



Clinical Policy Title: Speech therapy

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Effective Date: June 1, 2017
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Policy contains:

- Speech therapy.
- Speech testing.
- Speech fluency.
- Speech disorder.

Related policies:

- CP# 11.03.03** Frenectomy for ankyloglossia
- CP# 15.02.05** Speech generating devices
- CP# 17.02.02** Altered auditory feedback devices for treatment of speech dysfluency (stuttering)
- CP# 15.01.02** Speech evaluation recording

ABOUT THIS POLICY: AmeriHealth Caritas has developed clinical policies to assist with making coverage determinations. AmeriHealth Caritas' clinical policies are based on guidelines from established industry sources, such as the Centers for Medicare & Medicaid Services (CMS), state regulatory agencies, the American Medical Association (AMA), medical specialty professional societies, and peer-reviewed professional literature. These clinical policies along with other sources, such as plan benefits and state and federal laws and regulatory requirements, including any state- or plan-specific definition of "medically necessary," and the specific facts of the particular situation are considered by AmeriHealth Caritas when making coverage determinations. In the event of conflict between this clinical policy and plan benefits and/or state or federal laws and/or regulatory requirements, the plan benefits and/or state and federal laws and/or regulatory requirements shall control. AmeriHealth Caritas' clinical policies are for informational purposes only and not intended as medical advice or to direct treatment. Physicians and other health care providers are solely responsible for the treatment decisions for their patients. AmeriHealth Caritas' clinical policies are reflective of evidence-based medicine at the time of review. As medical science evolves, AmeriHealth Caritas will update its clinical policies as necessary. AmeriHealth Caritas' clinical policies are not guarantees of payment.

Coverage policy

AmeriHealth Caritas considers the use of speech therapy to be clinically proven and, therefore, medically necessary when the following criteria are met (Colquhoun 2017, American Speech-Language-Hearing Association [ASHA] 2017, Brady 2016, Tosh 2016, Roulstone 2015, Codas 2015, Akeroyd 2015, Costantino 2014, Lustyk 2014, Blomgren 2013):

- Age-appropriate speech fluency is not evidenced by objective standardized testing administered by a trained, licensed healthcare professional experienced in the diagnosis and treatment of speech disorders.

Limitations:

Speech therapy services for which there is no evidence of improved outcomes or for which there is no defined benefit in state or federal policy are not covered.

Included are:

- Speech therapy administered for achievement of academic goals (e.g., grammar, vocabulary, reading).
- Speech therapy administered in a language other than the member's language at home.

Alternative covered services:

- Routine in-network evaluation and management by primary care physicians and specialists, including specialty therapists, working in the area of speech deficit and speech fluency.

Background

Speech is an essential component of the human experience. Aberrations in development and execution of speech are usually identified as a congenital or developmental deficit or as the result of some insult to the auditory organs or the brain during pediatric or adult life. Speech can be evaluated by clinical examination and by age-appropriate standardized tests (Appendix A) with "standard scores" designed specifically to identify speech deficits and difficulties in speech fluency. It can also be evaluated serially by the same examinations administered at interval over the course of therapy.

Screening for, and diagnosis and treatment of, speech disorders are mandated by statute: Section 1905r (Early and Periodic Screening, Diagnostic and Treatment, or EPSDT) of the Social Security Act (the Act) provides for comprehensive prevention, diagnostic and treatment services for low-income infants, children and adolescents under age 21 (EPSDT 2017). This includes physician, nurse practitioner and hospital services; physical, speech/language, and occupational therapies; home health services, including medical equipment, supplies, and appliances; treatment for mental health and substance use disorders; treatment for vision, hearing and dental diseases and disorders, and others.

Modern treatment focuses on individualized behavioral approaches combined with education and training. In children, emphasis of treatment is on manipulating environmental factors (indirect approaches) and working exclusively on the speech of the child with direct therapeutic approaches (Blomgren 2013). Of note, EPSDT entitles enrolled infants, children and adolescents to any treatment or procedure that fits within any of the categories of Medicaid-covered services listed in Section 1905(a) of the Act if that treatment or service is necessary to "correct or ameliorate" defects and physical and mental illnesses or conditions. The affirmative obligation to connect children with necessary treatment makes EPSDT different from Medicaid for adults (Social Security 2017).

