

Local Coverage Determination (LCD): Speech-Language Pathology (L33580)

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Contractor Information

CONTRACTOR NAME	CONTRACT TYPE	CONTRACT NUMBER	JURISDICTION	STATE(S)
National Government Services, Inc.	MAC - Part A	06101 - MAC A	J - 06	Illinois
National Government Services, Inc.	MAC - Part B	06102 - MAC B	J - 06	Illinois
National Government Services, Inc.	MAC - Part A	06201 - MAC A	J - 06	Minnesota
National Government Services, Inc.	MAC - Part B	06202 - MAC B	J - 06	Minnesota
National Government Services, Inc.	MAC - Part A	06301 - MAC A	J - 06	Wisconsin
National Government Services, Inc.	MAC - Part B	06302 - MAC B	J - 06	Wisconsin
National Government Services, Inc.	A and B and HHH MAC	13101 - MAC A	J - K	Connecticut
National Government Services, Inc.	A and B and HHH MAC	13102 - MAC B	J - K	Connecticut
National Government Services, Inc.	A and B and HHH MAC	13201 - MAC A	J - K	New York - Entire State
National Government Services, Inc.	A and B and HHH MAC	13202 - MAC B	J - K	New York - Downstate
National Government Services, Inc.	A and B and HHH MAC	13282 - MAC B	J - K	New York - Upstate
National Government Services, Inc.	A and B and HHH MAC	13292 - MAC B	J - K	New York - Queens
National Government Services, Inc.	A and B and HHH MAC	14111 - MAC A	J - K	Maine
National Government Services, Inc.	A and B and HHH MAC	14112 - MAC B	J - K	Maine
National Government Services, Inc.	A and B and HHH MAC	14211 - MAC A	J - K	Massachusetts
National Government Services, Inc.	A and B and HHH MAC	14212 - MAC B	J - K	Massachusetts

CONTRACTOR NAME	CONTRACT TYPE	CONTRACT NUMBER	JURISDICTION	STATE(S)
Inc.	MAC			
National Government Services, Inc.	A and B and HHH MAC	14311 - MAC A	J - K	New Hampshire
National Government Services, Inc.	A and B and HHH MAC	14312 - MAC B	J - K	New Hampshire
National Government Services, Inc.	A and B and HHH MAC	14411 - MAC A	J - K	Rhode Island
National Government Services, Inc.	A and B and HHH MAC	14412 - MAC B	J - K	Rhode Island
National Government Services, Inc.	A and B and HHH MAC	14511 - MAC A	J - K	Vermont
National Government Services, Inc.	A and B and HHH MAC	14512 - MAC B	J - K	Vermont

LCD Information

Document Information

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L33580

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For services performed on or after 10/01/2015

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Speech-Language Pathology

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DL33580

Retirement Date

N/A

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Notice Period Start Date

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N/A

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CMS National Coverage Policy

Language quoted from Centers for Medicare and Medicaid Services (CMS), National Coverage Determinations (NCDs) and coverage provisions in interpretive manuals is italicized throughout the policy. NCDs and coverage provisions in interpretive manuals are not subject to the Local Coverage Determination (LCD) Review Process (42 CFR 405.860[b] and 42 CFR 426 [Subpart D]). In addition, an administrative law judge may not review an NCD. See Section 1869(f)(1)(A)(i) of the Social Security Act.

Unless otherwise specified, *italicized* text represents quotation from one or more of the following CMS sources:

Title XVIII of the Social Security Act (SSA):

Section 1833(e) of Title XVIII of the Social Security Act prohibits Medicare payment for any claim which lacks the necessary information to process the claim.

Section 1835(2)(D) of Title XVIII of the Social Security Act lists requirements for certification and recertification of outpatient speech-language pathology services.

Section 1862(a)(1)(A) of Title XVIII of the Social Security Act excludes expenses incurred for items or services which are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member.

Section 1862(a)(7) excludes routine physical examinations, unless otherwise covered by statute.

Code of Federal Regulations:

42 CFR, Section 410.61 describes plan of treatment requirements.

42 CFR, Section 410.62 describes outpatient speech-language pathology services: Conditions and exclusions for Outpatient Speech Language Pathology (SLP).

