BlueCross BlueShield of Vermont

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Speech Language Pathology/Therapy Services
Corporate Medical Policy

File Name: Speech Language Pathology/Therapy Services
File Code: 8.03.VT04
Origination: 01/1997 as a component of PT/OT/ST
Last Review: 05/2025
Next Review: 05/2026
Effective Date: 10/01/2025

Description/Summary

Speech-language pathology services (SLP), also referred to as speech therapy (ST) are the treatment of swallowing, speech-language, and cognitive-communication disorders. SLP services facilitate the development and maintenance of human communication and swallowing through assessment, diagnosis, and rehabilitation.

Policy

Coding Information

Click the links below for attachments, coding tables & instructions.
Attachment I CPT® & HCPCS Code List & Instructions

When a service may be considered medically necessary

SLP services are considered **medically necessary** when used to treat swallowing, speech- language, and cognitive-communication disorders due to disease, trauma, congenital anomalies, or prior therapeutic intervention.

I. To be considered **medically necessary,** SLP services must meet **ALL** of the following criteria:

- Services are for the treatment of communication impairment or swallowing disorders due to a covered injury, illness, or disease, and are appropriate treatment for the condition;
- Services are performed to restore and improve the functional needs of a patient who suffers from a communication disability or swallowing disorder due to

illness, injury, congenital anomaly, or prior therapeutic intervention;
- Treatments are expected to result in significant, practical improvement in the patient's level of functioning in a reasonable and generally predictable period of time or are necessary for the establishment of a safe and effective maintenance program. Treatments should be directed toward restoration or compensation for lost function. The improvement potential must be significant in relation to the extent and duration of therapy required;
- Treatment is rendered by a qualified provider of speech therapy services. A qualified provider is one who is licensed and certified where required and is performing within their scope of practice;
- The services must be considered under currently accepted standards of medical practice to be a specific and effective treatment for the patient's existing condition;
- The complexity and sophistication of the treatment and the patient's condition must require the judgment and knowledge of a speech pathologist;
- Services do not duplicate those provided by any other therapy, particularly occupational therapy.

II. If the above criteria are met, the following guidelines apply in determining medical necessity:

The treatments and procedures listed in Attachment I require the skills and expertise of a licensed eligible provider. In conjunction with delivering these services, the provider is expected to provide teaching and training to the patient and available family members and/or caregivers to facilitate their participation in and/or assumption of the total program.

Maintenance programs in themselves are not considered medically necessary and must be taught before the end of the active rehabilitation program.

The evaluation of patients with speech disorders is medically necessary to determine the causes of aphasia, dysphasia, dysarthria, cognitive communication disorders, apraxia or aphonia. The treatment plan is directed toward the active treatment of disease, trauma, congenital anomalies, or therapeutic processes that result in:

- Dysphagia - difficulty in swallowing
- Dysphasia - impairment of speech consisting of a lack of coordination and failure to arrange words in their proper order
- Dysarthria - impairment of articulation
- Aphasia - impairment of the power of expression by speech, writing or symbols, or of comprehending spoken or written language
- Apraxia - the inability to perform purposeful movement in the absence of paralysis or other motor or sensory impairment
- Dysphonia/Aphonia – inability or difficulty producing clear speech sounds from the larynx, due to paralysis, paresis or disease of the vocal cords/larynx, pharynx and/or oral cavity nerves
- Speech – language delay in children due to documented acquired hearing loss; e.g., repeated ear infections resulting in hearing loss
- Paradoxical vocal cord dysfunction - a form of laryngeal dyskinesia characterized by inappropriate adduction of the true vocal cords during inspiration, leading to

obstructive airway symptoms
- Tongue thrust therapy if a neuromuscular disorder is present

Speech Therapy for individuals diagnosed with Autism Spectrum Disorders (ASD)

According to the American Speech-Language-Hearing Association (ASHA), speech-language pathologists play a role in screening, diagnosing, and enhancing the development of social communication and quality of life of children, adolescents, and adults with ASD. They work with individuals with ASD to help diagnose and treat specific speech and language deficits as well as related feeding disorders. There is no single approach that is equally effective for all individuals with ASD, and based on outcome studies, not all individuals benefit to the same degree. Speech- language consultative services should be aimed at helping the communicative partner (e.g., teacher, parent, caregiver, peer, and sibling) to provide the support and employ specific teaching strategies to enhance active engagement in natural learning environments.

