Medical Policy and InterQual® Criteria

Speech Therapy, Language Therapy, Voice Therapy, or Auditory Rehabilitation in the Outpatient Setting

Policy Number: OCA 3.551
Version Number: 22
Version Effective Date: 02/01/22

Product Applicability

☐ **All Plan+ Products**

WellSense Health Plan
☐ NH Medicaid
☐ NH Medicare Advantage

Boston Medical Center HealthNet Plan
☒ MassHealth ACO
☒ MassHealth MCO
☒ Qualified Health Plans/ConnectorCare/Employer Choice Direct
☒ Senior Care Options

+ Note: Disclaimer and audit information is located at the end of this document.

Policy Summary

The Plan considers speech therapy (speech and language therapy, swallowing therapy, feeding therapy, aural or auditory rehabilitation, and/or voice therapy) provided in the outpatient setting to be **medically necessary**, including habilitative services and/or rehabilitative services, when **InterQual® criteria** are met for an adult or pediatric member or are required **EPSDT services** for a member age 20 or younger on the date of service (when applicable). Speech therapy (ST) must be provided within the scope of practice of the treating provider and follow all applicable state licensing and supervisory requirements. Review the Plan's *Gender Affirmation Services* medical policy, policy number OCA 3.11, for Plan guidelines when voice therapy is used to treat gender dysphoria.

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Prior authorization is required according to the guidelines outlined below:

A. Prior authorization is NOT required for an initial evaluation conducted by a participating provider certified in rendering ST.

B. Prior authorization is REQUIRED for ANY of the following services:

    1. All services provided by participating speech therapist after the initial evaluation, including but not limited to re-evaluation of the established plan of care; OR

    2. All outpatient ST rendered by a speech therapist who is NOT a Plan participating provider (including an initial evaluation).

Clinical Criteria

Speech therapy in the outpatient setting is considered medically necessary, including habilitative services and/or rehabilitative services, when InterQual® criteria are met for an adult or pediatric member or are required EPSDT services for a member age 20 or younger on the date of service (when applicable).

Limitations and Exclusions

1. ANY of the services in items a through c is considered a Plan limitation for all BMC HealthNet Plan members:

    a. Maintenance ST that can be performed safely and effectively without the skilled assistance of a qualified therapist; OR

    b. Treatment plans that address a self-correcting dysfunction such as natural dysfluency or developmental articulation errors; OR

    c. The therapy replicates concurrent therapeutic services the member is receiving, including but is not limited to ANY of the circumstances listed in item (1) or item (2):

        (1) Speech-language therapeutic services replicated/already provided to the member in a different setting or program (e.g., component of home health care services); OR

        (2) Occupational therapy and/or any other type of service with similar treatment goals, plan of care, and therapeutic modalities for the member (e.g., component of home health care services).

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2. Guidelines Related to Qualified Health Plan, ConnectorCare, and Employer Choice Direct Members:

   ST is considered medically necessary for the treatment of Autism Spectrum Disorders and the limitations do NOT apply. See the Plan's *Autism Spectrum Disorders (ASD) Medical Diagnosis and Treatment* medical policy, policy number OCA 3.724, for additional information.

3. Plan Medical Director review is required when applicable medical necessity criteria are NOT met. The Plan Medical Director will evaluate the member's individual needs and circumstances, including the factors in items a through m to determine the medical necessity of therapeutic services:

   a. Chronological age; AND

   b. Symptoms specific to the member's deficits; AND

   c. How the member's deficits are impacting the member's quality of life; AND

   d. How therapeutic interventions would benefit the member (based on a formal treatment plan with objective and measurable goals specific to the member's deficit); AND

   e. Expected duration of therapy to meet the member's therapeutic treatment goals (with the duration consistent and reasonable when compared to professionally recognized standards of practice for the applicable therapeutic services); AND

   f. Review of past therapy, the member's progress with treatment, and an evaluation of results; AND

   g. A review of concurrent therapeutic treatment received (if applicable); AND

   h. Complications; AND

   i. Progression of the member's condition, illness, or injury; AND

   j. Comorbidities and relevant medical behavioral health/pharmacotherapy history; AND

   k. Psychosocial circumstances; AND

   l. Home environment; AND

   m. Other applicable environmental factors.

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Variations

The Plan uses guidance from the Centers for Medicare & Medicaid Services (CMS) for medical necessity and coverage determinations for Senior Care Options (SCO) members, including but not limited to national coverage determinations (NCDs), local coverage determinations (LCDs), local coverage articles (LCAs), and documentation included in Medicare manuals. At the time of the Plan's most recent policy review, NCD 170.3 and LCD L33580 includes guidelines related to speech therapy. Verify CMS guidelines in effect on the date of the prior authorization request. When there is no guidance from CMS for the requested service, Plan-adopted clinical review criteria will be used to determine the medical necessity of the service.

