Cohere Medical Policy - Outpatient Speech Therapy

Clinical Policy for Medical Necessity Review

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Important Notices

Notices & Disclaimers:

GUIDELINES ARE SOLELY FOR COHERE'S USE IN PERFORMING MEDICAL NECESSITY REVIEWS AND ARE NOT INTENDED TO INFORM OR ALTER CLINICAL DECISION-MAKING OF END USERS.

Cohere Health, Inc. ("**Cohere**") has published these clinical guidelines to determine the medical necessity of services (the "**Guidelines**") for informational purposes only, and solely for use by Cohere's authorized "**End Users**". These Guidelines (and any attachments or linked third-party content) are not intended to be a substitute for medical advice, diagnosis, or treatment directed by an appropriately licensed healthcare professional. These Guidelines are not in any way intended to support clinical decision-making of any kind; their sole purpose and intended use is to summarize certain criteria Cohere may use when reviewing the medical necessity of any service requests submitted to Cohere by End Users. Always seek the advice of a qualified healthcare professional regarding any medical questions, treatment decisions, or other clinical guidance. The Guidelines, including any attachments or linked content, are subject to change at any time without notice.

Other Notices:

Fee schedules, relative value units, conversion factors and/or related components are not assigned by the AMA, are not part of CPT, and the AMA is not recommending their use. The AMA does not directly or indirectly practice medicine or dispense medical services. The AMA assumes no liability for data contained or not contained herein.

Policy Information:

Specialty Area: Speech Language Pathology
Policy Name: Cohere Medical Policy - Outpatient Speech Therapy
Type: [**X**] Adult (18+ yo) | [**X**] Pediatric (0-17 yo)

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Medical Necessity Criteria

Service: Outpatient Speech Therapy

Cohere Health takes an evidence-based approach to reviewing speech-language procedure requests, meaning that sufficient clinical information must be provided at the time of submission to determine medical necessity. Documentation must include a recent and detailed history, physical examination related to the onset or change in symptoms, relevant lab results, prior imaging, and details of previous treatments. Speech-language procedures should be requested after a clinical evaluation by the treating provider, which may include referral to a specialist.

- When a specific clinical indication is not explicitly addressed in the Cohere Health medical policy, medical necessity will be determined based on established clinical best practices, as supported by evidence-based literature, peer-reviewed sources, professional society guidelines, and state or national recommendations unless otherwise directed by the health plan.
- Requests submitted without clinical documentation, or those that do not align with the provided clinical information—such as mismatched procedure, laterality, body part, or CPT code—may be denied for lack of medical necessity due to insufficient or inconsistent clinical information.
- When there are multiple procedures requested simultaneously or within the past 3 months, each will be reviewed independently. Clinical documentation must clearly justify all of the following:
  - The medical necessity of each individual request
  - Why prior imaging or procedures were inconclusive, or why additional/follow-up studies are needed
  - How the results will impact patient management or treatment decisions.

Description

Treatment requires the judgment, knowledge, and skills of a licensed and certified speech-language pathologist who meets generally accepted standards of practice and is targeted and effective in treating the individual's diagnosed impairment or condition. Treatment is expected to produce clinically significant and measurable improvement in the member's functioning within a medically reasonable period; alternatively, the treatment is part of a medically necessary program to prevent significant functional regression.

Medical Necessity Criteria

Indications

Outpatient speech therapy is considered appropriate if **ALL** of the following are **TRUE**:

- Speech therapy services are provided by a licensed and appropriately credentialed speech/language professional acting within the applicable scope of practice for the jurisdiction where services are provided, allowing for care rendered under the direct supervision of an ancillary speech/language pathologist as permitted under state law(s); **AND**
- The amount, frequency, and duration of treatments are appropriate for the patient and diagnosis[1]; **AND**
- The patient has **ANY** of the following conditions:
  - Aphasia[1-6]; **OR**
  - Acquired apraxia[7]; **OR**
  - Cognitive-communication disorders; **OR**
  - Developmental language or speech disorders[A]; **OR**
  - Dysarthria[8]; **OR**
  - Dysphagia[9]; **OR**
  - Voice disorders[B]; **OR**
  - Organic voice disorders[C]; **AND**
- The plan of care (POC) documents **ALL** of the following:
  - The patient is compliant and active in therapy; **AND**
  - Objective measures demonstrate the necessity for a course of therapy; **AND**
  - Short and/or long-term treatment goals; **AND**