The following components for the management of ASD may be considered medically necessary when the specified medical criteria apply. In accordance with the terms defined in the applicable medical policies, benefit contracts on these topics, or where a state mandate provides for such coverage, speech therapy may be considered medically necessary when all of the following criteria are met:

- The individual has a documented Diagnostic and Statistical Manual of Mental Disorders (DSM-5) diagnosis of ASD and/or moderate to severe intellectual disability
- The individual has a history of a clinically significant impairment that interferes with the ability to negotiate their environment, communicate, learn, and/or demonstrate appropriate social behavior, which may include impaired speech, language and/or communication
- The parent(s) and/or caregiver(s) are willing and able to participate and follow the training and support that is incorporated into the treatment plan
- The therapy is rendered by or under the direction of a healthcare provider who is appropriately licensed to perform the therapy and who is eligible under the terms of the member's benefit contract
- The individual's progress in meeting the objectives of the treatment plan is measured on an ongoing basis for adjustment or refinement

The benefit for Speech Therapy services as treatment for ASD, in members until the age of 21 years, is not subject to the combined 30 PT/OT/ST visit limit. Members who reach the age of 21 years are subject to the combined PT/OT/ST 30 visit limit. Refer to Blue Cross VT Corporate Medical Policy Applied Behavior Analysis for eligible diagnoses of ASD.

When a service is considered not medically necessary

Services not meeting the criteria in sections I and II above are considered **not medically necessary**. These types of services may include, but are not limited to:

- Treatment of conversion disorder, selective mutism, anxiety, or psychotic conditions
- Treatment of dysfunctions that are self-correcting such as hoarseness

- Language therapy for young children with natural dysfluency or developmental articulation errors that are self-correcting
- Treatment of stammering or stuttering
- Treatment of functional dysphonia
- Instruction of other professional personnel in the patient's SLP treatment program.
- Collaboration with other professional personnel or with other community resources
- Inpatient benefits if the hospital admission is solely for the purpose of receiving SLP treatment
- Non-skilled Services- Certain types of treatment do not generally require the skills of a qualified provider of speech therapy services, such as treatments that maintain function by using routine repetitions, and reinforced procedures that are neither diagnostic nor therapeutic (e.g., practicing word drills for developmental articulation errors) or procedures that may be carried out effectively by the patient, family, or caregivers. A maintenance therapy program consists of drills, techniques, and exercises that preserve the patient's present level of function and prevent regression of that function. Maintenance begins when the therapeutic goals of a treatment plan have been achieved and when no further functional progress is apparent or expected to occur. Benefits for the maintenance program itself are not medically necessary
- Duplicate therapy- When patients receive both Occupational Therapy and SLP services, the therapies should provide different treatments and not duplicate the same treatment. They must also have separate treatment plans and goals. See Blue Cross VT Occupational Therapy Corporate Medical Policy

When a service is considered non-covered as they are a benefit exclusion:

- Biofeedback or other forms of self-care or self-help training
- Cognitive training or retraining and educational programs, including any program designed principally to improve academic performance, reading, or writing skills
- Communication devices and communication augmentation devices
- Computer technology or accessories and other equipment, supplies or treatment intended primarily to enhance occupational, recreational, or vocational activities, hobbies or academic performance
- Treatment for developmental delay. This exclusion does not apply to mandated treatment of Autism Spectrum Disorder up to age 21 as defined by Vermont law
- Care for which there is no therapeutic benefit or likelihood of improvement
- Care, the duration of which is based upon a predetermined length of time rather than the condition of the patient, the results of treatment or the individual's medical progress
- Care provided but not documented with clear, legible notes indicating patient's symptoms, physical findings, the provider's assessment, and treatment modalities used (billed)
- Education, educational evaluation or therapy, therapeutic boarding schools, services that should be covered as part of an evaluation for, or inclusion in, a Child's individualized education plan (IEP) or other educational program
- Therapy services that are considered part of custodial care
- Services, including modalities that do not require the constant attendance of a

provider
- Services beyond those needed to restore ability to perform Activities of Daily Living
- Unattended services or modalities (application of a service or modality) that do not require one-on-one patient contact by provider
- Supervised services or modalities that do not require the skill and expertise of licensed providers

Habilitative and Rehabilitative Services

Habilitative and rehabilitative services are services provided to achieve normal functions and skills necessary to perform age-appropriate basic activities of daily living, including ambulation, eating, bathing, dressing, speech, and elimination.

