pragmatics is the use of language components in a functional and socially appropriate communication.
- C. Central Auditory processing disorders are deficits in the information processing of audible signals. Examples of issues are the ability to attend, discriminate, identify acoustic signals, filter, sort, store, retrieve, decode and attach meaning.
- D. Dysphagia is a swallowing disorder that may be due to neurological or structural impairments. It may be the result of head trauma, cerebrovascular accident, neuromuscular degenerative diseases, head and neck cancer, and encephalopathy.
- E. Dysphonia is an impairment of the speaking or singing voice. It arises from an abnormality in the structures and functions of voice production.

- F. Dysarthria is a motor speech disorder exhibited by slurred speech, speaking softly or barely able to whisper, slow rate of speech, mumbling, abnormal rhythm, hoarseness, drooling, chewing and swallowing difficulty to name of a few.
- G. Verbal Dyspraxia includes Motor-Learning difficulties and is exhibited by an inability to express oneself under pressure or command, usually affecting children.

Diagnostic and Evaluation Services: Evaluation is a comprehensive service that requires professional skills to make clinical judgments about conditions for which services are indicated based on objective measurements and subjective evaluations of member performance and functional abilities. During the initial contact, the clinician evaluates & documents:

1. A diagnosis and description of the specific problem to be evaluated and treated. This should include the specific body area(s) evaluated and all conditions and complexities that may impact the treatment;
2. Objective measurements, preferably standardized patient assessment instruments and/or outcomes measurement tools related to current functional status;
3. The Clinician's clinical judgments or subjective impressions that describe the current functional status of the condition being evaluated, when they provide further information to supplement the measurement tools; and
4. The evaluation is necessary to the development of a plan, including goals and the selection of interventions.

SLP Therapeutic Services: The treatment/intervention, and follow-up services for disorders of speech, articulation, fluency and voice, language skills and the cognitive aspect of communication:

1. Provide consultation, counseling, and make referrals when appropriate;
2. Provide training and support to family members/caregivers and other communication partners of individuals with speech, voice, language, communication, fluency, hearing and swallowing disabilities;
3. Develop and establish effective augmentative and alternative communication techniques and strategies, including selecting, prescribing and dispensing of aids and devices as identified by State Practice Acts and training individuals, their family members/caregivers, and other communication partners in their use;
4. Select, fit, and establish effective use of appropriate prosthetic/adaptive devices for speaking;
5. Provide aural rehabilitation and related counseling service to individuals with hearing loss and to their family members/caregivers. This is needed sometimes following a cochlear ear implant and family and caregiver training. (See below for more information on auditory rehabilitation).
6. Provide interventions for individuals with central auditory processing disorders; and/or
7. Modify or train in use of a voice prosthetic. The patient is seen for sizing, fitting, placement or replacement and training of the voice prosthetic.

The following are **examples** of common medical disorders and resulting communication deficits, which may necessitate active restorative therapy.

- a. Cerebrovascular disease (e.g., cerebral vascular accidents presenting with dysphagia, aphasia/dysphasia, apraxia/dyspraxia and dysarthria)

- b. Neurological disease (e.g., Parkinsonism or Multiple Sclerosis) may exhibit dysphonia, dysarthria, dysphagia, or inadequate respiratory volume/control. Mental retardation in combination with acquired disorders [e.g., aphasia and dysarthria (ex. mental retardation with CVA)]; and
- c. Laryngeal carcinoma requiring laryngectomy resulting in aphonia (may warrant therapy to develop new communication skills).

POLICY STATEMENT

Coverage will be provided for speech-language pathology when it is determined to be medically necessary, as outlined in the below guidelines and medical criteria.

BENEFIT APPLICATION

Please refer to the member's individual Evidence of Coverage (EOC) for benefit determination. Coverage will be approved according to the EOC limitations if the criteria are met.

Coverage decisions will be made in accordance with:

- The Centers for Medicare & Medicaid Services (CMS) National Coverage Determinations (NCDs);
- General coverage guidelines included in Original Medicare manuals unless superseded by operational policy letters or regulations; and
- Written coverage decisions of local Medicare carriers and intermediaries with jurisdiction for claims in the geographic area in which services are covered.

Benefit payments are subject to contractual obligations of the Plan. If there is a conflict between the general policy guidelines contained in the Medical Coverage Policy Manual and the terms of the member's particular Evidence of Coverage (EOC), the EOC always governs the determination of benefits.

CRITERIA REQUIRED FOR COVERAGE APPROVAL

A. Preauthorization by the Plan is required.

B. Criteria for speech evaluation: The evaluation is the identification, assessment, and diagnosis of the following disorders:

- a) Speech articulation, fluency, and voice (including respiration, phonation, and resonance);
- b) Language skills (involving the parameters of phonology, morphology, syntax, semantics and pragmatics, including disorders of receptive and expressive communication in oral, written, graphic, and manual modalities);
- c) Cognitive aspects of communication (including communication disability and other functional disabilities associated with cognitive impairment);
- d) Aural rehabilitation.

