LCD for Speech-Language Pathology (L27404)

Contractor Information

Contractor Name

National Government Services, Inc.

Contractor Number

Number	Type	State(s)
00130	FI	IN
00131	FI	IL
00160	FI	KY
00332	FI	OH
00450	FI	WI
00452	FI	MI
00453	FI	VA, WV
00630	Carrier	IN
00660	Carrier	KY
13101	MAC	CT – Part A
13102	MAC	CT – Part B
13201	MAC	NY – Part A
13202	MAC	NY – Part B
13282	MAC	NY – Part B
13292	MAC	NY – Part B

Contractor Type

Carrier
Fiscal Intermediary
MAC – Part A
MAC- Part B

LCD Information

LCD ID Number

L27404

LCD Title

Speech-Language Pathology

Contractor's Determination Number

L27404 (R5)

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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. 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.

Primary Geographic Jurisdiction

Number	Type	State(s)
00130	FI	IN
00131	FI	IL

00160	FI	KY
00332	FI	OH
00450	FI	WI
00452	FI	MI
00453	FI	VA, WV
00630	Carrier	IN
00660	Carrier	KY
13101	MAC	CT – Part A
13102	MAC	CT – Part B
13201	MAC	NY – Part A
13202	MAC	NY – Part B
13282	MAC	NY – Part B
13292	MAC	NY – Part B

Oversight Region
Region I, II, III, V

Original Determination Effective Date
For services performed on or after 11/15/2008

Original Determination Ending Date

Revision Effective Date
For services performed on or after 10/01/2010

Revision Ending Date

Indications and Limitations of Coverage and/or Medical Necessity
Abstract:

Speech-language pathology services are those services provided within the scope of practice of speech-language pathologists and necessary for the diagnosis and treatment of speech and language disorders, which result in communication disabilities and for the diagnosis and treatment of swallowing disorders (dysphagia), regardless of the presence of a communication disability. (See CMS Publication 100-03, Medicare National Coverage Determinations (NCD) Manual, Part 3, Section 170.3) (CMS Publication 100-02, *Medicare Benefit Policy Manual*, Chapter 15, Section 230.3(A))

This LCD does not address dysphagia (swallowing) services rendered by speech-language pathologists, nor does it address audiology services. National Government Services has separate LCDs for Dysphagia Services by Speech-Language Pathologists and Audiologic and Vestibular Function Testing.

A qualified speech-language pathologist for program coverage purposes meets one of the following requirements:

- *The education and experience requirements for a Certificate of Clinical Competence in (speech-language pathology) granted by the American Speech-Language Hearing Association; or*

- *Meets the educational requirements for certification and is in the process of accumulating the supervised experience required for certification*. (CMS Publication 100-02, *Medicare Benefit Policy Manual*, Chapter 15, Section 230.3(B))

An SLP normally has a master's degree and a Certificate of Clinical Competence (CCC-SLP) or all the requirements leading to a Certificate of Clinical Competence, that is, he or she is in their clinical fellowship year (CFY-SLP).

Under the Medicare Program, an independently practicing speech pathologist may now bill the Medicare program directly. *Section 143 of the Medicare Improvements for Patients and Provider's Act of 2008 (MIPPA) authorizes the Centers for Medicare & Medicaid Services (CMS) to enroll speech-language pathologists (SLP) as suppliers of Medicare services and for SLPs to begin billing Medicare for outpatient speech-language pathology services furnished in private practice beginning July 1, 2009. Enrollment will allow SLPs in private practice to bill Medicare and receive direct payment for their services. Previously, the Medicare program could only pay SLP services if an institution, physician or nonphysician practitioner billed them*. (See CMS Publication 100-04, *Medicare Claims Processing Manual*, Chapter 5, Section 10)

However, the services of speech-language pathologists may continue to be billed by providers such as rehabilitation agencies, HHAs, CORFs, hospices, outpatient departments of hospitals, and suppliers such as physicians, non-physician practitioners (NPPs), physical and occupational therapists in private practice. When these services are billed by physicians or NPPs, they are covered when billed under the "incident to" provision. "Incident to" services or supplies are defined as those furnished as an integral, although incidental, part of the physician's or NPPs personal professional services in the course of diagnosis or treatment of an injury or illness. These services must be related directly and specifically to a written treatment regimen established by the physician/NPP, after any needed consultation with a qualified speech pathologist, or by the speech pathologist providing such services.