Habilitation and rehabilitation services may include respiratory therapy, speech therapy treatment, occupational therapy, and physical medicine treatments. Habilitation and rehabilitation services may be performed by those who are qualified to perform such services and do so within the scope of their license. Such services are evaluated based on objective documentation of measurable progress toward functional improvement goals. Measurement methods must be valid, reliable, repeatable, and evidence based.

Habilitative services, including devices, are provided for a person to attain a skill or function never learned or acquired due to a disabling condition.

Rehabilitation services, including devices, are provided to help a person regain, maintain or prevent deterioration of a skill or function that has been acquired but then lost or impaired due to illness, injury, or disabling condition.

Initial benefits for habilitation and rehabilitation services may be considered medically necessary when the criteria in this policy apply.

Additional habilitative and rehabilitative services are not considered medically necessary in the absence of objective documentation of ongoing clinically significant functional improvement being achieved, or when there is not a medically reasonable expectation that additional treatment will lead to additional clinically significant functional improvement.

The following services are excluded from benefits under our certificates of coverage: custodial care, vocational, recreational, educational services, and services that show no likelihood of improvement and/or no therapeutic benefit.

Related Policies

Applied Behavior Analysis
Cognitive Rehabilitation
Occupational Therapy
Physical Therapy/Medicine

Legislative Guidelines

§ 4088i-Early Childhood Developmental Disorders. Vermont Act 127- Autism Spectrum Disorders

Document Precedence

Blue Cross and Blue Shield of Vermont (Blue Cross VT) Medical Policies are developed to provide clinical guidance and are based on research of current medical literature and review of common medical practices in the treatment and diagnosis of disease. The applicable group/individual contract and member certificate language, or employer's benefit plan if an ASO group, determines benefits that are in effect at the time of service. Since medical practices and knowledge are constantly evolving, Blue Cross VT reserves the right to review and revise its medical policies periodically. To the extent that there may be any conflict between medical policy and contract/employer benefit plan language, the member's contract/employer benefit plan language takes precedence.

Audit Information

Blue Cross VT reserves the right to conduct audits on any provider and/or facility to ensure compliance with the guidelines stated in the medical policy. If an audit identifies instances of non-compliance with this medical policy, Blue Cross VT reserves the right to recoup all non- compliant payments.

Administrative and Contractual Guidance

Benefit Determination Guidance

NEHP/ABNE members may have different benefits for services listed in this policy. To confirm benefits, please contact the customer service department at the member's health plan.

Federal Employee Program (FEP): Members may have different benefits that apply. For further information please contact FEP customer service or refer to the FEP Service Benefit Plan Brochure. It is important to verify the member's benefits prior to providing the service to determine if benefits are available or if there is a specific exclusion in the member's benefit.

Coverage varies according to the member's group or individual contract. Not all groups are required to follow the Vermont legislative mandates. Member Contract language takes precedence over medical policy when there is a conflict.

Coverage requirements may differ for members diagnosed with conditions included within the definition of Autism Spectrum Disorder Please refer to the following Corporate Medical Policy: Applied Behavior Analysis including Autism.

If the member receives benefits through an Administrative Services Only (ASO) group, benefits may vary or not apply. To verify benefit information, please refer to the member's employer benefit plan documents or contact the customer service department. Language in the employer benefit plan documents takes precedence over medical policy when there is a conflict.

The plan covers up to 30 habilitative and up to 30 rehabilitative outpatient sessions, ***combined for*** PT/ OT/ST visits per plan year. This maximum applies to sessions provided in the home, an outpatient facility or professional office setting. The maximum number of visits included in covered benefits may vary for specific contracts or products. Please refer to the appropriate subscriber contract or employer benefit plan for the applicable benefit maximum.

