Molina Clinical Policy
Speech Therapy: Policy No. 269
Last Approval: 12/8/2021
Next Review Due By: December 2022

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.[1] References included were accurate at the time of policy approval and publication.

OVERVIEW

According to the American Speech Language Hearing Association (AHSA), Speech Language Pathology (SLP) services are defined as those necessary for the diagnosis and treatment of swallowing (dysphagia), speech-language, and cognitive-communication disorders resulting in communication disabilities. Disorders of speech 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 esophageal stages)

Note that articulation disorders represent:

1. Failure to use developmentally expected speech sounds that are appropriate for age and dialect. This includes errors in sound production, use, representation or organization. Examples include, but are not limited to, substitutions of one sound for another or omissions of sounds (e.g., final consonants, cluster of sounds). These children may be unintelligible.
2. Difficulties in speech sound productions that interfere with academic or occupational achievements or with social communication.
3. If an intellectual disability is present, a speech-motor deficit or an environmental deprivation is present that make language difficulties in excess of those usually associated with these problems.

Speech therapy is performed by speech-language pathologists (SLPs) who specialize in the evaluation and treatment of communication and swallowing disorders and work with those with physical or cognitive deficits/disorders resulting in difficulty communicating. Speech therapy services can be classified as rehabilitative or habilitative. Rehabilitative services help restore or improve abilities lost or impaired as a result of illness. Habilitative services are intended to maintain, develop or improve skills which have not (but normally would have) developed or which are at risk of being lost as a result of illness, injury, loss of a body part, or congenital abnormality.[9]

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 probability 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 a first option for children who qualify and are up to age 3 years. Each state has special programs available for education and related services. The purpose of early intervention is to lessen the effects of the disability or delay. Services are designed to identify and meet a child's needs in five developmental areas: physical, cognitive, communication, social or emotional, and adaptive. An early intervention program is available within each State (refer to State-specific criteria).

COVERAGE POLICY

Please review individual State and Federal mandates and applicable health plan regulations before applying the criteria below. Please refer to requirements, criteria, and guidance from 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 CNS 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** of the following:

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

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]).

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.

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.

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 Member's receiving speech therapy through an EIP.

Re-Evaluation for Speech Therapy

A re-evaluation for speech therapy is usually 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. Anatomic 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 at increased risk for developing feeding-related difficulties, including 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.
3. Impaired psychosocial functioning.
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]).

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.

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.

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

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 requests for treatment 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. For 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 an abundance of published peer reviewed literature about the efficacy of speech therapy for many 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 to base a treatment decision. Sources used in the creation of this policy are listed in the References section below.

The **American Speech Language Hearing Association (ASHA)** has published the following – links can be found below in the Reference section:

- Speech-Language Pathology Medical Review Guidelines
- Preferred Practice Patterns for the Profession of Speech-Language Pathology
- Scope of Practice in Speech-Language Pathology
- Speech-Language Pathology Assistant Scope of Practice
- Clinical Topics

The **American College of Radiology (ACR)** published *ACR Appropriateness Criteria Dysphagia* which summarizes the literature for the initial imaging of patients with symptoms of dysphagia. The *ACR Appropriateness Criteria* are evidence-based guidelines for specific clinical conditions; review is conducted annually by a multidisciplinary expert panel. The appropriateness of imaging and treatment procedures for specific clinical scenarios are graded; where evidence is lacking, expert opinion may supplement the available evidence to recommend imaging or treatment.

The **American Society for Gastrointestinal Endoscopy (ASGE)** published the *Guideline for the Role of Endoscopy in the Evaluation and Management of Dysphagia*. The guideline includes eight recommendations on the

various types of available treatment including various types of dilation, conjunction antisecretory treatment, adjunctive treatment, esophageal stent placement and botulinum toxin injection for achalasia; endoscopic and surgical treatment options for achalasia is also included.

The **American College of Gastroenterology (ACG)** *Clinical Guidelines: Clinical Use of Esophageal Physiologic Testing*. The ACG guideline includes discussion of the clinical value of esophageal physiologic tests and provides recommendations for utilization in routine clinical practice.

A **Choosing Wisely** and the **American Academy of Nursing (AAN)** published guidance for dysphagia occurs in 50-60% of patients who have had a stroke. Swallow screening is important in the rapid identification of risk of aspiration. While this evaluation is not necessary for all patients with acute stroke, a swallowing screen may identify patients who do not need a formal evaluation and who can safely take food and medication by mouth. The AAN also provides 25 things that both nurses and patients should be aware of regarding formal swallow evaluations.

SUPPLEMENTAL INFORMATION

Individuals with Disabilities Act (IDEA) and State Resources for Children and Adolescents

The Individuals with Disabilities Act (IDEA) is a federally mandated program that provides free and appropriate public education for children with diagnosed learning disabilities throughout the nation and ensures special education and related services to those children.** Funding is governed by IDEA and determines how states and public agencies (such as schools) provide early intervention, special education, and related services to over 7.5 million eligible infants, toddlers, children, and youth with disabilities.

- Children and youth ages 3 through 21 receive special education and related services under IDEA Part B.
- Infants and toddlers (birth through age 2) with disabilities and their families receive early intervention services under IDEA Part C.
- Formula grants are awarded to States to support special education and related services and early intervention services.
- Discretionary grants are awarded to State educational agencies, institutions of higher education, and other non-profit organizations to support research, demonstrations, technical assistance and dissemination, technology development, personnel development, and parent-training and -information centers.

Services provided include, but are not limited to social workers, speech therapists, occupational therapists, school nurses, school psychologists, and/or health or other support staff (e.g., aides). Congress reauthorized the IDEA in 2004 and amended the IDEA through the Every Student Succeeds Act in December 2015.

** Refer to State guidance regarding coverage of speech therapy for the conditions noted above.

CODING & BILLING INFORMATION

CPT 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

Covered HCPCS Codes

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

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 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

12/8/2021	Policy reviewed, reorganized Coverage Policy section, updated Summary of Medical Evidence and References.
3/8/2018, 6/19/2019, 4/23/2020 & 4/5/2021	Policy reviewed, no changes to criteria. References updated.

REFERENCES

Government Agencies

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2. Centers for Medicare and Medicaid Services (CMS). Pub. 100-02, chapter 15, sections 220: Coverage of Outpatient rehabilitation therapy services (physical therapy, occupational therapy, and speech-language pathology services) under medical insurance and section 230 (practice of physical therapy, occupational therapy, and speech-language pathology). Available at CMS. Updated March 2021. Accessed September 13, 2021.
3. Individuals with Disabilities Education Act (IDEA). About IDEA. Available at IDEA. Accessed September 13, 2021.

Other Evidence Based Reviews and Publications

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National and Specialty Organizations

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Peer Reviewed Publications

1. Barkmeier-Kraemer JM, Clark HM. Speech-language pathology evaluation and management of hyperkinetic disorders affecting speech and swallowing function. Tremor Other Hyperkinet Mov (N Y). 2017 Sep 21;7:489. doi: 10.7916/D8Z32B30. Accessed Sept. 13, 2021.
2. Finch E, Ward EC, Brown B, Cornwell P, Hill AE, Hill A, et al. Setting a prioritized agenda to drive speech-language therapy research in health. Int J Lang Commun Disord. 2021 Jul;56(4):768-783. doi: 10.1111/1460-6984.12626. Accessed September 13, 2021.
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APPENDIX

Reserved for State specific information *(to be provided by the individual States, not Corporate). 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.