C. Criteria for therapeutic interventions for language

- a) The services must meet accepted standards of practice and be a specific and effective treatment for the member's identified problems;

- b) The services must be at a level of complexity, which can be safely and effectively performed only by a qualified SLP;
- c) Objective measurement that the member is making progress toward goals whenever possible, keeping in mind that coverage does not turn on the presence or absence of a members potential for improvement from the therapy, but rather on the member's need for skilled care;
- d) There must be an expectation that the member's condition will improve materially in a reasonable (and generally predictable) period of time, or the services must be necessary to the establishment of a safe and effective maintenance program and;
- e) The amount, frequency and duration of the services must be reasonable under accepted standards of practice.

D. Criteria for Swallowing Interventions

Instrumental assessment of swallowing may be indicated for the evaluation of a patient with dysphagia who has a pharyngeal dysfunction or who is at risk for aspiration. At least one of the following conditions must be present:

- a) History of aspiration problems or aspiration pneumonia, or definite risk for aspiration, reverse aspiration, chronic aspiration, nocturnal aspiration, or aspiration pneumonia. Nasal regurgitation, choking, frequent coughing up food during swallowing, wet or gurgly voice quality after swallowing liquids, or delayed or slow swallowing reflex.
- b) Presence of oral motor disorders such as drooling, oral food retention, leakage of food or liquids placed in the mouth.
- c) Impaired salivary gland performance and/or presence of local structural lesions in the pharynx resulting in marked oropharyngeal swallowing difficulties.
- d) Incoordination of respiration and swallowing, sensation loss, postural difficulties or other neuromotor disturbances affecting oropharyngeal abilities necessary to close the bucal cavity and/or bite, chew, suck, shape, and squeeze the food bolus into the upper esophagus while protecting the airway.
- e) Post-surgical reaction affecting the ability to adequately use oropharyngeal structures used in swallowing.
- f) Significant weight loss with documentation to support that tube feedings may be indicated.
- g) Existence of other condition such as presence of a tracheostomy tube, reduced or inadequate laryngeal elevation, labial closure, velopharyngeal closure, laryngeal closure, or pharyngeal peristalsis, and cricopharyngeal dysfunction.

Examples of important clinical syndromes where instrumental assessment of swallowing may be helpful are:

- i. Patients with stroke or other central nervous system (CNS) disorder with associated impairment of speech and swallowing;
- ii. Patients with surgical ablation or radiation due to head and neck cancer with documented difficulty in swallowing;
- iii. Patients without obvious CNS disorder, but with documented difficulty in swallowing;
- iv. Patients with generalized debilitation and with difficulty swallowing food;
- v. Patients with neuromuscular diseases and rheumatologic diseases known to cause dysphagia;
- vi. Patients with a clinical history of aspiration or a history of aspiration pneumonia;
- vii. Patients with head or neck (throat) injury.

SPECIAL NOTE

Outpatient speech pathology services are covered for the treatment of dysphagia, regardless of the presence of a communication disability. Patients who are motivated, moderately alert and have some degree of deglutition and swallowing functions are appropriate candidates for dysphagia therapy. Elements of therapy can include:

- Thermal stimulation to heighten the sensitivity of the swallowing reflex (only covered in conjunction with other services; not covered separately);
- Exercises to improve oral motor control;
- Training in laryngeal adduction and compensatory swallowing;
- Positioning and dietary modifications.

E. Criteria for Auditory Rehabilitation

Auditory (or Aural) rehabilitation is performed by a qualified speech-language pathologist and may be covered when it has been determined by the SLP in collaboration with an audiologist that the beneficiary's current amplification options, (hearing aid, other amplification device or cochlear ear implant), will not sufficiently meet the patient's functional communication needs. It includes evaluation or aural rehabilitation status, hearing, and therapeutic services with or without speech processor programming. This may include:

- Extensive auditory rehabilitation therapy for members with cochlear implants focusing on audition, cognition, language and speech skills;
- Family member or caregiver training for auditory verbal techniques;
- Improve patients' auditory skills pertaining to the suprasegmental aspects;
- Improve the patients' ability to discriminate and exhibit improvements in speech (manner, place and voicing).

Maintenance Programs: A maintenance program may be developed to maintain functional status or prevent decline in function. The specialized services of the therapist would be required and services are covered to design or establish the plan, assure patient safety, train the patient, family members or unskilled personnel. The services of a qualified professional are not necessary to carry out a maintenance program, and are not covered in ordinary circumstances. The patient may perform the maintenance program with an assistant, unskilled personnel or family members.

If services required to maintain function involve the use of complex and sophisticated therapy procedures, the judgment and skill of the therapist may be necessary for the safe and effective delivery of such services. If the member's safety is at risk, those reasonable and necessary services shall be covered, even if the skills of the therapist are not ordinarily needed to carry out the activities performed as a part of the maintenance program.