Management of speech deficit and aberrations of speech fluency generally is conducted in the language of the home at intervals appropriate to the global condition of the patient. Indeed, all providers who

receive federal funds from Health and Human Services (HHS) for the provision of Medicaid services are obligated, under Title VI of the Civil Rights Act, to make language services available to those with limited English proficiency. The HHS Office for Civil Rights and the Department of Justice have provided guidance for recipients of federal funds on expectations of how to provide language services (United States Department of Justice 2017).

Home exercise programs (HEP) are also a helpful useful adjunct to managing speech deficit and speech fluency disorders.

Among conditions that might prompt speech therapy at intervals greater than once per week are profound speech dysfunction and autism.

Searches

AmeriHealth Caritas searched PubMed and the databases of:

- UK National Health Services Center for Reviews and Dissemination.
- Agency for Healthcare Research and Quality's National Guideline Clearinghouse and other evidence-based practice centers.
- The Centers for Medicare & Medicaid Services (CMS).

We conducted searches on March 26, 2018. Searched terms were: "speech deficit (MeSH)", "speech fluency (MeSH)" and "speech therapy."

We included:

- **Systematic reviews**, which pool results from multiple studies to achieve larger sample sizes and greater precision of effect estimation than in smaller primary studies. Systematic reviews use predetermined transparent methods to minimize bias, effectively treating the review as a scientific endeavor, and are thus rated highest in evidence-grading hierarchies.
- **Guidelines based on systematic reviews.**
- **Economic analyses**, such as cost-effectiveness, and benefit or utility studies (but not simple cost studies), reporting both costs and outcomes — sometimes referred to as efficiency studies — which also rank near the top of evidence hierarchies.

Findings

There is good evidence for the effectiveness of speech therapy in terms of improved “functional communication” (e.g., reading, writing, and expressive language) compared with no therapy (Brady 2016). However, the definition of “functional communication” varies widely in practice. A lack of consistent application of formal tools like standardized tests (Appendix A) to evaluate outcomes in speech therapy interventions hampers consistent interpretation of the available data. Indeed, there is awareness in the rehabilitative community that testing interventions are varied, often poorly described and their quality limited (Colquhoun 2017, Costantino 2014). Moreover, a single standardized test may

not measure all valid and accepted means of communication (e.g., gestures, facial expressions, tone of voice) encountered in a “functional” environment. Professional organizations within the speech and language therapy community such as the International Collegium of Rehabilitative Audiology (ICRA) within the last eighteen months have begun promulgating guidelines to promote a valid comparative basis for outcomes effectiveness (ICRA 2015).

There is some evidence (Brady 2016) that speech therapy at high intensity, high dose (four to fifteen hours of speech therapy per week) or over a longer period (up to eight years) may be beneficial; however, the benefits of high intensity/high dose speech therapy are diminished by a significantly higher dropout rate in these intervention groups. But, again, the data on different approaches to speech and language therapy lack consistent focus sufficient to draw conclusions based on sound medical evidentiary principles (ASHA 2017, Roulstone 2015, Codas 2015).

There is modest evidence that home speech therapy is an efficacious service delivery model, but it must be administered consistently and with direct parental involvement (Tosh 2016).

Policy updates:

During the past twelve months there has been further information published regarding speech therapy.

The American Academy of Otolaryngology-Head and Neck Surgery Foundation (Stachler 2018) created guidelines on treating patients who present with dysphonia. The guideline update group made strong recommendations for the following key action statements:

- Clinicians should assess the patient with dysphonia by history and physical examination to identify factors where expedited laryngeal evaluation is indicated.
- Clinicians should advocate voice therapy for patients with dysphonia from a cause amenable to voice therapy.
- Clinicians should identify dysphonia in a patient with altered voice quality, pitch, loudness, or vocal effort that impairs communication or reduces quality of life.
- Clinicians should assess the patient with dysphonia by history and physical examination for underlying causes of dysphonia and factors that modify management.
- Clinicians should perform laryngoscopy, or refer to a clinician who can perform laryngoscopy, when dysphonia fails to resolve or improve within 4 weeks or irrespective of duration if a serious underlying cause is suspected.
- Clinicians should perform diagnostic laryngoscopy, or refer to a clinician who can perform diagnostic laryngoscopy, before prescribing voice therapy and document/communicate the results to the speech-language pathologist.
- Clinicians should advocate for surgery as a therapeutic option for patients with dysphonia with conditions amenable to surgical intervention, such as suspected malignancy,

symptomatic benign vocal fold lesions that do not respond to conservative management, or glottic insufficiency.