    - Reasonable expectation of recovery or improvement in function to support onset or continuation of treatment; **AND**
- Treatment is for **ANY** of the following services:
    - Initial evaluation or screening; **OR**
    - The patient is already receiving therapy and requires re-evaluation with **ALL** of the following:
        - Documentation supports the need for further tests and measurements after the initial evaluation; **AND**
        - Indications for a re-evaluation include **ANY** of the following new clinical findings:
            - A significant change in the patient's condition; **OR**
            - Failure to respond to the therapeutic interventions outlined in the plan of care; **OR**
    - Therapeutic services related to the use of a non-speech generating device (SGD) for **ANY** of the following:
        - Programming of a device; **OR**
        - Modification of a device; **OR**
        - Services for a patient who is non-verbal or does not have the capacity for verbal communication; **OR**
        - Development of operational competence in using an SGD or aids (e.g., customizing features of the device to meet specific communication needs); **OR**
    - Auditory rehabilitation following cochlear implant (including hearing and therapeutic services with or without speech processor programming performed by an audiologist) with **ANY** of the following:
        - Extensive auditory rehabilitation therapy that focuses on audition, cognition, language, and speech skills (including suprasegmental aspects) to improve the patient’s ability to discriminate and exhibit improvements in speech (e.g., manner, place, and voicing); **OR**
        - Family member or caregiver training for auditory-verbal techniques.

Non-Indications

Outpatient speech therapy is not considered appropriate if **ANY** of the following is **TRUE**[1]:

- Non-diagnostic, non-therapeutic, routine, repetitive, and reinforcing procedures of previously learned material (e.g., practicing word drills without skilled feedback); **OR**
- Procedures which may be effectively carried out with the individual by a non-professional (e.g., family, restorative aide) after instruction is completed; **OR**
- Services for chronic disorders of memory and orientation without significant functional progress; **OR**
- Supervision of the use of memory aids (e.g., memory books, memory boards, or communication books); **OR**
- Therapy for which there is no clinical documentation or POC to support the need for speech language pathologist (SLP) services or continuing therapy; **OR**
- Unsupervised services provided by a non-licensed SLP (e.g., SLP assistant or aide when not under direct supervision); **OR**
- Laryngoscopy for medical diagnostic purposes performed by a non-physician; **OR**
- Group therapy sessions; **OR**
- Services and treatment for **ANY** of the following disorders:
  - Fluency disorder; **OR**
  - Conceptual handicap; **OR**
  - Dysprosody; **OR**
  - Stuttering and cluttering (except neurogenic stuttering caused by acquired brain damage); **OR**
  - Myofunctional disorders (e.g., tongue thrust).

Definitions

[A]**Developmental language or speech disorder** – Characterized by impaired articulation of speech sounds, fluency, or voice, or impaired comprehension and/or use of spoken, written and/or other symbol systems (e.g., the form of language [phonology, morphology, syntax], the content of language [semantics], and/or the function of language in communication [pragmatics] in any combination).[10,11]

[B]**Voice disorder** – Characterized by alterations in respiratory, laryngeal, or vocal tract mechanisms, or has resulted from inefficient use of the vocal mechanism when the physical structure is normal (e.g., vocal fatigue, muscle tension dysphonia or aphonia, diplophonia, or ventricular phonation).[10,11]

[C]**Organic voice disorder** – Characterized by physical changes in the vocal mechanism, such as alterations in vocal fold tissues (e.g., edema or vocal nodules) and/or structural changes due to aging or problems with the central or peripheral nervous system innervation to the larynx that affect the functioning of the vocal mechanism (e.g., vocal tremor, spasmodic dysphonia, or vocal fold paralysis).[12]

Level of Care Criteria

Outpatient

Procedure Codes (CPT/HCPCS)

CPT/HCPCS Code	Code Description
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, 2 or more individuals
92520	Laryngeal function studies (i.e., aerodynamic testing and acoustic testing)
92521	Evaluation of speech fluency (e.g., stuttering, cluttering)
92522	Evaluation of speech sound production (e.g., articulation, phonological process, apraxia, dysarthria)
92523	Evaluation of speech sound production (e.g., articulation, phonological process, apraxia, dysarthria); with evaluation of language comprehension and expression (e.g., receptive and expressive language)
92524	Behavioral and qualitative analysis of voice and resonance
92526	Treatment of swallowing dysfunction and/or oral function for feeding
92606	Therapeutic service(s) for the use of non-speech-generating device, including programming and modification

