Policy Number	**THE803.014**
Policy Effective Date	**01/01/2026**

Speech-Language Therapy (SLT)

Table of Contents
Coverage
Policy Guidelines
Description
Rationale
Coding
References
Policy History

Related Policies (if applicable)
SUR717.001: Gender Assignment Surgery and Gender Reassignment Surgery with Related Services

Disclaimer

Carefully check state regulations and/or the member contract.
Each benefit plan, summary plan description or contract defines which services are covered, which services are excluded, and which services are subject to dollar caps or other limitations, conditions or exclusions. Members and their providers have the responsibility for consulting the member's benefit plan, summary plan description or contract to determine if there are any exclusions or other benefit limitations applicable to this service or supply. **If there is a discrepancy between a Medical Policy and a member's benefit plan, summary plan description or contract, the benefit plan, summary plan description or contract will govern.**

Legislative Mandates

EXCEPTION: For Illinois only: Illinois Public Act 103-0458 [Insurance Code 215 ILCS 5/356z.61] (HB3809 Impaired Children) states all group or individual fully insured PPO, HMO, POS plans amended, delivered, issued, or renewed on or after January 1, 2025 shall provide coverage for therapy, diagnostic testing, and equipment necessary to increase quality of life for children who have been clinically or genetically diagnosed with any disease, syndrome, or disorder that includes low tone neuromuscular impairment, neurological impairment, or cognitive impairment.

EXCEPTION: For HCSC members residing in the state of Arkansas, § 23-79-130 relating to speech or hearing impairment, requires coverage for the necessary care and treatment of loss or impairment of speech or hearing. The phrase "loss or impairment of speech or hearing" shall include those communicative disorders generally treated by a speech pathologist or audiologist licensed by the Board of Examiners in Speech-Language Pathology and Audiology and which fall within the scope of his or her area of certification. Coverage shall not apply to hearing instruments or devices. This applies to the following: Fully Insured Group, Student, Small Group, Mid-Market, Large Group, HMO, EPO, PPO, POS. Unless indicated by the group, this mandate or coverage will not apply to ASO groups.

Coverage

For Montana, State Legislation Mandates may apply. Carefully check for Legislative Mandates that may apply for each plan.

This medical policy does NOT address Gender Reassignment Services (Transgender Services). This medical policy IS NOT TO BE USED for Gender Reassignment Services. Refer to SUR717.001, Gender Assignment Surgery and Gender Reassignment Surgery with Related Services.

Speech-Language Therapy

Rehabilitative Therapy

Rehabilitative speech-language therapy (SLT) services **may be considered eligible for benefit coverage** when:

- Prescribed by a licensed physician or other qualified provider (see **NOTE 1**) to restore or improve the function in an individual who has impaired physical function of phonation or swallowing, or communication disability related to expressive or receptive aphasia/ paraphasia and/or speech language impairment. (see Policy Guidelines for information regarding childhood ages with corresponding speech-language milestones and speech-language delay for children); **AND**
- Prescribed to achieve condition-specific corrective benefit for an individual who has a reasonable expectation of achieving measurable improvement (see Policy Guidelines for information regarding childhood ages with corresponding speech-language milestones and speech-language delay for children); **AND**
- Prescribed to provide specific, effective, and reasonable treatment for the individual's diagnosis and physical condition (see Policy Guidelines for information regarding childhood ages with corresponding speech-language milestones and speech-language delay for children); **AND**
- Provided under a documented plan of care that is updated as the patient's condition changes and is recertified by a physician or other qualified provider (see **NOTE 1**) every 90 days or less, based on an individual's needs, and includes:
    1. Specific long-term and short-term goals; **AND**
    2. Measurable objectives; **AND**
    3. Reasonable estimate of when goals will be reached; **AND**
    4. Specific treatment techniques and/or exercises to be used; **AND**
    5. Frequency and duration of treatment; **AND**
    6. Clearly document a reduction in the functional deficit over time as compared to normal or average function for members of the same or similar demographic; **AND**
- Services require the judgment, knowledge, and skills of a qualified provider (see **NOTE 1**) of SLT services due to the complexity and sophistication of the therapy and the physical condition of the individual (see Policy Guidelines for information regarding childhood ages with corresponding speech-language milestones and speech-language delay for children); **AND**

- Services cannot be reasonably taught to and implemented by nonprofessional or lay caregivers; **AND**
- Services are delivered by a qualified, licensed provider (see **NOTE 1**) of SLT services; **AND**
- Services do not duplicate services provided by any other therapy (e.g., occupational therapy).

