08.03.05 Treatment of Speech and Language Disorders *

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Original Effective Date: June 2004

Review Date: May 2025

Revised: May 2023

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Benefit determinations are based on the applicable contract language in effect at the time the services were rendered. Exclusions, limitations, or exceptions may apply. Benefits may vary based on contract, and individual member benefits must be verified. Wellmark determines medical necessity only if the benefit exists and no contract exclusions are applicable. This medical policy may not apply to FEP. Benefits are determined by the Federal Employee Program.

This Medical Policy document describes the status of medical technology at the time the document was developed. Since that time, new technology may have emerged, or new medical literature may have been published. This Medical Policy will be reviewed regularly and updated as scientific and medical literature becomes available; therefore, policies are subject to change without notice.

Summary

Description

Speech therapy involves the evaluation, diagnosis, and treatment of communication impairments and disorders. Speech-language pathologists (SLP), sometimes referred to as speech therapists, evaluate and treat disorders and impairments. These impairments often result from illness, trauma, disease, or congenital anomaly including speech articulation, apraxia, phonological disorders, voice disorders, cognitive disorders, language disorders, communication disorders, and related disorders. Speech therapy is a term that encompasses a variety of therapies including voice therapy.

The speech therapy services provided are intended to cover only episodes of therapy for situations where there must be a reasonable expectation an individuals' condition will improve significantly in a reasonable and generally predictable time.

Additional Information
None

OBJECTIVE

The objective of this medical policy is to provide criteria for determining whether the speech therapy is medically necessary and describe the required supporting documentation.

PRIOR APPROVAL

Prior approval is required.

POLICY

Special Considerations	*Note: Individual member benefits must be verified, as speech therapy benefits vary by product and group. Refer to the benefit document to determine coverage related to speech/voice therapy before applying any applicable medical necessity criteria.*
	• Limitations, frequency, and annual maximums may be applied and vary by product or by group.
	• Depending on the benefit document the example below may apply.
	  ○ Speech therapy/voice therapy is considered not a covered benefit in the following scenarios:
	  ▪ When speech/voice therapy services are not provided by a licensed or certified speech pathologist
	  ▪ Speech therapy to treat certain developmental, learning, or communication disorders, such as stuttering and stammering.
	  ▪ Items not primarily and customarily manufactured to serve a medical purpose, or which can be used in the absence of illness or injury. (e.g., iPads, computers, tablets not manufactured specifically for the use of speech and language therapy that have the ability to become non-dedicated speech and language devices after purchase).

Medically Necessary: Initial Speech Therapy	Speech therapy may be considered medically necessary when related to a specific injury, illness, impairment, or disease which involve the mechanics of language, phonation, or articulation include but may not be limited to one of the following indications:
	• Autism spectrum disorders (ASD); or
	• Brain injury or insult due to cerebrovascular accident or trauma influencing the speech center; or
	• Developmental apraxia of speech (oral motor apraxia); or
	• Developmental disorders including the following:
	  ○ Articulation disorders; or
	  ○ Expressive language disorder; or
	  ○ Phonological process disorders; or
	  ○ Receptive language disorder; or

	• Dysfunction occurring as a result of a therapeutic process which may include:
	  ○ Laryngectomy; or
	  ○ Ototoxic medication; or
	  ○ Radiation therapy; or
	• Neuromuscular disorders (e.g., cerebral palsy); or
	• Sensorineural hearing loss; or
	• Structural anomalies related to cleft palate and cleft lip;
	
