

## SPEECH THERAPY

**Policy Number: 200611-0002**

**Effective Date: 11/28/2006**

**Revision Date: 11/28/2006**

### Overview

In accordance with Chapter 345 of the Acts of 2000, FCHP covers the medically necessary diagnosis and treatment of speech, hearing and language disorders provided by in-plan, licensed speech-language pathologists or audiologists so long as the services are rendered within the lawful scope of practice of such licensed providers. Such coverage must be provided regardless of whether the services are provided in a hospital, clinic or private office. This mandated coverage does not extend to the diagnosis or treatment of speech, language and hearing disorders in a school-based setting. The benefits provided under this law are subject to the same terms and conditions (such as copayments, deductibles and coinsurance) established for any other medical condition under the member's plan.

### Covered Services

Authorization is based on medical necessity criteria below.

Requests for coverage require clinical documentation to include written results from formal testing, evaluations and/or office notes showing measurable progress.

For school-aged children, the treating SLP should communicate and coordinate with school or other therapists in order to optimize the member's progress.

### PEDIATRIC

Receptive/Expressive Speech/Language Delays

Delays in receptive/expressive speech/language MEET MEDICAL NECESSITY CRITERIA if:

Chronological Age	Delay
0-6 months	more than or equal to a 2 month delay
7-12 months	more than or equal to a 3 month delay
13-18 months	more than or equal to a 4 month delay
19-24 months	more than or equal to a 5 month delay
25-30 months	more than or equal to a 6 month delay
31-36 months	more than or equal to a 7 month delay

Age 3.0- 5

MEETS MEDICAL NECESSITY CRITERIA if more than a 9 month delay in receptive/expressive speech/language, articulation, or pragmatic language delay.

Age 5+ (School aged)

MEETS MEDICAL NECESSITY CRITERIA if a moderate receptive/expressive speech language delay, defined as greater than a year or more behind.

### **Articulation (any age)**

MEETS MEDICAL NECESSITY CRITERIA if any 2 of the following are identified:

1. Two or more phonological processes that are not developmentally age appropriate
2. Characteristics consistent with dyspraxia, dysarthria or motor speech disorder
3. Poor intelligibility at the sentence level

### **Cochlear Implant**

*Up to age 3 years.* Speech/language therapy is authorized if:

1. Clinical documentation supports gains.
2. Attendance is good
3. Family and patient actively participate in therapy and home carryover.

*School age 5 and older.* Coverage of speech therapy services will be considered on a case by case basis.

## **ADULT OR PEDIATRIC**

### **Voice Disorders**

MEETS MEDICAL NECESSITY CRITERIA when there is an underlying structural or physiological basis for the disorder and when there is an expectation that the patient's condition will (continue to) improve significantly in a reasonable and generally predictable period of time for the following conditions:

1. Structural abnormality, e.g., vocal nodule, polyp, GERD (gastroesophageal reflux), edema, vocal tremor, vocal cord bowing, vocal cord sulcus, granuloma, trauma
2. Restricted use of voice secondary to dysfunction, e.g., vocal fatigue, hoarseness, spasmodic dysphonia, laryngitis
3. Hypernasal voice when secondary to: cleft palate (repaired or unrepaired), velopharyngeal insufficiency/inefficiency, poor oral-motor control of soft palate due to weakness or incoordination.
4. Partial or total laryngectomy (adults)
5. Partial or total glossectomy (adults)
6. Velopharyngeal insufficiency

**Note:** Evaluation by an Otolaryngologist is required prior to authorization of speech/language treatment for any voice disorder in both adult and pediatric patients.

### **Oral-myofunctional therapy for treatment of myofunctional disorder/tongue thrust swallow pattern**

Coverage of speech therapy services for patients with myofunctional disorder/tongue thrust swallow pattern will be considered on a case by case basis. Taking into consideration patient/family motivation and patient need, among other factors, some of these patients may benefit from short term speech therapy services. Four visits typically suffice, and improvement should occur in that timeframe.

Medical conditions resulting in cognitive or communicative deficits impacting speech/language

Coverage of speech therapy services is not based solely on diagnosis. Although speech therapy services may be authorized for medical conditions resulting in cognitive or communicative deficits impacting speech and language, such as head injury, stroke, brain damage, neurological disorders (e.g., ALS, MS, Myasthenia Gravis, Parkinsonism), or laryngeal carcinoma requiring laryngectomy, coverage of speech therapy services will only be authorized when there is an expectation that the patient's condition will (continue to) improve significantly in a reasonable and generally predictable period of time.

Requests for speech therapy services must include the following documentation:

1. Documentation of long and short term goals, described in functional terms, including frequency, duration, and intensity.
2. Discussion of progress and discharge planning, including discussion of function.
3. Documentation of functional outcome measure

### Exclusions

1. Services provided by an out-of-plan provider
2. Services provided in a school-based setting

### Products to Which This Policy Applies

- FCHP Direct & Select Care
- Fallon Preferred Care (PPO)
- FCHP MassHealth
- Non-Group: FCHP Independent Care, Direct Enrollment, & Bill-at-Home
- Fallon Senior Plan™
- FHLAC Major Medical

### Committee Review Dates

Technology Assessment Subcommittee: 11/28/06

Technology Assessment Committee: 04/10/2007

Approved by:

*Signature on file*

Dennis A. Batey, MD – Chief Medical Officer

11/28/06

Date

#### **IMPORTANT NOTE**

**Not all services are covered for all products or employer groups.** This medical policy expresses FCHP's determination of whether certain services or supplies are medically necessary, experimental or investigational or cosmetic. FCHP has reached these conclusions based upon the regulatory status of the technology and a review of clinical studies published in peer-reviewed medical literature. Even though this policy may indicate that a particular service or supply is considered covered, this conclusion is not based upon the terms of your particular benefit plan. Each benefit plan contains its own specific provisions for coverage and exclusions. Not all benefits that are determined to be medically necessary will be covered benefits under the terms of your benefit plan. Members and their providers need to consult the Evidence of Coverage to determine if there are any exclusions or other benefit limitations applicable to this service or supply. If there is a discrepancy between this policy and the plan of benefits, the provisions of the benefits plan will govern. However, applicable state mandates will 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. With respect to Medicare and Medicaid members, this policy will apply unless Medicare and Medicaid policies extend coverage beyond this medical policy. Medicare and Medicaid policies will only apply to benefits paid for under Medicare or Medicaid rules, and not to any other health benefit plan benefits. CMS's Coverage Issues Manual can be found on the following website: <http://cms.hhs.gov/manuals/pub06pdf/pub06pdf.asp>