Group speech-language therapy (SLT) services **may be considered eligible for benefit coverage** when:

- **ALL** of the above criteria for rehabilitative speech-language therapy (SLT) services are met; **AND**
- The physician or therapist involved in group therapy services is in constant attendance; **AND**
- There are no more than four group members.

Maintenance Therapy

Maintenance speech-language therapy (SLT) services **may be considered eligible for benefit coverage** when:

- Prescribed by a licensed physician or other qualified, licensed provider (see **NOTE 1**); **AND**
- Prescribed to maintain the individual's current condition or to prevent or slow further deterioration in function; **AND**
- Provided under a documented plan of care that is updated as the patient's condition changes and is recertified by a physician or other qualified, licensed provider (see **NOTE 1**) every 90 days or less, based on an individual's needs; **AND**
- Services require the judgment, knowledge, and skills of a qualified, licensed provider (see **NOTE 1**) of SLT services for either of the following indications:
    - To establish or design a maintenance program, including instruction of the individual or caregiver regarding the maintenance program; **OR**
    - To carry out a maintenance program when the individual's special medical complications require skilled care for the safe and effective implementation of a maintenance program.

NOTE 1:

- A qualified provider is one who is licensed where required and performs within the scope of licensure and laws where he/she practices, e.g., speech pathologist, speech-language pathologist, etc. In Montana, scope of licensure for speech therapists allows direct access, i.e., evaluation and treatment without a physician's referral. Therefore, the speech therapist might be the qualified provider who will evaluate the patient, administer the treatment, and prepare the written plan of care.
- In conjunction with delivering SLT services, the speech therapist is expected to provide training to the patient, family, and/or caregivers to facilitate their participation in and assumption of the SLT, continued improvement and maintenance program. Periodic assessment of improvement and modification of patient- or caregiver-implemented interventions may be appropriate.

SLT services **are considered not medically necessary** for **ANY** of the following:

- Services are considered not reasonable, effective treatment for the individuals condition; AND
- Services do not require the skill(s) of a therapist or qualified, licensed provider; AND
- Services can be safely and effectively carried out by non-skilled personnel and/or caregivers.

Policy Guidelines

Refer to the Description for more information on the following:

- Additional information regarding childhood ages with corresponding speech-language milestones from the National Institutes of Health and the Centers for Disease Control and Prevention.
- Information regarding speech and language delay for children.
- For children, standardized testing scores may aid in the determination of a speech-language deficit. For example, a standard score of 70 or below, out of a 100-scale assessment, appears to indicate a severe impairment. (10)

CPT codes 92507, 92508 are not considered time-based codes; they are intended to be billed one time per session. The initial evaluation is usually completed in 1-3 sessions.

Each benefit plan, summary plan description or individual contract defines which speech therapy services are covered, which services are excluded, and which services are subject to dollar caps or other limitations, conditions, or exclusions. If there is a discrepancy between this medical policy and a member's benefit plan, summary plan description or contract, the benefit plan, summary plan description or contract will govern.

Description

Speech-language therapy (SLT) is the treatment of communication impairment and swallowing disorders. SLT services are designed to improve or restore speech and language functioning (communication) or swallowing function following disease, injury or loss of a body part. (1, 2)

Background

Communication disorders may affect individuals at many points across their lifetime. Approximately 1 in 14 (7.2%) U.S. children ages 3-17 has had a disorder related to voice, speech, or language in the past 12 months. An estimated 17.9 million adults in the United States, or 7.6%, report having had a problem with their voice in the past 12 months. Of those adults affected, 9.4 million (4.0%) report having a problem using their voice that lasted 1 week or longer during the last 12 months. Research suggests that the first 6 months of life are the most crucial to a child's development of language skills. For a person to become fully competent in any language, exposure must begin as early as possible, preferably before school age. (6)

Speech is the verbal production of language, whereas language is the conceptual processing of communication. Language includes receptive language (understanding) and expressive language (the ability to convey information, feelings, thoughts, and ideas). Expressive language includes conveying ideas in spoken, written, or visual forms. (5)

Speech language pathology (SLP) provides clinical services and provides education, speech therapy services and research in the areas of communication and swallowing across the life span. SLPs asses, diagnose and treat disorders of speech 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), and feeding and swallowing (e.g., oral, pharyngeal, and esophageal stages). (4)