Indications:

Speech-language pathology services must be reasonable and necessary.

To be considered reasonable and necessary, the following conditions must be met: (CMS Publication 100-02, Medicare Benefit Policy Manual, Chapter 15, Section 220.2(B))

- *The services shall be considered under accepted standards of medical practice to be a specific and effective treatment for the patient's condition. Acceptable practices for therapy services are found in:*

- *Medicare manuals (such as this manual and Publications 100-03 and 100-04),*

- *Contractors Local Coverage Determinations (LCDs and NCDs are available on the Medicare Coverage Database: http://www.cms.hhs.gov/mcd and*

- *Guidelines and literature of the professions of physical therapy, occupational therapy and speech-language pathology.*

- *The services shall be of such a level of complexity and sophistication or the condition of the patient shall be such that the services required can be safely and effectively performed only by a qualified therapist, or in the case of physical therapy and occupational therapy by or under the supervision of a qualified therapist. Services that do not require the performance or supervision of a therapist*

are not skilled and are not considered reasonable or necessary therapy services, even if they are performed or supervised by a qualified professional.

- *If the contractor determines the services furnished were of a type that could have been safely and effectively performed only by or under the supervision of such a qualified professional, it shall presume that such services were properly supervised when required. However, this presumption is rebuttable, and, if in the course of processing claims it finds that services are not being furnished under proper supervision, it shall deny the claim and bring this matter to the attention of the Division of Survey and Certification of the Regional Office.*

- *While a beneficiary's particular medical condition is a valid factor in deciding if skilled therapy services are needed, a beneficiary's diagnosis or prognosis should never be the sole factor in deciding that a service is or is not skilled. The key issue is whether the skills of a qualified therapist are needed to treat the illness or injury, or whether the services can be carried out by nonskilled personnel. See item C for descriptions of skilled (rehabilitative) services.*

- *There must be an expectation that the patient's condition will improve significantly in a reasonable (and generally predictable) period of time, or the services must be necessary for the establishment of a safe and effective maintenance program required in connection with a specific disease state. In the case of a progressive degenerative disease, service may be intermittently necessary to determine the need for assistive equipment and/or establish a program to maximize function (see item D for descriptions of maintenance services); and*

- *The amount, frequency, and duration of the services must be reasonable under accepted standards of practice. The contractor shall consult local professionals or the state or national therapy associations in the development of any utilization guidelines.*

The services of a maintenance program themselves are not covered. However, the development of a functional treatment plan for patient maintenance including evaluation, plan of treatment, and staff and family training, is covered, but it must require the skills of an SLP, and be a distinct and separate service which can only be done safely by a SLP. Reevaluation may be covered if necessary because of a change in the beneficiary's condition.

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.

Re-evaluations are usually focused on the current treatment and might not be as extensive as initial evaluations. Continuous assessment of the patient's progress is a component of ongoing therapy services

and is not payable as a re-evaluation. A re-evaluation is not a routine, recurring service but is focused on evaluation of progress toward current goals, making a professional judgment about continued care, modifying goals and/or treatment or terminating services. A formal re-evaluation is covered only if the documentation supports the need for further tests and measurements after the initial evaluation. Indications for a re-evaluation include 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.

A re-evaluation may be appropriate prior to planned discharge for the purposes of determining whether goals have been met, or for the use of the physician or the treatment setting at which treatment will be continued.

A re-evaluation is focused on evaluation of progress toward current goals and making a professional judgment about continued care, modifying goals and/or treatment or terminating services. Reevaluation requires the same professional skills as evaluation. The minutes for re-evaluation are documented in the same manner as the minutes for evaluation. Current Procedural Terminology does not define a re-evaluation code for speech-language pathology; use the evaluation code. (CMS Publication 100-02, *Medicare Benefit Policy Manual*, Chapter 15, Section 220.3.C)

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:

After the evaluation and establishment of the plan of treatment, therapeutic interventions are expected to improve the beneficiary's functional abilities. 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 hat 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.