	and additional documentation includes all of the following information:
	• For individuals with developmental apraxia of speech (oral motor apraxia) documentation must also include all of the following:
	  ○ Results from diadochokinetic testing (maximum repetition test); and
	  ○ Oral motor examination (including ROM, strength, impaired coordination, groping and oral management of food); and
	• For individuals with any other diagnosis, results from standardized testing (or equivalent) that measures overall receptive, expressive language and/or articulation using one of the following:
	  ○ standard scores or age equivalencies for pediatric assessments; or
	  ○ determinations of deficits in adult assessments as applicable; with short and long-term goals, will include the following; and
	• Are performed to meet the *functional* needs of an individual who has a physical disability, or communication disability due to an illness, disease, injury, congenital anomaly, or prior therapeutic intervention; and
	• Are performed to meet a *specific diagnosis-related goal* for an individual who has the potential to achieve measurable improvement in a generally predictable period of time; and
	• Requires the judgment, knowledge, and skills of a qualified provider of speech therapy services (e.g., speech pathologist, speech-language pathologist, or speech clinician because of the complexity and sophistication of the therapy and the physical condition of the individual.); and
	• Objective short – and long – term goals.

Medically Necessary: Ongoing Speech Therapy	Ongoing speech therapy may be considered medically necessary when the medical necessity criteria above and the policy guideline progress report requirements below have been met.

Speech Therapy: Miscellaneous Documentation Information:

- If there is an inability to use standardized testing: there is an expectation the use of non-standardized testing can evaluate normative development status and can quantify the extent of language/speech impairment, performance deviation, or pragmatic skill deficits. A description of functional receptive and expressive language skills should be utilized to demonstrate medical necessity of therapy.
- Children older than *three* years old must show:

- A minimum of 12 months difference between their chronological age and their age equivalency on standardized tests in any one language area; ***or***
- The standard score must fall at least one standard deviation below the normal range as designated by the standardized instrument utilized.

- Language tests that measure only a specific area, (e.g., receptive vocabulary) may be included but only as an additional/supplemental measure to quantify areas of strength and weakness. (*See the section objective measuring tools/tests utilized in speech below for more information.)*
- Speech therapy services utilizing applications or devices manufactured specifically for the use of speech and language therapy would need to be reviewed per the policy criteria to determine if therapy is medically necessary.

Medically Necessary: Initial Voice Therapy for After Vocal Cord Surgery, Anatomic Abnormality, Neurological Condition **(Except Parkinson's), Injury (e.g., Vocal Nodules or Polyps, Vocal Cord Paresis or Paralysis,)**	Voice therapy may be considered medically necessary, when related to a specific injury, illness, impairment, or disease which involves the mechanics of phonation to include but not be limited to one of the following indications: • After vocal cord surgery; or • Anatomic abnormality; or • Neurological condition (except Parkinson's); or • Injury (e.g., vocal nodules or polyps, vocal cord paresis or paralysis); And for therapy the *voice exam* includes all of the following components: • Documentation from the direct viewing (e.g., videostroboscopy, flexible laryngoscopy) of the vocal cords includes their health and function; and • Documentation of the diagnosis from viewing (e.g., vocal nodules, hyperfunction, muscle tension dysphonia); And the *voice evaluation* documentation includes all of the following: • Breath support; and • Loudness; and • Pitch; and • Quality; and • Respiration; and additional documentation includes all of the following information: • Supporting therapy to be performed to meet the *functional* needs of an individual who has a physical disability, or communication disability due to an illness, disease, injury, congenital anomaly, or prior therapeutic intervention; and • Supporting therapy to be performed to meet a *specific diagnosis-related goal* for an individual who has the potential to achieve measurable improvement in a generally predictable period of time; and • Requires the judgment, knowledge, and skills of a qualified provider of speech therapy services (e.g., speech pathologist, speech-language pathologist, or speech clinician because of the complexity and sophistication of the therapy and the physical condition of the individual.); and • Objective short – and long – term goals.