A communication disorder is an impairment in the ability to receive, send, process, and comprehend concepts of verbal, nonverbal, and graphic symbols. A communication disorder may be evident in the processes of hearing, language, and/or speech and may range in severity from mild to profound. It may be congenital or acquired. Individuals may demonstrate one or a combination of communication disorders. A communication disorder may result in a primary disability, or it may be secondary to other disabilities. SLT incorporates the processes of multiple disorders and the treatment of speech-language, swallowing, and cognitive-communication difficulties. Many disorders have a neurological basis such as head injury, PD, stroke, amyotrophic lateral sclerosis (ALS) and cerebral palsy. (4)

SLT covers a wide range of services which are tailored to each individual. SLT helps individuals gain the ability to communicate through speech and language. Speech therapists might use repetitive exercises and training as well as assistive devices for communication to assist with augmentive and alternative communication, or AAC, these devices produce speech or sound for those who are nonverbal. SLT therapy may be provided in a variety of inpatient and outpatient settings. Generally, this therapy is provided by SLPs who work with clients or patients who have the physical or cognitive impairment/deficit/disorder that results in difficult communication. This may include those adults and children who have previously learned how to read and write, then are diagnosed with a neurological impairment. SLPs may also provide services for patients with dysphagia (difficulty swallowing). (4, 5)

According to the American Speech-Language Hearing Association (ASHA) 2015 Speech-Language Pathology Medical Review Guidelines, the potential etiologies of communication and swallowing disorders may include the following (4):

- Neonatal problems (e.g., prematurity, low birth weight, substance exposure);
- Developmental disabilities (e.g., specific language impairment, dyslexia, and attention deficit/hyperactive disorder);
- Auditory problems (e.g., hearing loss or deafness, central auditory processing disorders);
- Oral anomalies (e.g., cleft lip/palate, dental malocclusion, macroglossia, oral-motor dysfunction);

- Respiratory compromise (e.g., bronchopulmonary dysplasia, chronic obstructive pulmonary disease);
- Pharyngeal anomalies (e.g., upper airway obstruction, velopharyngeal insufficiency/incompetence);
- Laryngeal anomalies (e.g., vocal fold pathology, tracheal stenosis, tracheostomy);
- Neurological disease/dysfunction (e.g., traumatic brain injury, cerebral palsy, cerebral vascular accident, dementia, PD, amyotrophic lateral sclerosis);
- Psychiatric disorder (e.g., psychosis, schizophrenia);
- Genetic disorders (e.g., Down syndrome, fragile X syndrome, Rett syndrome, velocardiofacial syndrome).

There are a number of guidelines issued by multiple societies, such as American Speech-Language-Hearing Association (ASHA), geared toward the assessment of speech-language development milestones for children under the age of 5 years. Table 1 is adapted from developmental checklists from the National Institutes of Health (NIH) (2022) and the Centers for Disease Control and Prevention (CDC) (2025).

Table 1. Language Development Milestones from Birth to 5 Years of Age (7, 8)

Child's Age	**Speech-Language Milestones**
By the end of 12 months	• Imitates speech sounds, • Calls a parent "mama" or "dada" or another special name. • Understands "no" and responds to requests ("come here"), • Recognizes words for common items, such as "shoe", • Turns and looks in the direction of sounds, • Waves "bye-bye."
By the end of 18 months	• Follows one-step directions without any gestures, like giving you the toy when you say, "Give it to me." • Tries to say three or more words besides "mama" or "dada".
2 years	• Use simple phrases, such as "more milk" (puts 2 words together), • Asks one- to two-word questions, such as "Go bye-bye?", • Follow simple commands and understand simple questions, • Acquires new words on a regular basis. • Points to things in a book when you ask, like "Where is the bear?", • Points to at least two body parts when you ask him to show you, • Uses more gestures than just waving and pointing, like blowing a kiss or nodding yes.
3 years	• Has a word for almost everything, • Uses two- or three-word phrases to talk about and ask for things, • Uses k, g, f, t, d, and n sounds, • Speaks in a way that is understood by family members and friends, • Names objects to ask for them or to direct attention to them.