There should be an expectation of measurable functional improvement.

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:

The terms, aural rehabilitation, auditory rehabilitation, auditory processing, lipreading and speech reading are among the terms used to describe covered services related to perception and comprehension of sound through the auditory system. (CMS Publication 100-02, *Medicare Benefit Policy Manual*, Chapter 15, Section 230.3.D.3) 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 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 under direct physician supervision.

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:

For claims submitted to the fiscal intermediary or Part A MAC: this coverage determination also applies within states outside the primary geographic jurisdiction with facilities that have nominated National Government Services to process their claims.

Bill type codes only apply to providers who bill these services to the fiscal intermediary or Part A MAC. Bill type codes do not apply to physicians, other professionals and suppliers who bill these services to the carrier or Part B MAC.

Limitation of liability and refund requirements apply when denials are likely, whether based on medical necessity or other coverage reasons. The provider/supplier must notify the beneficiary in writing, prior to rendering the service, if the provider/supplier is aware that the test, item or procedure may not be covered by Medicare. The limitation of liability and refund requirements do not apply when the test, item or procedure is statutorily excluded, has no Medicare benefit category or is rendered for screening purposes.

For outpatient settings other than CORFs, references to "physicians" throughout this policy include non-physicians, such as nurse practitioners, clinical nurse specialists and physician assistants. Such non-physician practitioners, with certain exceptions, may certify, order and establish the plan of care as authorized by State law. (See Sections 1861[s][2] and 1862[a][14] of Title XVIII of the Social Security Act; 42 CFR, Sections 410.74, 410.75, 410.76 and 419.22; 58 FR 18543, April 7, 2000.)

Speech-language pathology therapy services are covered CORF services if physical therapy services are the predominate rehabilitation services provided in the CORF. (CMS Publication 100-02, *Medicare Benefit Policy Manual*, Chapter 12, Section 40.4) To determine whether SLP therapy services are being given in conjunction with core CORF services, see CMS Publication 100-02, *Medicare Benefit Policy Manual*, Chapter 12, Section 20.1 for a description of required CORF services.

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.

Coding Information

Bill Type Codes:

Contractors may specify Bill Types to help providers identify those Bill Types typically used to

report this service. Absence of a Bill Type does not guarantee that the policy does not apply to that Bill Type. Complete absence of all Bill Types indicates that coverage is not influenced by Bill Type and the policy should be assumed to apply equally to all claims.

011x	Hospital Inpatient (Including Medicare Part A)
012x	Hospital Inpatient (Medicare Part B only)
013x	Hospital Outpatient
021x	Skilled Nursing - Inpatient (Including Medicare Part A)
022x	Skilled Nursing - Inpatient (Medicare Part B only)
023x	Skilled Nursing - Outpatient
034x	Home Health - Other (for medical and surgical services not under a plan of treatment)
074x	Clinic - Outpatient Rehabilitation Facility (ORF)
075x	Clinic - Comprehensive Outpatient Rehabilitation Facility (CORF)
085x	Critical Access Hospital

Revenue Codes:

Contractors may specify Revenue Codes to help providers identify those Revenue Codes typically used to report this service. In most instances Revenue Codes are purely advisory; unless specified in the policy services reported under other Revenue Codes are equally subject to this coverage determination. Complete absence of all Revenue Codes indicates that coverage is not influenced by Revenue Code and the policy should be assumed to apply equally to all Revenue Codes.

Revenue codes only apply to providers who bill these services to the fiscal intermediary or Part A MAC. Revenue codes do not apply to physicians, other professionals and suppliers who bill these services to the carrier or Part B MAC.

Please note that not all revenue codes apply to every type of bill code. Providers are encouraged to refer to the FISS revenue code file for allowable bill types. Similarly, not all revenue codes apply to each CPT/HCPCS code. Providers are encouraged to refer to the FISS HCPCS file for allowable revenue codes.

All revenue codes billed on the inpatient claim for the dates of service in question may be subject to review.

