Speech Therapy

Clinical Coverage Criteria

Overview

Speech Therapy is defined as therapy services, including diagnostic evaluation and therapeutic intervention, that are designed to improve, develop, correct, rehabilitate, or prevent the worsening of speech/language communication and swallowing disorders that have been lost, impaired, or reduced as a result of acute or chronic medical conditions, congenital anomalies, or injuries. Speech and language disorders are those that affect articulation of speech, sounds, fluency, voice, swallowing (regardless of the presence of a communication disability), and those that impair comprehension, or spoken, written, or other symbol systems used for communication.

Policy

Fallon Health covers the initial evaluation and speech therapy without prior authorization. Please consult the member's Evidence of Coverage for the specific amount of visits covered before prior authorization is required (typically 30 for most plans). After the initial period of coverage prior authorization is required. After the initial evaluation there should be detailed documentation of a treatment plan and progress. Fallon Health may request documentation of the progress during the treatment for review of additional visits.

For approval of subsequent treatment the below criteria must be met:

- The Member must have a documented speech disorder showing their performance is less than previous levels or below age appropriate speech milestones.
- The Member's clinical record supports measurable improvement can be achieved over a specific time-frame and is reasonable based on the Member's diagnosis.
- The complexity of the therapy can only be safely and effectively done by a licensed speech and language pathologist or audiologist.

Exclusions

- Speech Therapy that does not meet the above criteria
- Services that are primarily educational or vocational in nature
- Maintenance therapy once further improvement is not expected
- Treatment related to accent or dialect reduction
- Treatment for self-correcting disorders (natural dysfluency or articulation errors that are self- correcting)

Codes

Code type	Code	Description
CPT	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 (eg, stuttering, cluttering)
	92522	Evaluation of speech sound production (eg, articulation, phonological process, apraxia, dysarthria)
	92523	Evaluation of speech sound production (eg, articulation, phonological process, apraxia, dysarthria) with evaluation of language comprehension and expression (eg, receptive and expressive language)
	92524	Behavioral and qualitative analysis of voice and resonance

References

1. Massachusetts General Law (M.G.L) Chapter 176G Section 4N Coverage for speech, hearing, and language disorders.
2. Massachusetts Legislature Chapter 234 Acts of 2012: An act relative to the treatment of cleft palate and cleft lip.
3. Masshealth: Guidelines for Medical Necessity Determination for Speech and Language Therapy. Effective: March 30, 2017

Policy History

Origination date: 11/28/2006

Approval(s): Technology Assessment Subcommittee: 11/28/2006
Technology Assessment Committee: 04/10/2007, 12/03/2014 (updated criteria and references) 12/15/2015 (added code 92524), 12/07/2016 (annual review, no updates), 12/6/2017 (updated references), 02/01/2018 (clarified authorization language regarding initial visits, not reviewed via committee), 12/05/2018 (annual review, no updates) 12/04/2019 (annual review, no updates)

Not all services mentioned in this policy are covered for all products or employer groups. Coverage is based upon the terms of a member's particular benefit plan which may contain its own specific provisions for coverage and exclusions regardless of medical necessity. Please consult the product's Evidence of Coverage for exclusions or other benefit limitations applicable to this service or supply. If there is any discrepancy between this policy and a member's benefit plan, the provisions of the benefit plan will govern. However, applicable state mandates take precedence with respect to fully-insured plans and self-funded non-ERISA (e.g., government, school boards, church) plans. Unless otherwise specifically excluded, federal mandates will apply to all plans. For Medicare and Medicaid members, this policy will apply unless Medicare and Medicaid policies extend coverage beyond this policy.