	• Talks with you in conversation using at least two back-and-forth exchanges, • Asks "who," "what," "where," or "why" questions, like "Where is mommy/daddy?", • Says what action is happening in a picture or book when asked, like "running," "eating," or "playing", • Says first name, when asked. • Talks well enough for others to understand, most of the time.
4 Years	• Hears you when you call from another room, • Hears the television or radio at the same sound level as other, family members, • Answers simple "Who?" "What?" "Where?" and "Why?" questions, • Talks about activities at daycare, preschool, or friends' homes, • Uses sentences with four or more words, • Speaks easily without having to repeat syllables or words, • Says some words from a song, story, or nursery rhyme. • Answers simple questions like "What is a coat for?" or "What is a crayon for?"
5 Years	• Tells a story either heard or made up with at least two events. For example, a cat was stuck in a tree and a firefighter saved it. • Hears and understands most of what is said at home and in school, • Uses sentences that give many details, • Tells stories that stay on topic, • Communicates easily with other children and adults, • Says most sounds correctly except for a few (l, s, r, v, z, ch, sh, and th), • Names some letters and numbers, • Uses adult grammar, • Keeps a conversation going with more than three back-and-forth exchanges, • Uses or recognizes simple rhymes (bat-cat, ball-tall).

To determine the etiology of a possible communication deficit for adults and children, the ASHA recommends that the comprehensive speech and language pathology assessment includes these components: (9)

- Case history, including medical status, education, socioeconomic, cultural, and linguistic backgrounds and information from teachers and other related service providers.
- Patient/client/student and family interview.
- Review of auditory, visual, motor, and cognitive status.
- Standardized and/or non-standardized measures of specific aspects of speech, spoken and non-spoken language, cognitive-communication, and swallowing function, including observations and analysis of work samples.
- Identification of potential for effective intervention strategies and compensations.

- Selection of standardized measures for speech, language, cognitive-communication, and/or swallowing assessment with consideration for documented ecological validity and cultural sensitivity.
- Follow-up services to monitor communication and swallowing status and ensure appropriate intervention and support for individuals with identified speech, language, cognitive-communication, and/or swallowing disorders.

For standardized testing, different tests use different terms to describe levels or degrees of language or speech problems. As a rule of thumb, on a scale where 100 is the average. The following generally indicates interpretation of test scoring: (10)

- A standard score of 70 or below suggests a severe impairment.
- A standard score of 71-77 suggests a moderate impairment.
- A standard score of 78-85 suggests a mild impairment.
- A standard score of 86-114 suggests no impairment: treatment is not needed and should not be provided.

There are no grading standards or consistent test scoring for non-standardized testing.

For children, the assessment may have more elements to be reviewed in ascertaining the type of speech and language problem the child is experiencing, with consideration made for the age and linguistic development of the child. According to the ASHA, the additional factors should include the following: (11)

- Relevant case history, including birth and medical history:
  - Family history of speech, language, reading, or academic difficulties,
  - Family's concerns about the child's language (and speech),
  - Languages and/or dialects used in the home, including:
    - Age of introduction of a second language, as appropriate,
    - Circumstances in which each language is used,
  - Teachers' concerns regarding the impact of child's language difficulties in the classroom;
- Hearing screening, if not available from prior screening;
- Oral mechanism examination;
- Spoken language testing, including:
  - Phonology, including phonological awareness,
  - Semantics,
  - Morphology,
  - Syntax,
  - Pragmatics, including discourse-level language skills (conversation, narrative, expository).

Rupert et al. (2023) published information on speech and language delay in children. (5) The American Academy of Pediatrics guidelines recommend surveillance at every well-child visit, with particular attention before elementary school entry at four to five years of age. The differential diagnosis for speech and language delays is broad. Delays can be classified as

secondary to other conditions or as primary conditions without apparent underlying causes. Common primary and secondary causes of speech and language delays are outlined in Table 2.

Table 2. Speech and Language Problems in Children (5)

Disorder	Clinical Findings and Comments	Treatment and Prognosis
Primary Disorder*		
Childhood-onset fluency disorder (stuttering and cluttering)	Stuttering includes speech and fluency disturbances, such as sound repetitions and prolongations, broken words, speech pauses, circumlocutions, or excess physical tension with words. First-degree relatives of people who stutter have a three times higher risk of stuttering than the general population; multiple genes have been isolated and associated with stuttering. Cluttering is abnormally fast or irregular speech delivery rate, leading to unexpected sounds, phrases, patterns, or dysfluencies in speech.	Focuses on speaking more slowly, breathing regulation, feedback training, and muscle tension reduction.
Language disorder	Reduced vocabulary, limited sentence structure, and impaired ability to carry conversation in spoken, written, or sign language or other comprehension or production deficits. Not caused by hearing or other sensory loss, motor dysfunction, or another medical or neurologic condition. Highly heritable.	Focuses on knowledge and use of language for all modalities of communication. Likely to continue into adulthood; delays presenting after four years of age are predictive of long-term outcomes, whereas delays before four years of age are not.
Social (pragmatic) communication disorder	Social verbal and gestural difficulties, including appropriate use of eye contact, facial expressions, body language, and emotional expression.	Includes mediating social exchanges through instruction, modeling, role-play, and cognitive behavior therapies.