Medically Necessary: Initial Voice Therapy for Chronic Cough, Paradoxical Vocal Cord Motion, Parkinson's	Voice therapy may be considered medically necessary, when related to a specific injury, illness, impairment, or disease which involves the mechanics of phonation to include but not be limited to, one of the following indications: • Chronic cough; or • Paradoxical vocal cord motion or • Parkinson's and additional documentation includes all of the following information: • Supporting therapy to be performed to meet the *functional* needs of an individual who has a physical disability, or communication disability due to an illness, disease, injury, congenital anomaly, or prior therapeutic intervention; and • Supporting therapy to be performed to meet a *specific diagnosis-related goal* for an individual who has the potential to achieve measurable improvement in a generally predictable period of time; and • Requires the judgment, knowledge, and skills of a qualified provider of speech therapy services (e.g., speech pathologist, speech-language pathologist, or speech clinician because of the complexity and sophistication of the therapy and the physical condition of the individual.); and • Objective short – and long – term goals.

Medically Necessary: Ongoing Voice Therapy	Ongoing voice therapy may be considered medically necessary when the medical necessity criteria above and the policy guideline progress report requirements below have been met. *Note: All reviews for ongoing voice therapy for chronic cough, paradoxical vocal cord motion, and Parkinson's will require review by a speech pathologist or physician reviewer.*

Not Medically Necessary: Speech/ Voice Therapy	Speech/Voice therapy is considered not medically necessary including, but not limited to the following: • Alzheimer's disease, and other chronic disorders of memory and/or orientation • Fully computerized or Artificial Intelligence (AI) Speech Therapy • Voice dysphoria • Programs that are primarily educational in nature or that support an academic program (e.g., reading and writing) • Non-specific electrical stimulation methods for dysphagia (e.g., Deep Pharyngeal Neuromuscular Therapy (DPNS), Vita -Stim) • Therapy that can be performed at home without the skills of a speech language pathologist. ○ i.e., word drills, work on communication boards, interaction with electronic communication boards/tablets or applications, and work

	on behavioral issues surrounding speech which does not have a specialized need for therapy. • When the above criteria have not been met • When documentation requirements have not been met (e.g., initial evaluation or progress reports) • When the goal of treatment is instruction of others, professional or non-professional, in the individual's speech therapy program. • When functional progress is not supported by treatment notes or when therapy progress has plateaued.

POLICY GUIDELINES

Progress Reports Speech Therapy	Speech therapy may be medically necessary documentation includes all of the following information: • Start of care date; and • Time period covered by the report; and • Communication diagnosis; and • Statement of the individual's functional communication at the beginning of the progress report period; and • Statement of the individual's current status as compared to evaluation baseline data and the prior progress reports, including objective measures of member communication performance in functional terms that relate to the treatment goals; and • Changes in prognosis and why; and • Changes in plan of care and why; and • Changes in goals and why; and • Consultations with other professionals or coordination of services, if applicable; and • Completion of annual standardized testing should correlate to current goals (i.e., *If the plan of care includes goals for articulation, standardized testing results for articulation would be expected*); and • The individual is making functional progress.

Progress Reports Voice Therapy	Voice therapy may be medically necessary documentation includes all of the following information: • Start of care date; and • Time period covered by the report; and • Communication diagnosis; and • Statement of the individual's functional communication at the beginning of the progress report period; and • Statement of the individual's current status as compared to evaluation baseline data and the prior progress reports, including objective measures of member communication performance in functional terms that relate to the treatment goals; and • Changes in prognosis and why; and

	• Changes in plan of care and why; and • Changes in goals and why; and • Consultations with other professionals or coordination of services, if applicable; and • The individual is making functional progress.

Definitions

- **Aphasia:** This disorder involves the expression of language, the comprehension of language, or both. It can be classified into specific syndromes according to the ability to produce, understand and repeat language. The ability to produce language is assessed in terms of fluency, which is defined as the rate of speech and amount of effort in producing speech. There are several syndromes of aphasia, and each is associated with a particular set of language capabilities and disabilities. Global aphasia is when both expressive and receptive problems are present. These include:
    - Broca's: This syndrome is characterized with non-fluent speech, intact comprehension and poor repetition skills.
    - Wernicke's: This syndrome is characterized with fluent speech, poor comprehension and poor repetition skills.
    - Conduction: This syndrome is characterized by fluent speech, intact comprehension and poor repetition skills.
    - Transcortical motor: This syndrome is characterized with nonfluent speech, intact
    - comprehension and intact repetition skills.
    - Transcortical sensory: This syndrome is characterized by fluent speech, poor comprehension and intact repetition skills.
    - Anomic: This syndrome is characterized fluent speech, and intact comprehension and repetition skills.