- Clinicians should offer, or refer to a clinician who can offer, botulinum toxin injections for the treatment of dysphonia caused by spasmodic dysphonia and other types of laryngeal dystonia.
- Clinicians should inform patients with dysphonia about control/preventive measures.
- Clinicians should document resolution, improvement or worsened symptoms of dysphonia, or change in quality of life of patients with dysphonia after treatment or observation.
- Clinicians should not routinely prescribe antibiotics to treat dysphonia.
- Clinicians should not obtain computed tomography (CT) or magnetic resonance imaging (MRI) for patients with a primary voice complaint prior to visualization of the larynx.
- Clinicians should not prescribe antireflux medications to treat isolated dysphonia, based on symptoms alone attributed to suspected gastroesophageal reflux disease (GERD) or laryngopharyngeal reflux (LPR), without visualization of the larynx.

Clinicians should not routinely prescribe corticosteroids for patients with dysphonia prior to visualization of the larynx.

Summary of clinical evidence:

Citation	Content, Methods, Recommendations
<p>Stachler (2018)</p> <p>Clinical Practice Guideline: Hoarseness (Dysphonia) (Update).</p>	<p>Key points:</p> <ul style="list-style-type: none"> • The American Academy of Otolaryngology-Head and Neck Surgery Foundation created guidelines on treating patients who present with dysphonia. The guideline update group made strong recommendations for the following key action statements: • Clinicians should assess the patient with dysphonia by history and physical examination to identify factors where expedited laryngeal evaluation is indicated. • Clinicians should advocate voice therapy for patients with dysphonia from a cause amenable to voice therapy. • Clinicians should identify dysphonia in a patient with altered voice quality, pitch, loudness, or vocal effort that impairs communication or reduces quality of life. • Clinicians should assess the patient with dysphonia by history and physical examination for underlying causes of dysphonia and factors that modify management. • Clinicians should perform laryngoscopy, or refer to a clinician who can perform laryngoscopy, when dysphonia fails to resolve or improve within 4 weeks or irrespective of duration if a serious underlying cause is suspected. • Clinicians should perform diagnostic laryngoscopy, or refer to a clinician who can perform diagnostic laryngoscopy, before prescribing voice therapy and document/communicate the results to the speech-language pathologist. • Clinicians should advocate for surgery as a therapeutic option for patients with dysphonia with conditions amenable to surgical intervention, such as suspected malignancy, symptomatic benign vocal fold lesions that do not respond to conservative management, or glottic insufficiency. • Clinicians should offer, or refer to a clinician who can offer, botulinum toxin injections for the treatment of dysphonia caused by spasmodic dysphonia and other types of

Citation	Content, Methods, Recommendations
	<p>laryngeal dystonia.</p> <ul style="list-style-type: none"> • Clinicians should inform patients with dysphonia about control/preventive measures. • Clinicians should document resolution, improvement or worsened symptoms of dysphonia, or change in quality of life of patients with dysphonia after treatment or observation. • Clinicians should not routinely prescribe antibiotics to treat dysphonia. • Clinicians should not obtain computed tomography (CT) or magnetic resonance imaging (MRI) for patients with a primary voice complaint prior to visualization of the larynx. • Clinicians should not prescribe antireflux medications to treat isolated dysphonia, based on symptoms alone attributed to suspected gastroesophageal reflux disease (GERD) or laryngopharyngeal reflux (LPR), without visualization of the larynx. • Clinicians should not routinely prescribe corticosteroids for patients with dysphonia prior to visualization of the larynx. • Clinicians may perform diagnostic laryngoscopy at any time in a patient with dysphonia.
<p>Colquhoun (2017)</p> <p>A systematic review of interventions to increase the use of standardized outcome measures by rehabilitation professionals.</p>	<p>Key points:</p> <ul style="list-style-type: none"> • Systematic review evaluated 11 studies involving 1200 providers about attitudes towards and use of standardized outcome measures in rehabilitation professionals. • All study designs testing interventions were included as were all provider and patient types. • Nine of the studies showed improvements in outcome measure use rates but only three of these studies used an experimental or quasi-experimental design. • Eight of the studies used an educational approach in the intervention and three used audit and feedback. • Poor intervention description and quality of studies limited recommendations. • The authors concluded that increased attention to testing interventions focused on known barriers, matched to behavior change techniques, and with stronger designs is warranted.
<p>ASHA (2017)</p> <p>Medical Review Guidelines of the American Speech-Language-Hearing Association</p>	<p>Key points:</p> <ul style="list-style-type: none"> • Treatment for language disorders constitutes intervention services for children and adults with spoken and/or written language disorders. • These conditions include problems in areas of language form (phonology and alphabetic symbols, morphology and orthographic patterns, and syntax), content (semantics), and/or use (pragmatics or social communication) across spoken and written modalities. • Knowledge and use of language for listening, speaking, reading, writing, and thinking may include work on print symbols, syntax, and semantics. • Understanding and formulating complex spoken and written sentences may be a goal of treatment, as well as developing self-regulatory strategies for handling complex language and literacy demands.
<p>Brady (2016)</p> <p>Speech and language therapy for aphasia following stroke</p>	<p>Key points:</p> <ul style="list-style-type: none"> • Cochrane reviewed results of 57 RCTs involving 3002 participants undergoing speech therapy • Speech therapy resulted in clinically and statistically significant benefits to patients' functional communication (standardized mean difference (SMD) 0.28, 95% confidence