92609	Therapeutic services for the use of speech-generating device, including programming and modification
92610	Evaluation of oral and pharyngeal swallowing function
92611	Motion fluoroscopic evaluation of swallowing function by cine or video-recording
92630	Auditory rehabilitation; prelingual hearing loss
92633	Auditory rehabilitation; postlingual hearing loss
96105	Assessment of aphasia (includes assessment of expressive and receptive speech and language function, language comprehension, speech production ability, reading, spelling, writing, e.g., by Boston Diagnostic Aphasia Examination) with interpretation and report, per hour
97039	Unlisted modality (specify type and time if constant attendance)
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)
97139	Unlisted therapeutic procedure (specify)
97150	Therapeutic procedure(s), group (2 or more individuals)
S9152	Speech therapy, re-evaluation
V5362	Speech screening
V5363	Language screening
V5364	Dysphagia screening

Medical Evidence

Sackley et al. (2024) performed a randomized controlled trial to evaluate the effectiveness of two speech and language therapy (SLT) approaches—Lee Silverman Voice Treatment (LSVT LOUD) and routine NHS SLT— compared with no therapy for dysarthria in Parkinson's disease. A total of 388 participants with Parkinson's-related dysarthria were randomized in a 1:1:1 ratio. LSVT LOUD involved four 50-minute sessions per week for 4 weeks, supplemented by daily home practice. NHS SLT dosage and methods were therapist-determined and generally lower in intensity. The primary outcome was patient-reported Voice Handicap Index (VHI) score at 3 months, with follow-up at 6 and 12 months. At 3 months, the LSVT LOUD group reported significantly better outcomes, and NHS SLT showed no evidence of improvement compared with no therapy. Secondary outcomes also favored LSVT LOUD, with benefits in VHI emotional and functional subscales, communication-related quality of life, and dysarthria-specific measures, sustained over 12 months. Adverse events, mostly mild vocal strain, were more common with LSVT LOUD but were transient and manageable. The study concluded that LSVT LOUD is superior to both NHS SLT and no therapy in reducing the impact of dysarthria in Parkinson's disease.[13]

Research on speech-language therapy for children with developmental disabilities shows significant improvements in language ability, speech production, self-esteem, and social skills. One systematic literature review, conducted by Osman et al. (2023), found that effective communication, cognitive ability, and social skills increased in individuals with autism spectrum disorder (ASD) who underwent early initiation of speech therapy.[14] Another systematic review and meta-analysis (Sand et al. [2023]) in individuals born with a cleft palate found that speech production and self-reported outcomes improved with speech therapy, especially among younger children.[15] These studies underscore the importance of early intervention of speech therapy for individuals with developmental disabilities.

Breitenstein et al. (2017) conducted a randomized controlled trial to determine the effect of intensive speech and language therapy in adults with chronic aphasia after stroke. Across rehabilitation centers in Germany, adults younger than 70 years of age with persistent aphasia greater than or equal to 6 months post-stroke were randomized into an intervention or a waiting list group. Participants had at least 10 hours of intensive speech and language therapy for 3 weeks, with a language test as the primary outcome. Overall, the intervention group showed greater improvements in the language test, as well as in linguistic abilities, and improved psychosocial quality of life, compared with the waitlisted group. The authors concluded that 3 weeks of intensive speech and language therapy under routine clinical conditions significantly enhances everyday communication in chronic aphasia. These findings challenge the long-held assumption that language recovery is limited in the chronic stage post-stroke.[16]

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Policy Revision History/Information

Original Date: September 19, 2024		
Review History		
Version 2	05/01/2025	Restructured policy to align with the Medicare policy. Condensed sub-bullets for symptoms and services. Expanded indication for provider licensing requirements. Added indications for: "Therapeutic services related to the use of a non-speech-generating device;" and "Auditory rehabilitation following a cochlear implant." Added Definitions section (restorative/ rehabilitative therapy, maintenance therapy, maintenance program, and re-evaluation).
Version 3	10/16/2025	Annual review. Added CPT 92610, 92611, 92521, 92522, 92523, 92524, and 96105. Added indications for plan of care (POC). Restructured indication formatting: initial and repeat evaluation sections now require that POC criteria are met. Modified indications for usability. Updated Definitions section. Updated Medical Evidence section.