42 CFR, Section 485.705 describes personnel qualifications.

CMS Publications:

CMS Publication 100-02, *Medicare Benefit Policy Manual*, Chapter 12:

40.4 Speech-language pathology services

CMS Publication 100-02, *Medicare Benefit Policy Manual*, Chapter 15:

220 Coverage of outpatient rehabilitation therapy services (physical therapy, occupational therapy, and speech-language pathology services) under medical insurance

220.1 Conditions of coverage and payment for outpatient physical therapy, occupational therapy, or speech-language pathology services

220.1.1 Outpatient therapy must be under the care of a physician/nonphysician practitioners (NPP) (orders/referrals and need for care)

220.1.3 Certification and recertification of need for treatment and therapy plans of care

220.1.4 Requirement that services be furnished on an outpatient basis

230.3 Practice of speech-language pathology

230.6 Therapy services furnished under arrangements with providers and clinics

CMS Publication 100-03, *Medicare National Coverage Determinations (NCD) Manual*, Part 1:

50.2 Electronic speech aids

CMS Pub. 100-03, *Medicare National Coverage Determinations (NCD) Manual*, Part 3:

170.2 Melodic intonation therapy

CMS Pub. 100-04, *Medicare Claims Processing Manual*, Chapter 5:

10.2 Financial limitation

20 HCPCS coding requirement

CMS Pub. 100-04, *Medicare Claims Processing Manual*, Chapter 6,

10.3 Types of services subject to the consolidated billing requirement for SNFs

CMS Transmittal No. 179, Publication 100-02, *Medicare Benefit Policy Manual*, Change Request #8458, January 14, 2014, provides revised portions of the relevant chapters of the program manual used by Medicare contractors, in order to clarify that coverage of skilled nursing and skilled therapy services "...does not turn on the presence or absence of a beneficiary's potential for improvement, but rather on the beneficiary's need for skilled care." Skilled care may be necessary to improve a patient's current condition, to maintain the patient's current condition, or to prevent or slow further deterioration of the patient's condition based on the Jimmo v. Sebelius Settlement Agreement.

CMS Transmittal No. 4149, Publication 100-04, *Medicare Claims Processing Manual*, October 23, 2018, removes Functional Reporting requirements and edits for outpatient therapy services.

CMS Transmittal No. 111, Publication 100-02, *Medicare Benefit Policy Manual*, Change Request #6005, September 25, 2009, advises that speech-language pathology therapy services are covered CORF services if physical therapy services are the predominate rehabilitation services.

CMS Transmittal No. 106, Publication 100-02, *Medicare Benefit Policy Manual*, Change Request #6381, April 24, 2009, advises that enrolled speech-language pathologists may bill for services provided on or after July 1, 2009.

CMS Transmittal No. 1717, Publication 100-04, *Medicare Claims Processing Manual*, Change Request #6381, April 24, 2009, advises that enrolled speech-language pathologists may bill for services provided on or after July 1, 2009.

CMS Transmittal No. 88, Publication 100-02, *Medicare Benefit Policy Manual*, Change Request #5921, May 7, 2008, Therapy Personnel Qualifications and Policies Effective January 1, 2008.

Coverage Guidance

Coverage Indications, Limitations, and/or Medical Necessity

Abstract:

This Local Coverage Determination (LCD) describes the coverage and limits of coverage for speech and language pathology therapy services when billed to either the Medicare Part A or Part B. This LCD shall not be construed to expand coverage to services defined as non-covered by National Coverage Determinations (NCDs).

Definitions:

Rehabilitative therapy includes services designed to address recovery or improvement in function and, when possible, restoration to a previous level of health and well-being. (CMS Publication 100-02, *Medicare Benefit Policy Manual*, Chapter 15, Section 220.2(C)) and 220.3

MAINTENANCE PROGRAM (MP) means a program established by a therapist that consists of activities and/or mechanisms that will assist a beneficiary in maximizing or maintaining the progress he or she has made during therapy or to prevent or slow further deterioration due to a disease or illness. (CMS Publication 100-02, *Medicare Benefit Policy Manual*, Chapter 15, Section 220 (A))

Indications:

Speech-language pathology services may be considered reasonable and necessary when the criteria in this LCD, as well as the National Coverage provisions listed in the related Billing and Coding Article, are met. (Please refer the Billing and Coding Article A52866)

Evaluation of Language Disorders:

The order or referral for the evaluation and any specific testing in areas of concern should be designated by the referring physician in consultation with an SLP. The physician's certification of the need for care (e.g., approval of the plan of care) may substitute for the order. The documentation of the evaluation or re-evaluation by the SLP should demonstrate that an actual hands-on assessment occurred to support the medical necessity for reimbursement of the evaluation or re-evaluation. The documentation should differentiate between evaluation or re-evaluation and screening. Screening assessments are noncovered and should not be billed. The initial screening assessments of patients or regular routine reassessments of patients are not covered. Evaluations in the absence of signs and symptoms are not covered.