Applicable Coding

The Plan uses and adopts up-to-date Current Procedural Terminology (CPT) codes from the American Medical Association (AMA), International Statistical Classification of Diseases and Related Health Problems, 10th revision (ICD-10) diagnosis codes developed by the World Health Organization and adapted in the United Stated by the National Center for Health Statistics (NCHS) of the Centers for Disease Control under the U.S. Department of Health and Human Services, and the Health Care Common Procedure Coding System (HCPCS) established and maintained by the Centers for Medicare & Medicaid Services (CMS). Since the AMA, NCHS, and CMS may update codes more frequently or at different intervals than Plan policy updates, the list of applicable codes included in this Plan policy is for informational purposes only, may not be all inclusive, and is subject to change without prior notification. Whether a code is listed in the Applicable Coding section of this Plan policy does not constitute or imply member coverage or provider reimbursement. Providers are responsible for reporting all services using the most up-to-date industry-standard procedure and diagnosis codes as published by the AMA, NCHS, and CMS at the time of the service.

Providers are responsible for obtaining prior authorization for the services specified in the Clinical Criteria section and Limitations and Exclusions section of this Plan policy, even if an applicable code appropriately describing the service that is the subject of this Plan policy is not included in this Applicable Coding section of this Plan policy. Review the Plan's reimbursement policies for Plan billing guidelines. Coverage for services is subject to benefit eligibility under the member's benefit plan. Member benefit documents are available at www.bmchp.org for BMC HealthNet Plan members and at www.SeniorsGetMore.org for Senior Care Options members.

At the time of this policy's last annual review, per 130 CMR 432.412, 130 CMR 413.417 and 130 CMR 430.601(A)(10), MassHealth does not pay a therapist for services provided by a person under the therapist's supervision. This includes services by therapy assistants. **Services furnished in whole or in part by a speech-language pathology assistant or aide are NOT payable by the Plan** according to the guidelines stated in the Plan's applicable reimbursement policies. It is recommended that providers verify the Plan's payment guidelines in effective on the date of service for the requested therapy and the type of provider rendering the service(s).

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CPT Codes	Description: Codes Covered When Medically Necessary
92507	Treatment of speech, language, voice, communication, and/or auditory processing disorder; individual Plan note: This code is used for individual treatment after the initial evaluation.
92508	Treatment of speech, language, voice, communication, and/or auditory processing disorder; group, two or more individuals Plan note: This code is used for group treatment after the initial evaluation.
92526	Treatment of swallowing dysfunction and/or oral function for feeding Plan note: This code is used for treatment after the initial evaluation.
92630	Auditory rehabilitation; prelingual hearing loss Plan note: This code may be used when billing for treatment after the initial evaluation with a BMC HealthNet Plan member (excluding a Senior Care Options member).
92633	Auditory rehabilitation; postlingual hearing loss Plan note: This code may be used when billing for treatment after the initial evaluation with a BMC HealthNet Plan member (excluding a Senior Care Options member).
97129	Therapeutic interventions that focus on cognitive function (e.g., attention, memory, reasoning, executive function, problem solving, and/or pragmatic functioning) and compensatory strategies to manage the performance of an activity (e.g., managing time or schedules, initiating, organizing, and sequencing tasks), direct (one-on-one) patient contact; initial 15 minutes
97130	Therapeutic interventions that focus on cognitive function (e.g., attention, memory, reasoning, executive function, problem solving, and/or pragmatic functioning) and compensatory strategies to manage the performance of an activity (e.g., managing time or schedules, initiating, organizing, and sequencing tasks), direct (one-on-one) patient contact; each additional 15 minutes (List separately in addition to code for primary procedure)

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Policy History

Original Approval Date	Original Effective Date* and Version Number	Policy Owner	Original Policy Approved by

Regulatory Approval: N/A Internal Approval: 03/16/11: Medical Policy, Criteria, and Technology Assessment Committee (MPCTAC) 04/27/11: Quality Improvement Committee (QIC)	07/01/11 Version 1	Medical Policy Manager as Chair of MPCTAC	MPCTAC and QIC