0440	Speech Therapy - Language Pathology - General Classification
0444	Speech Therapy - Language Pathology - Evaluation or Reevaluation
0449	Speech Therapy - Language Pathology - Other Speech Therapy

CPT/HCPCS Codes

31579	LARYNGOSCOPY, FLEXIBLE OR RIGID FIBEROPTIC, WITH STROBOSCOPY
92506	EVALUATION OF SPEECH, LANGUAGE, VOICE, COMMUNICATION, AND/ OR AUDITORY PROCESSING
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
92597	EVALUATION FOR USE AND/OR FITTING OF VOICE PROSTHETIC DEVICE TO SUPPLEMENT ORAL SPEECH
92607	EVALUATION FOR PRESCRIPTION FOR SPEECH-GENERATING AUGMENTATIVE AND ALTERNATIVE COMMUNICATION DEVICE, FACE-TO-FACE WITH THE PATIENT; FIRST HOUR
92608	EVALUATION FOR PRESCRIPTION FOR SPEECH-GENERATING AUGMENTATIVE AND ALTERNATIVE COMMUNICATION DEVICE, FACE-TO-FACE WITH THE PATIENT; EACH ADDITIONAL 30 MINUTES (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)
92609	THERAPEUTIC SERVICES FOR THE USE OF SPEECH-GENERATING DEVICE, INCLUDING PROGRAMMING AND MODIFICATION
92626	EVALUATION OF AUDITORY REHABILITATION STATUS; FIRST HOUR
92627	EVALUATION OF AUDITORY REHABILITATION STATUS; EACH ADDITIONAL 15 MINUTES (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)
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
96110	DEVELOPMENTAL TESTING; LIMITED (EG, DEVELOPMENTAL SCREENING TEST II, EARLY LANGUAGE MILESTONE SCREEN), WITH INTERPRETATION AND REPORT
96111	DEVELOPMENTAL TESTING; EXTENDED (INCLUDES ASSESSMENT OF MOTOR, LANGUAGE, SOCIAL, ADAPTIVE AND/OR COGNITIVE FUNCTIONING BY STANDARDIZED DEVELOPMENTAL INSTRUMENTS) WITH INTERPRETATION AND REPORT
97532	DEVELOPMENT OF COGNITIVE SKILLS TO IMPROVE ATTENTION, MEMORY, PROBLEM SOLVING (INCLUDES COMPENSATORY TRAINING), DIRECT (ONE-ON-ONE) PATIENT CONTACT BY THE PROVIDER, EACH 15 MINUTES
97533	SENSORY INTEGRATIVE TECHNIQUES TO ENHANCE SENSORY PROCESSING AND PROMOTE ADAPTIVE RESPONSES TO ENVIRONMENTAL DEMANDS, DIRECT (ONE-ON-ONE) PATIENT CONTACT BY THE PROVIDER, EACH 15 MINUTES

ICD-9 Codes that Support Medical Necessity

It is the responsibility of the provider to code to the highest level specified in the *ICD-9-CM* (e.g., to the fourth or fifth digit). The correct use of an ICD-9-CM code does not assure coverage of a service. The service must be reasonable and necessary in the specific case and must meet the criteria specified in this determination.