The evaluation should include the beneficiary's history and the onset or exacerbation date of the current disorder. The history in conjunction with the current symptoms must establish support for additional treatment. Prior level of functioning should be documented, as well as current baseline abilities, to establish the basis for the therapeutic interventions. Evaluations must include the plan, goals (realistic, long-term, functional, communication goals) duration of therapy, frequency of therapy, and definition of the type of service. Diagnostic and assessment testing services to ascertain the type, causal factor(s) and severity of speech and language disorders, should be identified during the evaluation.

For information on Re-evaluations please refer to the related Billing and Coding Article.

Documentation is expected to support the ability of the beneficiary to learn and retain instruction. Absence of such documentation may result in a denial of services. If the patient has questionable cognitive skills, a brief cognitive-communication assessment should be performed in order to establish the patient's learning ability. The brief cognitive assessment may also determine the need for more comprehensive cognitive performance testing.

For additional information on Medicare requirements for PT, OT, and Speech-Language Pathology evaluation and re-evaluation of services see CMS Publication 100-02, *Medicare Benefit Policy Manual*, Chapter 15, Section 220.

Skilled Procedures and Modalities:

Skilled procedures include:

- Design of a treatment program addressing the beneficiary's disorder. Continued assessment and analysis during the implementation of the services is expected at regular intervals.
- Establishment of compensatory skills for communication (e.g., air injection techniques or word finding)

strategies).

- Establishment of a hierarchy of speech-language tasks and cueing that directs a beneficiary toward communication goals.
- Analysis of actual progress toward goals.
- Establishment of treatment goals specific to speech dysfunction and designed to specifically address each problem identified in initial assessment.
- The selection and initial training of a device for augmentative or alternative communication systems.
- Patient and family training to augment restorative treatment or to establish a maintenance program. Education of staff and family must begin at the time of evaluation.

Documentation is expected to support the ability of the beneficiary to learn and retain instruction. Absence of such documentation may result in a denial of services. If the patient has questionable cognitive skills, a brief cognitive-communication assessment should be performed in order to establish the patient's learning ability. The brief cognitive assessment may also determine the need for more comprehensive cognitive performance testing.

Aural Rehabilitation:

Coverage for speech reading is only allowed with documentation that supports a loss of hearing sensitivity that cannot be corrected with a hearing aid or amplification. Documentation should also support visual acuity of the beneficiary sufficient to participate in aural rehabilitation.

Speech reading is considered medically necessary when determined by a licensed audiologist that the use of a hearing aid or other amplification would not significantly improve the beneficiary's understanding of speech. Speech reading training is not medically necessary for beneficiaries who refuse to wear a hearing aid. Routine screening for hearing acuity or evaluations aimed at the use of hearing aids is not a covered service.

Determination of the medical necessity for the speech reading will be based on the following criteria:

- Documentation of basic hearing evaluation and audiogram;
- Documentation identifying type and extent of hearing loss;
- Documentation of adequate cognitive and memory skills;
- Documentation that visual acuity, with glasses if applicable, is sufficient to allow the beneficiary to participate in the therapy;
- Documentation of the beneficiary's motivation to participate in therapy in order to improve understanding of speech.

See CMS Publication 100-02, *Medicare Benefit Policy Manual*, Chapter 15, Section 230.3.D.3 and the related Billing and Coding Article for more information on aural rehabilitation.

Group Therapy:

Group therapy sessions must meet the individualized plan of treatment requirement and are not subject to reimbursement if these criteria are not met. Group therapy coverage for speech reading can be covered (if medically justified) if the following criteria are met:

- Services are rendered under an individualized plan of care
- The group has no more than four group members
- Group therapy does not represent the entire plan of treatment

Laryngoscopy, flexible or rigid fiberoptic, with stroboscopy

This procedure may be used for assessing voice production and vocal function. It may be performed by qualified speech-language pathologists.

Speech-language pathologists should have evidence that they meet the ASHA (American Speech-Language—Hearing Association) training requirements as outlined in the ASHA's *Training Guidelines for Laryngeal Videoscopy/Stroboscopy*.