*Effective Date for the BMC HealthNet Plan Commercial Product: 01/01/12
*Effective Date for the Senior Care Options Product: 01/01/16
* Effective Date for the BMC HealthNet Plan Commercial Product: 01/01/12.
* Effective Date for the WellSense New Hampshire Medicaid Product: 01/01/13 to 01/10/15 (until separate medical policies were developed for the WellSense New Hampshire Medicaid product effective 01/11/15, policy number OCA 3.542, for *Speech Therapy, Language Therapy, Voice Therapy, or Auditory Rehabilitation for a Member 21 Years of Age or Older in the Outpatient Setting* for WellSense New Hampshire Medicaid product).
* Policy title changed from *Speech Therapy, Language Therapy, Voice Therapy, or Auditory Rehabilitation for a Member Age 22 or Older in the Outpatient Setting* to the following effective 04/01/17: *Speech Therapy, Language Therapy, Voice Therapy, or Auditory Rehabilitation for a Member Age 21 or Older in the Outpatient Setting.* Policy title changed to *Speech Therapy, Language Therapy, Voice Therapy, or Auditory Rehabilitation in the Outpatient Setting* as of 02/01/22 to include adult and pediatric members.

Policy Revisions History

Review Date	Summary of Revisions	Revision Effective Date and Version Number	Approved by
03/19/12	Updated references.	Version 2	03/21/12: MPCTAC 04/25/12: QIC
08/01/12	Off cycle review. Revised Summary statement, reformatted Medical Policy Statement, revised Applicable Coding introductory paragraph, updated code list, revised Limitations, and updated references.	Version 3	08/13/12: MPCTAC 09/06/12: QIC
11/01/12	Review for effective date 03/01/13. Updated references. Revised title so policy applies to members age 22 or older (rather than members over the age of 21). Added language in Summary section to clarify text. Referenced Plan reimbursement policy 4.609 for therapy reimbursement guidelines. Reorganized clinical criteria in Medical Policy Statement section and referenced InterQual® criteria. Revised applicable code list.	03/01/13 Version 4	11/21/12: MPCTAC 12/20/12: QIC

Policy Revisions History			
08/14/13 and 08/15/13	Off cycle review. Incorporate policy revisions dated 11/01/12 (as specified above) for the Well Sense Health Plan product; these policy revisions were approved by MPCTAC on 11/21/12 and QIC on 12/20/12 for applicable Plan products. Additional review of policy conducted.		08/14/13: MPCTAC (via electronic vote) 08/15/13: QIC
11/01/13, 12/01/13, 01/01/14, and 02/01/14	Review for effective date 05/01/14. Revised Applicable Coding section by updating code definitions and Plan notes, introductory paragraph, and applicable codes for the BMC HealthNet Plan products and the Well Sense product. Reformatted Limitations section without changing criteria. Updated references.	05/01/14 Version 5	02/11/14: MPCTAC 02/18/14: QIC
10/01/14 and 11/19/14	Review for effective date 01/11/15. Policy reformatted to include BMC HealthNet Plan products only. References and Summary sections updated. Revised review calendar.	01/11/15 Version 6	10/15/14: MPCTAC 11/12/14: QIC 11/19/14: MPCTAC 12/10/14: QIC
11/25/15	Review for effective date 01/01/16. Updated template with list of applicable products and notes. Administrative changes made to the Medical Policy Statement section and Limitations section without changing criteria. Updated Summary section. Revised language in the Applicable Coding section.	01/01/16 Version 7	11/18/15: MPCTAC 11/25/15: MPCTAC (electronic vote) 12/09/15: QIC
12/01/15	Review for effective date 02/01/16. Clarified text in the Medical Policy and Limitations section without changing criteria. Updated the Summary and Definitions sections.	02/01/16 Version 8	12/16/15: MPCTAC 01/13/16: QIC
12/01/16	Review for effective date 04/01/17. Updated Summary, Clinical Background Information, References, and Reference to Applicable Laws and Regulations sections. Plan notes added to applicable codes. Revised title and policy guidelines to apply to members 21 years of age or older on the date of service.	04/01/17 Version 9	12/21/16: MPCTAC 01/11/17: QIC
05/01/17	Review for effective date 08/01/17. Removed CPT code 92524 from the applicable code list because it is an initial evaluation code for voice and resonance.	08/01/17 Version 10	05/17/17: MPCTAC
12/01/17	Review for effective date 01/01/18. Industry-wide updates to codes included in the Applicable Coding section. Annual review of	01/01/18 Version 11	12/20/17: MPCTAC