Secondary Causes		
Autism spectrum disorder	Deficits in social-emotional reciprocity, nonverbal communicative behaviors, and understanding relationships; restricted, repetitive patterns of behavior, interests, or activities.	Focuses on specific speech-language deficits, including motor function, semantics, social communication, and receptive and expressive language skills; augmentative and alternative communication methods may also be used.[†] Not a degenerative disorder; positive prognostic factors include absence of intellectual disability, language impairment, and additional mental health problems.
Cerebral palsy	Movement disorder from perinatal brain damage, which causes subsequent intellectual and sensory deficits; speech and gestural difficulties are common.	Focuses on language skills, articulation, and proper breathing for speech and swallowing; augmentative and alternative communication methods may also be used.[†]
Craniofacial disorders	Cleft lip/palate, dental malocclusion, macroglossia, or 22q11.2 deletion syndrome.	Requires multidisciplinary approach, including craniofacial, dental, audiologic, and speech-language services.
Global developmental delay	Failure to meet developmental milestones in several areas of intellectual function in children younger than five years.	Precursor to intellectual disability.
Hearing loss after spoken language established	Often affects speech articulation and volume and leads to gap in vocabulary attainment. Conductive hearing loss is often due to outer and middle ear pathology (e.g., auditory canal obstruction, otitis media or externa, tympanic membrane rupture, tympanostomy tubes). Sensorineural hearing loss is due to damage to inner ear or neural pathways (e.g., from congenital infections, meningitis, ototoxic medications, tumors, or trauma).	Involves addressing underlying cause, audiologic rehabilitation, and compensating for hearing loss with alternative communication modalities (e.g., sign language), hearing aids (for conductive or sensorineural hearing loss), or cochlear implants with intensive audiologic rehabilitation for profound hearing loss. Early detection and intervention are critical to minimizing sequelae of hearing loss.

Hearing loss before onset of speech	Speech expression and comprehension are delayed.	Hearing loss at birth or within first few months of life has the most profound effect on language development.
Intellectual developmental disorder	Deficits in intellectual functions and adaptive functioning in comparison with peers that is first noted during developmental period. Child often has associated difficulties with social judgment; self-management of behavior, emotions, or relationships; and communication skills. Known causes include genetic syndromes (e.g., Down syndrome, fragile X syndrome, Williams syndrome, Rett syndrome).	Lifelong, but generally nonprogressive except in certain genetic disorders (e.g., Rett syndrome) or epilepsy disorders (e.g., Lennox-Gastaut syndrome).
Myofunctional disorder (tongue thrust)	Tongue thrusting at rest or during swallowing, lip incompetency, and sucking habits.	Structural assessment and diagnostic procedures guide management.
Vocal cord dysfunction	Inappropriate vocal cord movement that affects respiratory function and voice production; often presents with chronic cough, episodes of breathing difficulty, throat or chest tightness, and sensation of choking; often misdiagnosed as asthma, allergies, gastroesophageal reflux disease, or upper airway obstruction.	Focuses on behavior interventions to improve symptoms and reduce recurrences, such as relaxed-throat breathing, breathing exercises, and chronic cough suppression strategies.

This table is not an exhaustive list of conditions affecting speech and language in children.

* Primary speech or language disorder affects phonology, vocabulary, grammar, morphology, narrative skills, and/or pragmatic language with no known etiology despite adequate intelligence, accessibility to learning, and no comorbid neurologic deficit.

† Augmentative and alternative communication includes gestures, sign language, facial expressions, pictures, graphic symbols, written cues, and/or speech-generating devices.

Dysphagia is a swallowing disorder that may be due to various neurological, structural, and cognitive deficits. (1) Dysphagia may be the result of head trauma, cerebrovascular accident,

neuromuscular degenerative diseases, head and neck cancer, and encephalopathies. While dysphagia can afflict any age group, it most often appears among the elderly. SLT programs are focused on helping the patient swallow safely and effectively, in order to maintain adequate oral nutrition intake. Interventions may include thermal stimulation to heighten the sensitivity of the swallowing reflex, exercises to improve oral-motor control, training in laryngeal adduction and compensatory swallowing techniques, and positioning and dietary modifications.