- **Aphonia:** This is the total loss of speech sounds.
- **Apraxia/dyspraxia:** This is the inability or difficulty to form words or speak, despite the ability to use the oral and facial muscles to make sounds.
- **Dysarthria**: With this impairment, there is an impairment or clumsiness in the uttering of words due to diseases that affect the oral, lingual or pharyngeal muscles; speech may be difficult to understand, but the ability to communicate is present.
- **Dysphasia:** impairment of speech resulting from a brain lesion, stroke or neurodevelopmental disorder
- **Stuttering:** disruption in the fluency of speech; affected persons repeat letters or syllables, pause, or hesitate abnormally, or fragment words when attempting to speak.
- **Voice Dysphoria:** Negative feelings about one's voice.
- **Voice Therapy:** A subset of speech therapy, the intervention is conducted to achieve improved voice production and coordination of respiration and laryngeal valving.

Objective Measuring Tools/Tests Utilized in Speech

- *Note: Supplemental tests (not standardized tests) may help provide additional information but cannot replace standardized testing/documentation. If supplemental tests are the only test(s) utilized for assessing deficits, then the documentation requirements have not met medical policy*

requirements. Below are common tests both supplemental or standardized, which may be seen in documentation. The list is not all-inclusive.

Aphasia: Standardized Tests

Assessment of Language-Related Functional Activities (ALFA)		
Ages Covered	**Normal Range**	**Reported As**
16-95	WNL- 90-100% *Or* Independent Functioning Rating of: • 1 = WNL • 2 = some need for assistance • 3=not able to complete task without assistance	Percentages in subtests or Functioning Rates

Boston Diagnostic Aphasia Exam		
Ages Covered	**Normal Range**	**Reported As**
18-79	WNL - 90-100%	Percentages in categories of: • Auditory Comprehension • Oral Expression • Understanding Written Language
Note: Individual subtests are within categories and can show deficits.		

Boston Naming		
Ages Covered	**Normal Range**	**Reported As**
18-79	90-100%	Percentage

Western Aphasia Battery		
Ages Covered	**Normal Range of Standard Scores**	**Reported As**
18-89	• 0-25 Very Severe • 26-50 Severe • 51-75 Moderate • 76 and up Mild	Severity Rates

Articulation: Standardized Tests

Goldman Fristoe Test of Articulation (GFTA)		
Ages Covered	**Score Ranges/Percentages**	**Reported As**
2-6 through 21-0	85-115	• Standard Score • Age Equivalent Score

Clinical Assessment of Articulation and Phonology (CAAP)		
Ages Covered	**Score Ranges/Percentages**	**Reported As**
2-6 through 11-11	85-115	• Standard Score • Age Equivalent Score

Photo Articulation Test (PAT)		
Ages Covered	**Score Ranges/Percentages**	**Reported As**
3-0 through 8-11	85-115	• Standard Score • Age Equivalent Score

Overall Receptive/Expressive Language Skills: Standardized Tests

Clinical Evaluation of Language Fundamentals (CASL)		
Ages Covered	**Score Ranges/Percentages**	**Reported As**
3-21	85-115	• Receptive Language Index • Expressive Language Index
Note: Individual subtests are reported as scaled scores. Need to report "Index Scores" as noted above.		

Clinical Evaluation of Language Fundamentals (CELF-5)		
Ages Covered	**Score Ranges/Percentages**	**Reported As**

5-21 years	86 -114	• Core Language Score • Receptive Language • Expressive Language
Note: Individual subtests are reported as scaled scores. Need to report "Composite Scores" as listed above.		