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Policy Revisions History			
	policy with administrative changes made to the Definitions and References sections.		
11/01/18	Review for effective date 02/01/19. Administrative changes made to the Limitations, Definitions, References, Other Applicable Policies, and Reference to Applicable Laws and Regulations sections. Updated the applicable code list.	02/01/19 Version 12	11/21/18: MPCTAC
07/01/19	Review for effective date 08/01/19. Updated Plan note in the Applicable Coding section to be consistent with the Plan's reimbursement guidelines.	08/01/19 Version 13	07/17/19: MPCTAC
12/01/19	Review for effective date 01/01/20. Industry-wide update to coding (as a code deletion) included in the Applicable Coding section.	01/01/20 Version 14	Not applicable because industry-wide code changes
11/01/19	Review for effective date 02/01/20. Administrative changes made to the Policy Summary, References, and Reference to Applicable Laws and Regulations sections. Criteria revised in the Medical Policy Statement and Limitations sections.	02/01/20 Version 15 Renumbered to version 15 to implement industry-wide code updates effective 01/01/20 included in version 14	11/20/19: MPCTAC
12/01/19	Review for effective 02/01/20. Industry-wide update to coding effective 01/01/20 included in the Applicable Coding section of the policy version 11 effective 02/01/20.	02/01/20 Version 16	Not applicable because industry-wide code changes
03/01/20	Review for effective date 06/01/20. Criteria revised in the Medical Policy Statement and Limitations sections. Administrative changes made to the Policy Summary, Description of Item or Service, and Reference to Applicable Laws and Regulations sections.	06/01/20 Version 17	03/12/20: MPCTAC (electronic vote)
09/01/20	Review for effective date 12/01/20. Administrative changes made to the Policy Summary and Other Applicable Policies sections. Criteria revised in the Medical Policy Statement and Limitations sections.	12/01/20 Version 18	09/16/20: MPCTAC
11/01/20	Review for effective date 02/01/21. Administrative changes made to the Policy Summary, Description of Item or Service,	02/01/21 Version 19	11/18/20: MPCTAC

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Policy Revisions History			
	Definitions, Applicable Coding, References, and Reference to Applicable Laws and Regulations sections. Revised criteria in the Medical Policy Statement section.		
05/01/21	Review for effective date 08/01/21. Administrative changes made to the Policy Summary, Medical Policy Statement, Limitations, Definitions, and References sections. Codes added to the Applicable Coding section.	08/21/21 Version 20	05/19/21: MPCTAC
10/01/21	Review for effective date 01/01/22 Adopted new medical policy template; removed administrative sections, Medical Policy Statement section renamed Clinical Criteria section, and Limitations section renamed Limitations and Exclusions section. Administrative changes made to the Policy Summary, Limitations and Exclusions, and Applicable Coding sections. Added gender dysphoria as a medically necessary indication for voice therapy in the Criteria section.	01/01/22 Version 21	10/01/21: MPCTAC
11/01/21	Review for effective date 02/01/22. Administrative changes made to the Policy Summary and References section. Revised policy title because policy will apply to adult and pediatric members. Adopted InterQual criteria to determine medical necessity and retired medical policy criteria. Gender dysphoria specified as a medically necessary indication for voice therapy in the *Gender Affirmation Services* medical policy, OCA 3.11, as of 01/01/22.	02/01/22 Version 22	11/17/21: MPCTAC

Next Review Date

11/01/22

Authorizing Entity

MPCTAC

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Disclaimer Information: +

Medical Policies are the Plan's guidelines for determining the medical necessity of certain services or supplies for purposes of determining coverage. These Policies may also describe when a service or supply is considered experimental or investigational, or cosmetic. In making coverage decisions, the Plan uses these guidelines and other Plan Policies, as well as the Member's benefit document, and when appropriate, coordinates with the Member's health care Providers to consider the individual Member's health care needs.

Plan Policies are developed in accordance with applicable state and federal laws and regulations, and accrediting organization standards (including NCQA). Medical Policies are also developed, as appropriate, with consideration of the medical necessity definitions in various Plan products, review of current literature, consultation with practicing Providers in the Plan's service area who are medical experts in the particular field, and adherence to FDA and other government agency policies. Applicable state or federal mandates, as well as the Member's benefit document, take precedence over these guidelines. Policies are reviewed and updated on an annual basis, or more frequently as needed. Treating providers are solely responsible for the medical advice and treatment of Members.

The use of this Policy is neither a guarantee of payment nor a final prediction of how a specific claim(s) will be adjudicated. Reimbursement is based on many factors, including member eligibility and benefits on the date of service; medical necessity; utilization management guidelines (when applicable); coordination of benefits; adherence with applicable Plan policies and procedures; clinical coding criteria; claim editing logic; and the applicable Plan – Provider agreement.

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