Note: ICD-9-CM code V72.83 should be reported for pre-laryngectomy examinations

307.0	ADULT ONSET FLUENCY DISORDER
315.00	DEVELOPMENTAL READING DISORDER UNSPECIFIED
315.01	ALEXIA
315.02	DEVELOPMENTAL DYSLEXIA
315.09	OTHER SPECIFIC DEVELOPMENTAL READING DISORDER
315.1	MATHEMATICS DISORDER
315.2	OTHER SPECIFIC DEVELOPMENTAL LEARNING DIFFICULTIES
315.31	EXPRESSIVE LANGUAGE DISORDER
315.32	MIXED RECEPTIVE-EXPRESSIVE LANGUAGE DISORDER
315.34	SPEECH AND LANGUAGE DEVELOPMENTAL DELAY DUE TO HEARING LOSS
315.35	CHILDHOOD ONSET FLUENCY DISORDER
315.39	OTHER DEVELOPMENTAL SPEECH DISORDER
315.5	MIXED DEVELOPMENT DISORDER
315.8	OTHER SPECIFIED DELAYS IN DEVELOPMENT
352.1	GLOSSOPHARYNGEAL NEURALGIA
352.2	OTHER DISORDERS OF GLOSSOPHARYNGEAL (9TH) NERVE
352.3	DISORDERS OF PNEUMOGASTRIC (10TH) NERVE
352.4	DISORDERS OF ACCESSORY (11TH) NERVE
352.5	DISORDERS OF HYPOGLOSSAL (12TH) NERVE
352.6	MULTIPLE CRANIAL NERVE PALSIES
356.8	OTHER SPECIFIED IDIOPATHIC PERIPHERAL NEUROPATHY
389.00	CONDUCTIVE HEARING LOSS UNSPECIFIED
389.01	CONDUCTIVE HEARING LOSS EXTERNAL EAR
389.02	CONDUCTIVE HEARING LOSS TYMPANIC MEMBRANE
389.03	CONDUCTIVE HEARING LOSS MIDDLE EAR
389.04	CONDUCTIVE HEARING LOSS INNER EAR
389.05	CONDUCTIVE HEARING LOSS, UNILATERAL

389.06	CONDUCTIVE HEARING LOSS, BILATERAL
389.08	CONDUCTIVE HEARING LOSS OF COMBINED TYPES
389.10	SENSORINEURAL HEARING LOSS UNSPECIFIED
389.11	SENSORY HEARING LOSS, BILATERAL
389.12	NEURAL HEARING LOSS, BILATERAL
389.13	NEURAL HEARING LOSS, UNILATERAL
389.14	CENTRAL HEARING LOSS
389.15	SENSORINEURAL HEARING LOSS, UNILATERAL
389.16	SENSORINEURAL HEARING LOSS, ASYMMETRICAL
389.17	SENSORY HEARING LOSS, UNILATERAL
389.18	SENSORINEURAL HEARING LOSS, BILATERAL
389.20	MIXED HEARING LOSS, UNSPECIFIED
389.21	MIXED HEARING LOSS, UNILATERAL
389.22	MIXED HEARING LOSS, BILATERAL
438.0	COGNITIVE DEFICITS
438.10	SPEECH AND LANGUAGE DEFICIT UNSPECIFIED
438.11	APHASIA
438.12	DYSPHASIA
438.13	LATE EFFECTS OF CEREBROVASCULAR DISEASE, DYSARTHRIA
438.14	LATE EFFECTS OF CEREBROVASCULAR DISEASE, FLUENCY DISORDER
438.19	OTHER SPEECH AND LANGUAGE DEFICITS
438.6	ALTERATIONS OF SENSATIONS
438.83	FACIAL WEAKNESS
478.30	UNSPECIFIED PARALYSIS OF VOCAL CORDS
478.31	PARTIAL UNILATERAL PARALYSIS OF VOCAL CORDS
478.32	COMPLETE UNILATERAL PARALYSIS OF VOCAL CORDS
478.33	PARTIAL BILATERAL PARALYSIS OF VOCAL CORDS
478.34	COMPLETE BILATERAL PARALYSIS OF VOCAL CORDS
478.5	OTHER DISEASES OF VOCAL CORDS
784.3	APHASIA
784.40	VOICE AND RESONANCE DISORDER, UNSPECIFIED
784.41	APHONIA
784.42	DYSPHONIA
784.51	DYSARTHRIA

784.52	FLUENCY DISORDER IN CONDITIONS CLASSIFIED ELSEWHERE
784.59	OTHER SPEECH DISTURBANCE
784.61	ALEXIA AND DYSLEXIA
784.69	OTHER SYMBOLIC DYSFUNCTION
996.79	OTHER COMPLICATIONS DUE TO OTHER INTERNAL PROSTHETIC DEVICE IMPLANT AND GRAFT
V40.1	MENTAL AND BEHAVIORAL PROBLEMS WITH COMMUNICATION (INCLUDING SPEECH)
V41.2	PROBLEMS WITH HEARING
V41.3	OTHER EAR PROBLEMS
V41.4	PROBLEMS WITH VOICE PRODUCTION
V43.81	LARYNX REPLACEMENT STATUS
V52.8	FITTING AND ADJUSTMENT OF OTHER SPECIFIED PROSTHETIC DEVICE
V72.83	OTHER SPECIFIED PRE-OPERATIVE EXAMINATION