Limitations:

Following are some examples of interventions which would generally be considered non-skilled and therefore not covered under Medicare:

- Non-diagnostic, non-therapeutic, routine, repetitive and reinforcing procedures (e.g., the practicing of word drills without skilled feedback).
- Procedures which are repetitive and/or that reinforce previously learned material which the beneficiary, staff or family may be instructed to repeat.
- Procedures which may be effectively carried out with the beneficiary by any non-professional (family or restorative aide) after instruction is completed.
- Services rendered by a SLP assistant or aide.
- Provision of practice for use of augmentative or alternative communication systems after being taught their use.
- Although speech-language pathologists may perform laryngoscopy for the assessment of voice production and vocal function, laryngoscopy for medical diagnostic purposes must be performed by a physician.

Generally, group therapy sessions, except as specified above, are not covered. Group therapy sessions in social organizations such as the stroke club or lost cord club are not covered. See the "Indications" section above for information on when group therapy might be covered.

Speech-language pathology services provided for chronic disorders of memory and orientation are covered services when significant functional progress is demonstrated at early stages of the disorder. When functional progress plateaus, the development of a maintenance program, including training of caregivers and family members is covered.

Preparation of memory aids such as memory books, memory boards, or communication books may be covered. Supervision of the use of such aids is not covered as these services do not require the skills of a qualified therapist.

All SLP services provided by anyone other than an SLP who is licensed or otherwise authorized by the State in which they practice, including a speech-language pathology assistant or aide, are not covered.

The following disorders are typically non-covered for the geriatric Medicare beneficiary:

- Fluency disorder
- Conceptual handicap
- Dysprosody
- Stuttering and cluttering (except neurogenic stuttering caused by acquired brain damage)
- Myofunctional disorders, e.g., tongue thrust

Speech-language pathology is considered medically appropriate treatment for individuals with mental retardation

when comorbid disorders such as aphasia or dysarthria are exhibited.

Speech therapy interventions to instruct the beneficiary in English phrases, who has a primary language other than English, are not covered. However, when the primary language of the beneficiary is other than English, speech therapy interventions in the patient's primary language will be covered within the parameters of this LCD.

Other Comments:

There may be rare cases of children who fall under criteria specified in this LCD. Claims for services rendered to children may be covered and approved upon individual consideration.

Summary of Evidence

N/A

**Analysis of Evidence
(Rationale for Determination)**

N/A

General Information

Associated Information

Sources of Information

This bibliography presents those sources that were obtained during the development of this policy. National Government Services is not responsible for the continuing viability of Web site addresses listed below.

Comments from American Speech-Language-Hearing Association

- *Preferred Practice Patterns for the Profession of Speech-Language-Pathology*. American Speech-Language-Hearing Association; 2004
- *The Roles of Otolaryngologists and Speech-Language Pathologists in the Performance and Interpretation of Stroboscaryngoscopy*. American Speech-Language-Hearing Association; 1998
- *Training Guidelines for Laryngeal Videoscaryngoscopy*. American Speech-Language -Hearing Language

Fred Martin, ed. Hearing Handicapped Adult. Prentice Hall Publication; 1984.

Bibliography

N/A

Revision History Information

REVISION HISTORY DATE	REVISION HISTORY NUMBER	REVISION HISTORY EXPLANATION	REASON(S) FOR CHANGE
12/19/2019	R10	Consistent with Change Request 10901, all coding information, National coverage provisions, and Associated Information (Documentation Requirements, Utilization Guidelines) have been removed from the LCD and placed in the related Billing and Coding Article, A52866. There has been no change in coverage with this LCD revision.	<ul style="list-style-type: none"> • Revisions Due To Code Removal
01/01/2019	R9	<p>CMS Transmittal No. 4149, dated October 23, 2018, removed Functional Reporting requirements and edits for outpatient therapy services, effective January 1, 2019. Documentation Requirements and CMS National Coverage sections have been updated accordingly.</p> <p><i>DATE 02/01/2019: At this time, the 21st Century Cures Act will apply to new and revised LCDs that restrict coverage which require comment and notice. This revision is not a restriction to the coverage determination; and therefore, not all the fields included are applicable as noted in this policy</i></p>	<ul style="list-style-type: none"> • Provider Education/Guidance
01/01/2019	R8	<p>Due to the annual HCPCS update, CPT code 96111 was deleted from the "CPT/HCPCS Codes" section and the following new codes have been added: 96112 and 96113.</p> <p><i>DATE (01/01/2019): At this time, the 21st Century Cures Act will apply to new and revised LCDs that restrict coverage which requires comment and notice. This revision is not a restriction to the coverage determination; and, therefore not all the fields included on the LCD are applicable as noted in this policy.</i></p>	<ul style="list-style-type: none"> • Revisions Due To CPT/HCPCS Code Changes
01/01/2018	R7	Due to the annual HCPCS update, CPT code 97532 was deleted and removed from the "CPT/HCPCS Codes" section.	<ul style="list-style-type: none"> • Revisions Due To CPT/HCPCS Code