WHEN COVERAGE WILL NOT BE APPROVED

Any condition that does not meet criteria listed in Criteria for Coverage Approval.

Therapy performed repetitively to maintain a level of function is not eligible for coverage.

Services involving non-diagnostic, non-therapeutic, routine, repetitive, and reinforced procedures or services do not constitute speech pathology services for coverage purposes-

VitalStim® is a type of neuromuscular stimulator for the treatment of dysphagia, which uses small electrical currents to stimulate the muscles responsible for swallowing and is not covered. However, because the code for dysphagia treatment is a comprehensive code that includes all treatment approaches, payment may be made if other medically necessary dysphagia treatments occur during the same session that electrical stimulation is rendered.

BILLING/ CODING/PHYSICIAN DOCUMENTATION INFORMATION

This policy may apply to the following codes. Inclusion of a code in the section does not guarantee reimbursement.

Applicable Codes: 70371, 91010, 92507, 92508, 92521, 92522, 92523, 92524, 92526, 92597, 92607, 92608, 92609, 92610, 92611, 92612, 92614, 92616, 92626, 92627, 92630, 92633, 96105, 96110, 96111, 97532, 97533

The Plan may request medical records for determination of medical necessity. When medical records are requested, letters of support and/or explanation are often useful, but are not sufficient documentation unless all specific information needed to make a medical necessity determination is included.

SPECIAL NOTES

- The plan of care must contain:
 - Clear goals,
 - Must address each problem identified in the assessment, and
 - Documentation of an anticipated timeframe for completion. The documentation must also indicate that the treatment is designed to ensure that it is safe for the patient to swallow during oral feedings. Advancement of the patient's diet to the most appropriate and safest level to improve or maintain weight should be the primary emphasis and goal of treatment.

- Endoscopic assessments of swallowing functions are not recommended if an oral or esophageal lesion is suspected and there is limited oral access due to a dental disorder or mandibular dysfunction.

- Requests for additional therapy should include documentation of:
 - periodic follow up testing with comparison to baseline testing;
 - specific goals and progress made towards those goals;
 - If swallowing is the issue, the type of oral intake and percentage of oral intake for daily fluid and caloric needs should be documented.

References:

1. Medicare National Coverage Determination for Speech-Language Pathology Services for the Treatment of Dysphagia (ID #170.3); Effective date: 10/2/2006; Accessed via www.cms.gov; 11/12/19.
2. Medicare Local Coverage Determination for Outpatient Speech-Language Pathology – Palmetto GBA Part A and B (L34429); Effective date: 10/1/2015; Accessed via www.cms.gov; 11/12/19.
3. Medicare Local Coverage Determination – Swallowing Studies for Dysphagia – Palmetto GBA Part A and Part B (L33449); Effective 10/1/215; Accessed via www.cms.gov 11/12/19.
4. Medicare Benefit Policy Manual; Chapter 15, Section 230.3; Accessed via www.cms.gov. 11/12/19.

5. Model Medical Review Guidelines for Dysphagia Services; American Speech-Language-Hearing Association; viewed online at <http://www.asha.org/uploadedFiles/practice/reimbursement/medicare/DynCorpDysphHCEC.pdf> on 11/06/2017.
6. Medicare Local Coverage Determination for Home Health Speech-Language Pathology – Palmetto GBA Part A and B L34563; Effective 10/1/2015; Viewed via www.cms.gov; 11/06/17.
7. LSVT Global Website; viewed at <http://www.lsvtglobal.com/>. See LOUD therapy link; Viewed on 01/06/2014.
8. American Speech-Language Hearing Association; Definitions of Communication Disorders and Variations; viewed on line at <http://www.asha.org/policy/RP1993-00208.htm>; viewed on 11/06/2017.

Policy Implementation/Update Information:

Revision Date: January 19, 1998; February 26, 2001; February 18, 2004; January 7, 2005; June 28, 2006; February 20, 2008

Policy renamed: Speech Language Pathology (SLP) Services, 2/2004. Previous policy name “Speech Therapy”

Revision Date: January 24, 2011; Language added pertaining to Vitalstim coverage for clarification per CMS guidelines.

Revision Date: December 18, 2013; Edited policy for clarification according to Medicare; added definitions and defined Maintenance Programs according to CMS/ LCD guidelines.

Revision Date: Annual Review, no new CMS guidance; minor revisions only and reference section updated.

Revision Date: November 15, 2017; Annual Review, no new CMS guidance; minor revisions only.

Revision Date: November 20, 2019; Annual Review, No CMS Updates. Minor Revisions Only.

Approval Dates:

Medical Coverage Policy Committee: November 20, 2019

Policy Owner: Carolyn Wisecarver, RN, BSN
Medical Policy Coordinator