A self-pay agreement must be entered into with the member prior to rendering any services described in this policy when members choose to pay, at their own expense for services that exceed the limitations of coverage (i.e. visits beyond the 30 combined visit limit) or any other excluded or non-covered services i.e. care designed to prepare them for specific occupational, hobbies, sports, leisure & recreational activities, acupuncture or massage therapy (not all inclusive). This self-pay agreement must be maintained as part of the member's medical record.

A plan of care which should be updated as the member's condition changes, be recertified by a physician at least every 30 days, and include **ALL** of the following:

- Specific statements of long- and short-term goals
- Measurable objectives
- A reasonable estimate of when the goals will be reached
- Specific treatment techniques and/or exercises to be used in the treatment
- Frequency and duration of the treatment.

<u>Sessions:</u>

- A ST session is defined as up to one hour of ST (treatment and/or evaluation) on any given day.
- Multiple ST sessions on the same day are applied collectively as a single daily session to the benefit limit of 30 PT/OT/ST sessions per plan year.
- Up to three evaluation sessions are considered medically necessary to evaluate the patient and to develop a written plan of care.

The benefit for Speech Therapy services as treatment for ASD, in members until the age of 21 years, is not subject to the combined 30 PT/OT/ST visit limit. Members who reach the age of 21 years are subject to the combined PT/OT/ST 30 visit limit.

Speech Therapy services in the Emergency Room apply to the PT, OT and ST combined defined visit benefit limit.

Speech Therapy services rendered at an inpatient level of care to members in an acute inpatient or rehabilitation facility, or under hospice care, do not apply to the defined

benefit limit.

Policy Implementation/Update information

5/2009	Policy extracted from the former Physical Therapy, Occupational Therapy and Speech Therapy Medical Policy and established as a separate and distinct medical policy which mirrors BCBSA medical policy. Reviewed by CAC.
08/2011	New policy format for BCBSVT medical policies. Expanded criteria for covered and non-covered services. Added language relating to benefits mandated by Vermont Act 127 for Autism Spectrum Disorder Coverage. Added references. Expanded ICD-9 coding. Added "related policy" reference. Changed references of calendar year to plan year.
08/2011	Coding is appropriate per Medical/Clinical Coder SAR.
05/2012	removed six months after initiation of therapy language
06/2012	added diagnosis 478.75 as allowable
09/2012	2012 Updated policy to reflect ECDD mandate. Minor format changes and some coding additions and changes, new table formats for codes. Added "audit information" and "legislative guidelines" section. Medical/Clinical Coder reviewed-RLJ.
11/2013	Added Habilitative language to policy as mandated by Section 1302 of the Affordable Care Act. ICD changes to reflect changes to Autism and ECDD policies.
05/2015	Reference to speech therapist changed to speech-language pathologist. Cognitive rehabilitation language from BCBSA policy added. Definitions for aphasia/dysphasia and aphonia/dysphonia added. CPTs- 92521-92524, 96125 and 97532 added.
07/2018	Reviewed and voted at HPC 06/12/2017 with the following summary: Changed policy name Speech Therapy to Speech Language Pathology / Therapy Services from Speech Therapy Services, Updated description section. Added language around Autism Spectrum Disorder. Updated eligible providers. Removed section on Cognitive Rehabilitation – new separate policy. Update related policies. Updated document precedence. Added CPT® G0505, added HCPCS level II modifier-SZ, clarified rehabilitative/habilitative definition headers, update references, removed ICD-10-CM coding table. Added CPT® code 96105, updated related policies, new Cognitive Rehabilitation medical policy created to address Cognitive Rehabilitation services. 01/01/2018 Adaptive Maintenance Summary of changes: New code 97127 was added for therapeutic interventions specific to cognitive function and strategies to compensate and manage activity performance with direct patient contact. This code can only be reported once per day. Code 97532 was deleted and the service would now be reported with the new code. Removed – SZ modifier and added -96 modifier to the coding table. G0515 Added. 99483 added can only be reported every 180 days.
03/2019	Added clarifying language for ASD and prior approval requests: For Physical Therapy services for ASD (for children through the age of 21, ending the day before their 22nd birthday), prior approval is required for additional visits beyond 30 combined sessions of PT/ST/OT visits.