Clinical Evaluation of Language Fundamentals Preschool (CELF-P)		
Ages Covered	**Score Ranges/Percentages**	**Reported As**
3-6 years	85-115	• Core Language score • Receptive Language Index • Expressive Language Index
Note: Individual subtests are reported as scaled scores. Need to report "Index Scores".		

Oral and Written Language Scales (OWLS)		
Ages Covered	**Score Ranges/Percentages**	**Reported As**
3-21 years	85-115	• Listening Comprehension • Oral Expression
Note: Provides age equivalent score for listening comprehension and oral expression.		

Preschool Language Scale-5 (PLS-5)		
Ages Covered	**Score Ranges/Percentages**	**Reported As**
0-7	85-115	• Total Language • Auditory Comprehension • Expressive Communication
Note: Provides age equivalent scores for both auditory comprehension and expressive communication.		

Test of Early Language Development-4 (TELD-4)		
Ages Covered	**Score Ranges/Percentages**	**Reported As**
3-7 years	85-115	• Receptive Language Index • Expressive Language Index
Note: Individual subtests are reported as scaled scores. Need to report "Index Scores" as noted above.		

Overall Receptive/Expressive Language Skills: Criterion Reference Tests

Functional Communication Profile		
Ages Covered	**Score Ranges/Percentages**	**Reported As**
3 years through adult	None provided	Only narrative information is provided and severity levels as: Mild, Moderate, Severe, Profound
Note: Yields an overall inventory of an individual's communication abilities, mode of communication (e.g., verbal, sign, nonverbal, augmentative), and degree of independence.		

Receptive-Expressive Emergent Language Test (REEL)		
Ages Covered	**Score Ranges/Percentages**	**Reported As**
0-3 years	90-110	• Receptive Language Ability Score • Expressive Language Ability Score
Note: Age equivalent scores are also provided for receptive and expressive language.		

Rosetti Infant Toddler Language Scales		
Ages Covered	**Score Ranges/Percentages**	**Reported As**
0-3 years	Not reported by Standard scores	Basal and Ceiling Age Equivalent scores for: • Interaction Attachment • Pragmatics • Gesture • Play • *Language Comprehension • *Language Expression
Note: Will list each basal and ceiling age equivalent as a range such as Basal 0-3 months; Ceiling 16-18 months. Only needed age equivalents are for language comprehension and language expression.		

Test of Early Communication and Emerging Language (TECEL)		
Ages Covered	**Score Ranges/Percentages**	**Reported As**
All Ages	90-110	Communicative Ability Index (Encompasses receptive and expressive language skills)
Note: A single age equivalent is provided for "Overall" receptive/expressive language skills.		

Pragmatic Language Skills: Standardized Tests

Clinical Assessment of Pragmatics (CAPS)		
Ages Covered	**Score Ranges/Percentages**	**Reported As**
7-0 through 18-0	85-115	Core Pragmatic Language Composite
Note: Individual subtests are reported as scaled scores. Need to report "Composite score" as noted above. There is no Age Equivalent score for this assessment.		

Test of Pragmatic Language (TOPL)		
Ages Covered	**Score Ranges/Percentages**	**Reported As**
6-0 through 18-11	85-115	• Pragmatic Language Usage • Index • Age Equivalent Score

TBI/Post Concussion/Cognition: Standardized Tests

Behavioral Assessment of the Dysexecutive Syndrome (BADS)		
Ages Covered	**Normal Range of Standard Scores**	**Reported As**
16-87	85-115	Standard Score

Cognitive Language Quick Test (CLQT)		
Ages Covered	**Score Ranges/Percentages**	**Reported As**
18-89	4.0-3.5=WNL	Composite Severity Rating of: WNL, Mild, Moderate, Severe

Functional Assessment of Verbal Reasoning and Executive Strategies (FAVRES)		
Ages Covered	**Score Ranges/Percentages**	**Reported As**
18-79	85-115	

		Three types of scores are gathered for each subtest: time, accuracy and reasons. • Plan an Event • Schedule a Work day • Decide on a Gift • Build a Case to Solve a Common Problem

Repeatable Battery for the Assessment of Neuropsychological Status (RBANS)		
Ages Covered	**Score Ranges/Percentages**	**Reported As**
12-89	85-115	• Overall Total Ability Score Or • Immediate Memory • Visuospatial/Constructional • Language • Attention • Delayed Memory
Note: Can provide total scale score or individual subtest scores.		