Citation	Content, Methods, Recommendations
	<p>interval (CI) 0.06 to 0.49, $P = 0.01$), reading, writing, and expressive language</p> <ul style="list-style-type: none"> • Nine randomized comparisons (447 participants) assessed speech therapy with social support and stimulation; meta-analyses found no evidence of a difference in functional communication, but more participants withdrew from social support interventions than speech therapy. • Functional communication was significantly better in people with aphasia that received therapy at a high intensity, high dose, or over a long duration compared to those that received therapy at a lower intensity, lower dose, or over a shorter period of time.
<p>Tosh (2016)</p> <p>Parent-implemented home therapy programmes for speech and language: a systematic review.</p>	<p>Key points:</p> <ul style="list-style-type: none"> • Systematic review lays out the evidence base for parent-delivered home programs to remediate speech and language difficulties in young children. • There is preliminary evidence that these endeavors can lead to growth in a child's speech and language skills and are more effective than no intervention • The authors concluded that home therapies are a potentially useful service delivery model, but caution should be exercised when considering their use to address broader service delivery challenges.
<p>Roulstone (2015)</p> <p>Evidence-based intervention for preschool children with primary speech and language impairments: Child Talk – an exploratory mixed-methods study.</p>	<p>Key points:</p> <ul style="list-style-type: none"> • Results of the “Child Talk” study aimed at informing the decision-making of therapists in treating children with primary speech and language impairments • The study emphasized the link between children's early speech and language skills and their broader well-being and outcomes in later life. • Quantitative methods included surveys and investigated the prevalence and patterns of intervention such as qualitative data collection (e.g., focus groups, interviews and reflection to investigate participants' perspectives and understandings of interventions). • Data analysis methods included descriptive and inferential statistics, thematic and content analysis and framework analysis. • The authors concluded that further research is needed to address gaps in the intervention framework and evaluate its effectiveness and cost-effectiveness in improving outcomes for preschool children with primary speech and language impairments.
<p>Codas. (2015)</p> <p>Tools for the assessment of childhood apraxia of speech.</p>	<p>Key points:</p> <ul style="list-style-type: none"> • A systematic review sought to identify the tools therapists use to evaluate childhood apraxia of speech (CAS). • Five tools were identified: Verbal Motor Production Assessment for Children, Dynamic Evaluation of Motor Speech Skill, The Orofacial Praxis Test, Kaufman Speech Praxis Test for Children, and Madison Speech Assessment Protocol. • The authors noted there are few instruments available for CAS assessment and most of them are intended to assess praxis and/or orofacial movements, sequences of orofacial movements, articulation of syllables and phonemes, spontaneous speech, and prosody. • The authors concluded that there are some tests for assessment and diagnosis of CAS; however, few studies on this topic have been conducted at the national level, as well as protocols to assess and assist in an accurate diagnosis.
<p>Akeroyd (2015)</p> <p>International Collegium of Rehabilitative Audiology (ICRA) Working Group on Multilingual Speech Tests</p>	<p>Key points:</p> <ul style="list-style-type: none"> • ICRA guidelines for the development of speech-perception tests that can be applied and interpreted in the same way across languages. • The guidelines cover the digit triplet and the matrix sentence tests that are most commonly used to test speech recognition in noise. • The recommendations are based on reviews of existing evaluations of the digit triplet