01/2020	Adaptive Maintenance Changes: Deleted code 97127 effective 01/01/2020. Moved codes 99483, 96125, 99483 & G0515 to Corporate Cognitive Rehabilitation Medical Policy.
12/2020	Policy reviewed. Added codes 0208T, 0209T, 0210T, 0211T, 0212T to coding table as eligible services.
05/2021	Policy Reviewed. No change to policy statement.
07/2021	Revised Autism Spectrum Services for members, beginning at birth and continuing until the member reaches age 21.
06/2022	Policy Reviewed. Added modifier(-GN) with instructions to coding table.
04/2023	Policy reviewed. Clarification that a prescription is not needed for SLP services. Clarification of benefit for ST for ASD without change to benefit or criteria. Minor formatting changes for clarity and consistency.
07/2024	Policy reviewed. No change to policy statement. Removed references to archived BCBSVT policies. Clarified coverage CPT® 92520 as an eligible service and added to coding table. Minor formatting changes.
06/2025	Policy reviewed. Clarification of benefit for Oral sensorimotor therapy or myofunctional therapy. ***Policy updated to show prior approval no longer required for visits beyond defined benefit limit (combined 30 PT/OT/ST) when related to ASD. Removed statement indicating "SLP services are considered investigational for the treatment of individuals over the age of 21 years." Minor formatting changes.

Eligible providers

Qualified healthcare professionals practicing within the scope of their license(s)

Approved by Blue Cross VT Medical Directors

Tom Weigel, MD, MBA
Vice President and Chief Medical Officer

Tammaji P. Kulkarni, MD
Senior Medical Director

Attachment I
CPT® & HCPCS Code List & Instructions

Code Type	Number	Description	Policy Instructions
The following codes will be considered as medically necessary when applicable criteria have been met.			
CPT®	0208T	Pure tone audiometry (threshold), automated; air only	
CPT®	0209T	Pure tone audiometry (threshold), automated; air and bone	
CPT®	0210T	Speech audiometry threshold, automated;	
CPT®	0211T	Speech audiometry threshold, automated; with speech recognition	
CPT®	0212T	Comprehensive audiometry threshold evaluation and speech recognition (0209T, 0211T combined), automated	
CPT®	92507	Treatment of speech, language, voice, communication, and/or auditory processing disorder; individual	
CPT®	92520	Laryngeal function studies (ie, aerodynamic testing and acoustic testing)	
CPT®	92521	Evaluation of speech fluency (eg, stuttering, cluttering)	
CPT®	92522	Evaluation of speech sound production (eg, articulation, phonological process, apraxia, dysarthria)	
CPT®	92523	Evaluation of speech sound production (eg, articulation, phonological process, apraxia, dysarthria); with evaluation of language comprehension and expression (eg, receptive and expressive language)	
CPT®	92524	Behavioral and qualitative analysis of voice and resonance	
CPT®	92526	Treatment of swallowing dysfunction and/or oral function for feeding	
CPT®	92610	Evaluation of oral and pharyngeal swallowing function	

CPT®	92611	Motion fluoroscopic evaluation of swallowing function by cine or video recording	
CPT®	96105	Assessment of aphasia (includes assessment of expressive and receptive speech and language function, language comprehension, speech production ability, reading, spelling, writing, eg, by Boston Diagnostic Aphasia Examination) with interpretation and report, per hour	
HCPCS	G0153	Services, performed by a qualified speech-language pathologist in the home health or hospice setting, each 15 minutes	
HCPCS	S9128	Speech therapy, in the home, per diem	
HCPCS	S9152	Speech therapy re-evaluation	
Modifier	-96	Habilitative Services	Modifier must be reported when habilitative services are provided. This will allow for the service to accumulate to the correct benefit.
Modifier	-97	Rehabilitative Services	Modifier must be reported when rehabilitative services are provided. This will allow for the service to accumulate to the correct benefit.
Modifier	-GN	Services delivered under an outpatient speech language pathology plan of care	Modifier must be reported when speech therapy services are provided.
REV	0440 0441 0442 0444 0449 0979	Speech Therapy Revenue Codes	

CPT®	92508	Treatment of speech, language, voice, communication, and/or auditory processing disorder; group, 2 or more individuals	Non Covered Benefit Exclusion