SLT services may include those services for rehabilitation therapy or maintenance programs. (3) Both require the skilled services of a therapist; however they differ in intent. Rehabilitative therapy focuses on services designed to address recovery or functional improvement, hopefully resulting in the restoration to a previous level of health and well-being. Maintenance programs focus on skilled interventions designed to prevent or slow further deterioration in status, hoping to maintain the patient's baseline condition.

Glossary of Terms:

- Anomic aphasia (also known as anomia or nominal aphasia): Impairment of language marked by difficulty or inability in finding the proper word and especially the name of objects. Anomic aphasia typically results from an injury to the brain (e.g., stroke). Patients with anomic aphasia have intact repetition, intact comprehension, and fluent speech, but have difficulty naming. (12)
- Aphasia or dysphasia: Loss or impairment of the power to use or comprehend words usually resulting from brain damage (e.g., stroke, head injury, or infection) or disease. (13, 14)
- Aphonia: The loss of voice and of all but whispered speech. (15)
- Apraxia of speech (also known as acquired apraxia of speech, verbal apraxia or childhood apraxia of speech): A neurological disorder that affects the brain pathways involved in planning the sequence of movements involved in producing speech. The brain knows what it wants to say but cannot properly plan and sequence the required speech sound movements. (18)
- Broca's (expressive) aphasia: Results from injury to speech and language brain areas such the left hemisphere inferior frontal gyrus, among others. Such damage is often a result of stroke but may also occur due to brain trauma. Patients have difficulty producing grammatical sentences and their speech is limited mainly to short utterances of less than four words. Producing the right sounds or finding the right words is often a laborious process. (19)
- Dysphagia: Impaired swallowing is a swallowing disorder involving the oral cavity, pharynx, esophagus, or gastroesophageal junction. Consequences of dysphagia include malnutrition and dehydration, aspiration pneumonia, compromised general health, chronic lung disease, choking, and even death. (20)
- Dysphonia: A defective use of the voice characterized by altered vocal quality, pitch, loudness, or vocal effort. (17)
- Fluency: Refers to the continuity, smoothness, rate, and effort in speech production. (21)
- Fluency disorder: A interruption in the flow of speaking characterized by atypical rate, rhythm, and repetitions in sounds, syllables, words, and phrases. (21)

- Intonation: The rise and fall of pitch in the voice while speaking. (16)
- Morphology: Units of language, including words and parts of speech. (22)
- Phonology: Language-based sounds: in particular, phonemes, which are the units that make up words. (22)
- Pragmatics: How the context of language contributes to meaning. (22)
- Semantics: The study of meanings in language. (22)
- Stuttering: Frequent repetition of words or parts of words that disrupts the smooth flow of speech. (22)
- Syntax: Sentence formation and structure. (22)
- Voice Disorders: Group of problems involving abnormal pitch, loudness, or quality of the sound produced by the larynx (voice box). (22)
- Wernicke's aphasia (also known as receptive or fluent aphasia): Disorder in which someone can speak but can't understand language in its written or spoken form; caused by damage to the medial temporal lobe of the brain. (22)

Regulatory Status

SLT is not subject to regulation by the U.S. Food and Drug Administration (FDA).

Rationale

This policy is based on a review of coverage guidance from the Centers for Medicare and Medicaid Services (CMS) specific to speech-language therapy and a society guideline.

Coding

Procedure codes on Medical Policy documents are included **only** as a general reference tool for each policy. **They may not be all-inclusive.**

The presence or absence of procedure, service, supply, or device codes in a Medical Policy document has no relevance for determination of benefit coverage for members or reimbursement for providers. **Only the written coverage position in a Medical Policy should be used for such determinations.**

Benefit coverage determinations based on written Medical Policy coverage positions must include review of the member's benefit contract or Summary Plan Description (SPD) for defined coverage vs. non-coverage, benefit exclusions, and benefit limitations such as dollar or duration caps.

CPT Codes	92507, 92508, 92521, 92522, 92523, 92524, 92526, 92610, 92630, 92633
HCPCS Codes	G0153, G0161, S9128

*Current Procedural Terminology (CPT®) ©2024 American Medical Association: Chicago, IL.

References

Centers for Medicare and Medicaid Services:

1. Centers for Medicare and Medicaid Services. National Coverage Determination for Speech-Language Pathology Services for the Treatment of Dysphagia (170.3). Version 2. (October 1, 2006). Available at <https://www.cms.gov> (accessed November 5, 2025).