Citation	Content, Methods, Recommendations
	<p>and matrix tests as well as on the research experience of members of the ICRA Working Group.</p> <ul style="list-style-type: none"> The authors opined that by following these guidelines for the development of any new test of this kind, clinicians and researchers working in any language will be able to perform tests whose results can be compared and combined in cross-language studies.
<p>Costantino (2014)</p> <p>A scoping review of interventions to supplement spoken communication for children with limited speech or language skills.</p>	<p>Key points:</p> <ul style="list-style-type: none"> Systematic review of augmentative and alternative communication (AAC) used for treating 666 children with severe disorders of speech-language production and/or comprehension. Papers were of average quality and all but one had been published during the previous 10 years by one of 8 research groups, 5 of which from the United States. Seven studies directly addressed AAC use by children with different disabilities. Both interventions and outcome measures varied widely between studies. Overall findings demonstrate the effectiveness of the AAC interventions considered, but the focus on RCTs alone appears too restrictive. The authors concluded that better data points must be generated, and different methods are needed besides RCTs.
<p>Lustyk (2014)</p> <p>Evaluation of disfluent speech by means of automatic acoustic measurements.</p>	<p>Key points:</p> <ul style="list-style-type: none"> To determine whether the level of the speech fluency disorder can be estimated by means of automatic acoustic measurements. These measures analyze, for example, the amount of silence in a recording or the number of abrupt spectral changes in a speech signal. All the measures were designed to take into account symptoms of stuttering. In the experiment, 118 audio recordings of read speech by Czech native speakers were employed. The results indicate that the human-made rating of the speech fluency disorder in read speech can be predicted on the basis of automatic measurements. The number of abrupt spectral changes in the speech segments turns out to be the most appropriate measure to describe the overall speech performance. The results also imply that there are measures with good results describing partial symptoms (especially fixed postures without audible airflow).
<p>Blomgren (2013)</p> <p>Behavioral treatments for children and adults who stutter: a review</p>	<p>Key points:</p> <ul style="list-style-type: none"> Multifactorial and operant treatments are designed for young children. Speech restructuring and anxiolytic approaches are used with adults. Speech restructuring approaches focus on the mechanics of speech production, and anxiolytic treatments tend to focus on the symptoms and social and vocational challenges of stuttering. Response contingent therapy (for children) and speech restructuring therapy (for adults) have the most robust empirical evidence base. Comprehensive approaches for adults address both improved speech fluency and speech management.

References

Professional society guidelines/other:

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<http://www.asha.org/PRPSpecificTopic.aspx?folderid=8589935321§ion=Overview>. Accessed March 26, 2018.

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Roulstone SE, Marshall JE, Powell GG, et al. *Evidence-based intervention for preschool children with primary speech and language impairments: Child Talk – an exploratory mixed-methods study*. Southampton (UK): NIHR Journals Library; 2015.

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50.2 Electronic speech aids. CMS Medicare Coverage Database Web site.

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50.1 Speech generating devices. CMS Medicare Coverage Database Web site.

https://www.cms.gov/medicare-coverage-database/details/ncd-details.aspx?NCDId=274&ncdver=2&CoverageSelection=Both&ArticleType=All&PolicyType=Final&s=All&Keyword=Speech&KeywordLookUp=Title&KeywordSearchType=And&list_type=ncd&bc=gAAAACAAAAAAA%3d%3d& . Accessed March 26, 2018.

170.3 Speech language pathology services for the treatment of dysphagia.

https://www.cms.gov/medicare-coverage-database/details/ncd-details.aspx?NCDId=192&ncdver=2&CoverageSelection=Both&ArticleType=All&PolicyType=Final&s=All&Keyword=Speech&KeywordLookUp=Title&KeywordSearchType=And&list_type=ncd&bc=gAAAACAAAAAAA%3d%3d& . Accessed March 26, 2018.

Local Coverage Determinations (LCDs):

L34046 SPEECH-Language Pathology

https://www.cms.gov/medicare-coverage-database/details/lcd-details.aspx?LCDId=34046&ver=17&CoverageSelection=Both&ArticleType=All&PolicyType=Final&s=All&Keyword=Speech&KeywordLookUp=Title&KeywordSearchType=And&list_type=ncd&bc=gAAAACABAAA& Accessed March 26, 2018

L34891 Speech-Language Pathology (SLP) Services: Dysphagia; Includes VitalStim® Therapy.