Diagnoses that Support Medical Necessity

Not applicable

ICD-9 Codes that DO NOT Support Medical Necessity

Not applicable

ICD-9 Codes that DO NOT Support Medical Necessity Asterisk Explanation

Diagnoses that DO NOT Support Medical Necessity

Not applicable

General Information

Documentation Requirements

The patient's medical record must contain documentation that fully supports the medical necessity for

services included within this LCD. (See "Indications and Limitations of Coverage.") This documentation includes, but is not limited to, relevant medical history, physical examination, and results of pertinent diagnostic tests or procedures. Not only should documentation describe the condition of the patient that necessitates the skilled intervention of the speech-language pathologist, but should also report clinical judgment and describe the skilled nature of the treatment. Documenting the skilled components of activities will assist in supporting that the services are medically necessary.

Documentation of speech language services, like other therapy services, must be objective, clear, concise, and must show evidence of the beneficiary's progress in meeting treatment goals. Documentation in the clinical record must be descriptive, clearly related to functionality, and complement and correlate with other disciplines. Medical necessity may not be established if there is conflicting documentation between disciplines or widely fluctuating abilities indicating an unstable condition. Prior level of functioning must be documented and considered in the patient's treatment plan, to establish reasonable goals for the patient's present condition. Statements such as "mildly impaired to moderately impaired" or "fair plus to good minus" do not offer sufficient objective and measurable information to support progress and may result in denial of services as not medically necessary. Documentation of discharge planning should be indicated early in the treatment plan.

Where a valid expectation of improvement existed at the time services were initiated, or thereafter, the services may be covered even though the expectation may not be realized. Progress reports must document a continued reasonable expectation that the patient's condition will improve significantly, i.e., a measurable and substantial increase in the patient's level of communication, independence, and functional competence compared to the level when treatment was initiated. Documentation should include improvements, setbacks, and intervening medical complications—whatever is deemed pertinent to justify the need for continued intervention.

For additional information on Medicare documentation requirements for speech-language pathology services see: CMS Publication 100-02, *Medicare Benefit Policy Manual*, Chapter 15, Section, 220, including the subsections under Section 220.

Appendices

Not applicable

Utilization Guidelines

Not applicable

Sources of Information and Basis for Decision

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 Strobovideolaryngoscopy*. American Speech-Language-Hearing Association; 1998

- *Training Guidelines for Laryngeal Videoscopy/Stroboscopy*. American Speech-Language -Hearing Language Association; 1998

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

Advisory Committee Meeting Notes

Carrier Advisory Committee Meeting Date(s):

Indiana: 05/19/2008
Kentucky: 05/22/2008
New York: 04/30/2008

This coverage determination does not reflect the sole opinion of the contractor or contractor Medical Director. Although the final decision rests with the contractor, this determination is developed in consultation with representatives from Advisory Committee members and/or from various state and local provider organizations.

Start Date of Comment Period

04/17/2008

End Date of Comment Period

05/31/2008

Start Date of Notice Period

10/01/2010

Revision History Number

R5

Revision History Explanation

R5 (effective 10/01/2010): Due to the annual ICD-9-CM code update for 2011, ICD-9-CM codes 315.35 and 784.52 were added to the "ICD-9-CM Codes that Support Medical Necessity" section. ICD-9-CM code 307.0 was revised.

No comment and notice periods required and none given.

R4 (effective 03/01/2010): The Therapy Cap Exception Process expired on 12/31/2009. Therefore, the three paragraphs in the "Other Comments" section which referenced this process were removed. Added ICD-9-CM codes 438.13 and 438.14 to the “ICD-9-CM Codes that Support Medical Necessity” section. ICD-9-CM codes 438.13 and 438.14 were included as new diagnosis codes with the annual ICD-9-CM code update for 2010 and should have been added to the LCD with the 10/01/2009 revision. As a result, the ICD-9-CM codes will be considered covered retroactive to 10/01/2009.