2. Centers for Medicare and Medicaid Services. Local Coverage Determination for Speech-Language Pathology (SLP) Services: Communication Disorders (L35070). Revision 11. (August 13, 2020). Available at <https://www.cms.gov> (accessed November 5, 2025).
3. Centers for Medicare and Medicaid Services. CMS IOM Publication 100-02, Medicare Benefit Policy Manual. Chapter 15. (Rev. 13108) (April 11, 2025). Available at <https://www.cms.gov> (accessed October 31, 2025).

Other:

4. Speech-Language Pathology Review Guidelines. American Speech Language Hearing Association (ASHA). 2015. Available at <https://www.asha.org> (accessed November 7, 2025).
5. Rupert J, Hughes P, Schoenherr D. Speech and Language Delay in Children. Am Fam Physician. Aug 2023; 108(2):181-188. PMID 37590860
6. NIH-NIDCD – Quick Statistics About Voice, Speech, Language. National Institutes of Health and National Institute of Deafness and Other Communication Disorders. (Last updated July 8, 2025). Available at <https://www.nidcd.nih.gov> (accessed November 21, 2025)
7. NIH-NIDCD – Speech and language developmental milestones. National Institutes of Health and National Institute of Deafness and Other Communication Disorders. (Oct 2022). Available at <https://www.nidcd.nih.gov> (accessed November 21, 2025).
8. CDC-Center for Disease Control and Prevention. Milestone checklists by age. Aug 18 2025. Available at <https://www.cdc.gov> (accessed November 21, 2025).
9. ASHA – Assessment and evaluation of speech-language disorders in schools. n.d. Available at <https://www.asha.org> (accessed November 20, 2025).
10. Kinnane D. Test scores: What do they mean? (2022). Banter Speech and Language. Available at <https://www.banterspeech.com> (accessed November 20, 2025).
11. ASHA – Spoken Language Disorders. n.d. American Speech-Language-Hearing Association. Available at <https://www.asha.org> (accessed November 20, 2025).
12. “Anomic aphasia.” Merriam-Webster.com Medical Dictionary, Merriam-Webster. (2025). Available at <https://www.merriam-webster.com> (accessed November 20, 2025).
13. “Aphasia.” Merriam-Webster.com Dictionary, Merriam-Webster. (Updated November 15, 2025). Available at <https://www.merriam-webster.com> (accessed November 20, 2025).
14. “Dysphasia.” Merriam-Webster.com Dictionary, Merriam-Webster. (2025). Available at <https://www.merriam-webster.com> (accessed November 20, 2025).
15. “Aphonia.” Merriam-Webster.com Dictionary, Merriam-Webster. (2025). Available at <https://www.merriam-webster.com> (accessed November 20, 2025).
16. “Intonation.” Merriam-Webster.com Dictionary, Merriam-Webster. (Updated November 15, 2025) Available at <https://www.merriam-webster.com> (accessed November 20, 2025).
17. ASHA - Voice Disorders. n.d. American Speech-Language-Hearing Association. Available at <https://www.asha.org> (accessed November 20, 2025).
18. Apraxia of Speech. National Institute on Deafness and Other Communication Disorders. (Oct 2017). Available at <https://www.nidcd.nih.gov> (accessed November 20, 2025).
19. Broca’s (Expressive) Aphasia. National Aphasia Association. n.d. Available at <https://www.aphasia.org> (accessed November 20, 2025).

20. ASHA – Adult dysphagia. n.d. American Speech-Language-Hearing Association. Available at <https://www.asha.org> (accessed November 20, 2025).
21. ASHA - Fluency Disorders. n.d. American Speech-Language-Hearing Association. Available at <https://www.asha.org> (accessed November 20, 2025).
22. Glossary. National Institute on Deafness and other Communication Disorders (Updated April 4, 2025). Available at <https://www.nidcd.nih.gov> (accessed November 20, 2025).

Centers for Medicare and Medicaid Services (CMS)

The information contained in this section is for informational purposes only. HCSC makes no representation as to the accuracy of this information. It is not to be used for claims adjudication for HCSC Plans.

The Centers for Medicare and Medicaid Services (CMS) does have a national Medicare coverage position. Coverage may be subject to local carrier discretion.

A national coverage position for Medicare may have been changed since this medical policy document was written. See Medicare's National Coverage at <https://www.cms.hhs.gov>.