<https://www.cms.gov/medicare-coverage-database/details/lcd-details.aspx?LCDId=34891&ver=10&CoverageSelection=Both&ArticleType=All&PolicyType=Final&s=All&>

[Keyword=Speech&KeywordLookUp=Title&KeywordSearchType=And&list_type=ncd&bc=gAAACAAAAAAA%3d%3d&](https://www.cms.gov/medicare-coverage-database/details/lcd-details.aspx?LCDId=33580&ver=26&CoverageSelection=Both&ArticleType=All&PolicyType=Final&s=All&Keyword=Speech&KeywordLookUp=Title&KeywordSearchType=And&list_type=ncd&bc=gAAACAAAAAAA%3d%3d&) Accessed March 26, 2018.

L33580 Speech language pathology. https://www.cms.gov/medicare-coverage-database/details/lcd-details.aspx?LCDId=33580&ver=26&CoverageSelection=Both&ArticleType=All&PolicyType=Final&s=All&Keyword=Speech&KeywordLookUp=Title&KeywordSearchType=And&list_type=ncd&bc=gAAACABAAA& Accessed March 26, 2018.

L33739 Speech-Language Pathology (SLP) Services: Communication Disorders. Effective 10/01/2016 CMS web site. https://www.cms.gov/medicare-coverage-database/details/lcd-details.aspx?LCDId=33739&ver=10&CoverageSelection=Both&ArticleType=All&PolicyType=Final&s=All&Keyword=Speech&KeywordLookUp=Title&KeywordSearchType=And&list_type=ncd&bc=gAAACABAAA& Accessed March 26, 2018.

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Commonly submitted codes

Below are the most commonly submitted codes for the service(s)/item(s) subject to this policy. This is not an exhaustive list of codes. Providers are expected to consult the appropriate coding manuals and bill accordingly.

CPT Code	Description	Comments
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	

ICD-10 Code	Description	Comments
R47.9	Speech disorder	

HCPCS Level II Code	Description	Comments
G0153	Services performed by a qualified speech-language pathologist in the home health or hospice setting, each 15 minutes	

Appendix A

Speech Therapy Standardized Diagnostic Testing Scores

Diagnostic Test	Abbreviation	Normal Range for Standard Score	Normal Range for Scaled Score	Speech Subset
Preschool Language Scale 4 th Ed	PLS-4	85-115		Language-Preschool
Preschool Language Scale 5 th Ed.	PLS-5	85-115		Language-Preschool
Comprehensive Assessment of Spoken Language	CASL	85-115		Language – Comprehensive
Goldman Fristoe Test of Articulation – 2 nd Ed.	GFTA-2	85-115		Articulation
Test of Auditory Processing Skills	TAPS-3	85-115	7-13	Auditory
Clinical Assessment of Articulation and Phonology	CAAP	85-115		Articulation
Receptive-Expressive Emergent Language Test – 3 rd Ed.	REEL-3	85-115		Language-Preschool
Gray Oral Reading Test – 4 th Ed	GORT-4	90-110	8-12	Reading Fluency
Test of Language Development (4 th ed.)	TOLD-4	85-115	7-13	Language – Comprehensive
Expressive One-Word Picture Vocab Test	EOWPVT	90-110		Language -Vocabulary
Receptive One-Word Picture Vocab Test	ROWPVT	90-110		Language -Vocabulary
Kaufman Speech Praxis Test	KSPT	85-115		Apraxia
Stuttering Severity Instrument	SSI		Children <6 Adults <17	Fluency
LinguiSystemes Articulation Test	LAT	85-115		Articulation
Oral-Written Language Scale 2 nd Ed	OWLS-2	85-115		Language – Comprehensive
Khan-Lewis Phonological Analysis – 2 nd Ed	KLPA-2	85-115		Phonology
Peabody Picture Vocab Test – 4 th ed	PPVT-IV	85-115		Language -Vocabulary
Children's Communication	CCC-2		7-13	
Arizona Articulation	Arizona-3	85-115		
Woodstock-Johnson	WJ-VI-COG	85-115		
Auditory Processing Abilities	APAT	>90		
Test of Info Processing Skills	TIPS	85-115		
Fluharty Preschool Speech and Language Screen		7-13		Ages 3.0-6.11
Hodgson Assessment of Phonological Patterns	HAPP	86-114		
Montgomery Assessment of Vocab Acquisition	MAVA	85-115		
CELF	CELF	85-115	7-13	
CPT	CPT	85-115		
PEDI – CAT	PEDI-CAT	30-70		
Diagnostic Eval of Articulation and P	DEAP	85-115		

Mild 76-84 Moderate 66-75 Severe 50-65