Scales of Cognitive Ability for Traumatic Brain Injury (SCATBI)		
Ages Covered	**Score Ranges/Percentages**	**Reported As**
15 and older	• 130 WNL • 115-130 Borderline • 110-115 Mild	Standard Score

Scales of Cognitive and Communication Abilities for Neurorehabilitation (SCCAN)		
Ages Covered	**Score Ranges/Percentages**	**Reported As**
18-91	Raw Score of 87-94	SCCAN Degree of Severity: Typical Functioning, Mild, Moderate, Severe

Ross Information Processing Assessment-2 or Geriatric		
Ages Covered	**Score Ranges/Percentages**	**Reported As**
15 and up	• 14-20 Mild: 90-100% • 11-13 Moderate: 60-90% • 8-10 Marked: 30-60%	***Subtests***: • Immediate Memory

	• 1-7 Severe: 0-30%	• Temporal Orientation (Recent Memory) • Temporal Orientation (Remote Memory) • Spatial Orientation • Orientation to Environment • Recall of General Information • Problem Solving • Abstract Reasoning; Organization • Auditory Processing • Retention
Note: Can be reported as percentages or standard score.		

Screening instruments used to verify deficits after traumatic brain injury (TBI) may be used as an additional/supplemental measure to quantify assessment but would not qualify as standardized testing independent of additional testing. The following list is *not* all inclusive:

- Mini mental state examination (Mini Mental)
- Montreal cognitive assessment (MoCA)
- St. Louis University mental status (SLUMS)
- Sport concussion assessment tool (SCAT)

Coding

See the Codes table for details.

SUPPLEMENTAL INFORMATION

The purpose of the following information is to provide reference material. Inclusion does not imply endorsement or alignment with the evidence review conclusions.

Practice Guidelines and Position Statements

Guidelines or position statements will be considered for inclusion in 'Supplemental Information' if they were issued by, or jointly by, a US professional society, an international society with US representation, or National Institute for Health and Care Excellence (NICE). Priority will be given to guidelines that are informed by a systematic review, include strength of evidence ratings, and include a description of management of conflict of interest.

Ongoing and Unpublished Clinical Trials

Some currently ongoing and unpublished trials that might influence this review can be located at clinicaltrials.gov.

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CODES

To report provider services, use appropriate CPT codes, HCPCS codes, Revenue codes, and/or ICD diagnosis codes.

Codes	Number	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, two or more individuals
HCPCS		
	S9152	Speech therapy, re-evaluation
Type of Service	Therapy	
Place of Service	Outpatient	

POLICY HISTORY

Date	Reason	Action
May 2025	Annual Review	Policy Renewed
May 2024	Annual Review	Policy Renewed
May 2023	Annual Review	Policy Revised
March 2022	Annual Review	Policy Revised
March 2021	Annual Review	Policy Revised
March 2020	Annual Review	Policy Revised
March 2019	Annual Review	Policy Revised
March 2018	Annual Review	Policy Revised
March 2017	Annual Review	Policy Revised

Date	Reason	Action
July 2016	Interim Review	Policy Revised
March 2016	Annual Review	Policy Revised
March 2015	Annual Review	Policy Revised
March 2014	Annual Review	Policy Revised
April 2013	Annual Review	Policy Renewed
August 2012	Interim Review	Policy Revised
June 2011	Annual Review	Policy Renewed

New information or technology that would be relevant for Wellmark to consider when this policy is next reviewed may be submitted to:

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