Policy History/Revision

Date	Description of Change
01/01/2026	Document updated. The following changes were made to Coverage: 1) Created section for Rehabilitative therapy with addition of Group therapy criteria; 2) Changed timeframe concerning updates or recertification to plan of care to “90 days or less, based on an individual’s needs”; 3) Added coverage criteria for Maintance therapy; 4) Moved NOTES 2 and 3 to Policy Guidelines with modification of content; 5) Significantly revised not medically necessary section; 6) Removed coverage statements specific to Auditory rehab along with associated NOTE 4; and 7) Removed coverage statement for Speech Volume Modulation System (e.g., SpeechVive™). Added references 1-3, 5-6; others updated/removed.
09/15/2024	Reviewed. No changes.
04/15/2024	Document updated with literature review. The following changes were made in Coverage: 1) Modified language from “due to illness/disease, trauma, surgery, congenital anomalies, or prior therapeutic intervention” to “speech language impairment” 2) Removed “in a reasonable and predictable period of time (usually 4-6 months, but not less than 8 weeks) 3) Removed the entire 5th bullet which includes a list of conditions under developmental delay 4) Added aural rehab/auditory rehab is considered experimental, investigational, and/or unproven in individuals with the following conditions: Tinnitus; and/or Hearing loss without a cochlear implant 5) Added NOTE 4 that refers to SUR714.004 for information on coverage of aural rehab. 6) Combined notes 1 and 2 specific to provider information AND notes 3 and 4

	specific to children although no change to the intent and/or language in the notes. Added references 3, 8, 9, 12-22, 25, 31-36, 38, 39; others updated; some removed.
01/01/2023	Reviewed. No changes.
01/15/2022	Document updated with literature review. Coverage unchanged. Added references 11, 12, 33; others updated.
10/01/2020	Document updated with literature review. The following change was made to Coverage: Added "The use of a speech volume modulation system (e.g., SpeechVive) to improve vocal loudness and/or speech clarity in patients with hypophonia secondary to Parkinson's disease (PD) is considered experimental, investigational and/or unproven". Added references 31 and 32.
09/15/2019	Document updated with literature review. Coverage unchanged. The following 3 NOTES were added: NOTE 3: For additional information regarding childhood ages with corresponding speech-language milestones from the American Speech-Language-Hearing Association, the National Institutes of Health, the American Academy of Pediatrics, and the American Academy of Pediatric Dentistry, refer to the Description; NOTE 4: Refer to the Description of information regarding speech and language delay for children from the American Academy of Family Physicians; and NOTE 5: For children, standardized testing scores may aid in the determination of a speech-language deficit. For example, a standard score of 70 or below, out of a 100-scale assessment, appears to indicate a severe impairment. Refer to the Description for more information. The following references were added: 3-10, 13-17, and 25-29; none removed. The title changed from Speech Therapy.
04/15/2018	Document updated with literature review. The following was added to the medically necessary coverage statement: "illness" and "surgery" under prescribed by a licensed physician or other qualified provider to restore or improve the function in a member. The following was added to not medically necessary coverage statement: 1) Under development delay, for stammering or stuttering, "e.g., a congenital abnormality of the teeth, tongue, jaw, palate"; 2) Group speech or computer-based therapies, as these therapies are not one-to-one individualized treatment; and, 3) medical conditions causing communication difficulties that are not correctable (e.g., muscle disorders of face, mouth, lips or jaw [a tongue thrust], including orofacialmyology or myofunctional treatment).
04/15/2016	Reviewed. No changes.
03/15/2015	Document updated with literature review. The following changes were made to Coverage: 1) The bullet "Prescribed by a licensed physician or other qualified provider* to restore or improve the function in a member who has impaired physical function of phonation or swallowing, or communication disability related to expressive or receptive aphasia/paraphasia, due to

	disease, trauma, congenital anomalies, or prior therapeutic intervention" was modified by the addition of "or communication disability related to expressive or receptive aphasia/paraphasia"; 2) Everywhere that stated the need for a physician's referral, prescription, or certification was modified to include "or other qualified provider".
09/15/2014	Reviewed. No changes.
10/01/2013	Literature reviewed. No changes.
03/15/2008	Policy reviewed without literature review; new review date only
07/01/2007	Codes Revised/Added/Deleted
01/15/2006	Revised/Updated Entire Document
03/01/2000	Revised/Updated Entire Document
11/01/1999	Codes Revised/Added/Deleted
04/01/1994	Codes Revised/Added/Deleted
10/01/1993	Codes Revised/Added/Deleted
10/01/1992	New medical document