REVISION HISTORY DATE	REVISION HISTORY NUMBER	REVISION HISTORY EXPLANATION	REASON(S) FOR CHANGE
		<p>An explanatory note regarding the code deletion was added to this section. HCPCS code G0515 was added as the replacement code.</p> <p><i>DATE (01/01/2018): At this time, the 21st Century Cures Act will apply to new and revised LCDs that restrict coverage which requires comment and notice. This revision is not a restriction to the coverage determination; and, therefore not all the fields included on the LCD are applicable as noted in this policy.</i></p>	Changes
01/01/2017	R6	Due to annual HCPCS update, the descriptor was changed for CPT code 31579.	<ul style="list-style-type: none"> • Revisions Due To CPT/HCPCS Code Changes
10/01/2016	R5	<p>Due to the annual ICD-10-CM code update for 2017, ICD-10-CM codes were deleted I69.01, I69.11, I69.21, I69.31, I69.81, I69.91, T85.89XA, T85.89XD and T85.89XS from the "ICD-10-CM Codes that Support Medical Necessity" section of the LCD. ICD-10-CM codes I69.010, I69.011, I69.012, I69.013, I69.014, I69.015, I69.018, I69.019, I69.110, I69.111, I69.112, I69.113, I69.114, I69.115, I69.118, I69.119, I69.210, I69.211, I69.212, I69.213, I69.214, I69.215, I69.218, I69.219, I69.310, I69.311, I69.312, I69.313, I69.314, I69.315, I69.318, I69.319, I69.810, I69.811, I69.812, I69.813, I69.814, I69.815, I69.818, I69.819, I69.910, I69.911, I69.912, I69.913, I69.914, I69.915, I69.918, I69.919, T85.898A, T85.898D and T85.898S were added as the replacement codes. ICD-10-CM codes H90.A11, H90.A12, H90.A21, H90.A22, H90.A31 and H90.A32 were added.</p>	<ul style="list-style-type: none"> • Revisions Due To ICD-10-CM Code Changes
10/01/2015	R4	ICD-10-CM codes H90.5, H91.10, H91.93, I69.91, I69.920, I69.922, I69.928 and I69.990 were added to the "ICD-10-CM Codes that Support Medical Necessity" section.	<ul style="list-style-type: none"> • Other
10/01/2015	R3	Based on a practitioner request, ICD-10-CM codes I69.091, I69.191, I69.291, I69.391 and I69.891 were added to the "ICD-10-CM Codes that Support Medical Necessity" section.	<ul style="list-style-type: none"> • Revisions Due To ICD-10-CM Code Changes
10/01/2015	R2	Minor template language change.	<ul style="list-style-type: none"> • Other
10/01/2015	R1	Incorporated all changes to the "Indications" and "Documentation Requirements" sections to comply with the	<ul style="list-style-type: none"> • Provider Education/Guidance

REVISION HISTORY DATE	REVISION HISTORY NUMBER	REVISION HISTORY EXPLANATION	REASON(S) FOR CHANGE
		Jimmo v. Sebelius Settlement Agreement. Added ICD-10-CM codes J38.5, K21.9, R05, R13.11, R13.12, R13.13, R13.14, R13.19, T85.89XD and T85.89XS to the "ICD-10-CM Codes that Support Medical Necessity" section.	<ul style="list-style-type: none"> Revisions Due To ICD-10-CM Code Changes

Associated Documents

Attachments

N/A

Related Local Coverage Documents

Article(s)

A52866 - Billing and Coding: Speech-Language Pathology

Related National Coverage Documents

N/A

Public Version(s)

Updated on 12/13/2019 with effective dates 12/19/2019 - N/A

Some older versions have been archived. Please visit the MCD Archive Site to retrieve them.

Keywords

- Dysphagia
- Swallowing