No comment and notice periods required and none given.

R3 (effective 12/01/2009): The following reference was added to the "CMS National Coverage Policy" section:

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.

Based on the aforementioned Change Request, the following paragraph in the "Indications and Limitations of Coverage and/or Medical Necessity" section was revised:

Speech-language pathology therapy services are covered CORF services if physical therapy services are the predominate rehabilitation services provided in the CORF. (CMS Publication 100-02, *Medicare Benefit Policy Manual*, Chapter 12, Section 40.4) To determine whether SLP therapy services are being given in conjunction with core CORF services, see CMS Publication 100-02, *Medicare Benefit Policy Manual*, Chapter 12, Section 20.1 for a description of required CORF services.

Minor template changes were made to reflect current template language. No comment and notice periods required and none given.

R2 (effective 10/01/2009): The following references were added to the "CMS National Coverage Policy" section:

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.

Due to the annual ICD-9-CM code update for 2010, ICD-9-CM code 784.40 was revised. ICD-9-CM code 784.42 was added to the "ICD-9-CM Codes that Support Medical Necessity" section for CPT codes 31579, 92506, 92507, 92508, 92597, 92607, 92608, 92609, 92626, 92627, 96105, 96110, 96111, 97532 and 97533. ICD-9-CM code 784.49 was removed from the LCD for dates of service on or after 10/01/2009. For dates of service on or after 10/01/2009, ICD-9-CM code 784.42 should be reported.

ICD-9-CM code 784.5 was deleted. ICD-9-CM codes 784.51 and 784.59 were added as replacement codes.

Minor template changes were made to reflect current template language. No comment and notice periods required and none given.

R1 (effective 07/01/2009): Source of revision - Internal. Due to CR 6292 and CR 6381, an independently practicing speech pathologist may now bill the Medicare program directly. The abstract was adjusted with the CR information. There were no changes to the coding or billing instruction. Minor template changes were made to reflect current template language. No comment and notice periods required and none given.

05/15/2009 - In accordance with Section 911 of the Medicare Modernization Act of 2003, fiscal intermediary numbers 00180 and 00181 were removed from this LCD as the claims processing for Maine and Massachusetts was transitioned to NHIC, the Part A/Part B MAC contractor in these states.

06/05/2009 - In accordance with Section 911 of the Medicare Modernization Act of 2003, fiscal intermediary number 00270 was removed from this LCD as the claims processing for New Hampshire

and Vermont was transitioned to NHIC, the Part A/Part B MAC contractor in these states.

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The following are administrative notes entered by the Medicare Coverage Database Contractor:

08/08/2009 - This policy was updated by the ICD-9 2009-2010 Annual Update.

8/1/2010 - The description for Bill Type Code 11 was changed
8/1/2010 - The description for Bill Type Code 12 was changed
8/1/2010 - The description for Bill Type Code 13 was changed
8/1/2010 - The description for Bill Type Code 21 was changed
8/1/2010 - The description for Bill Type Code 22 was changed
8/1/2010 - The description for Bill Type Code 23 was changed
8/1/2010 - The description for Bill Type Code 34 was changed
8/1/2010 - The description for Bill Type Code 74 was changed
8/1/2010 - The description for Bill Type Code 75 was changed
8/1/2010 - The description for Bill Type Code 85 was changed

8/1/2010 - The description for Revenue code 0440 was changed
8/1/2010 - The description for Revenue code 0444 was changed
8/1/2010 - The description for Revenue code 0449 was changed

09/06/2010 - This policy was updated by the ICD-9 2010-2011 Annual Update.

Reason for Change

ICD9 Addition/Deletion

Last Reviewed On Date

10/01/2010

Related Documents

Article(s)
A47407 - Speech-Language Pathology – Supplemental Instructions Article

LCD Attachments

Speech-Language Pathology - Comment and Response (232,011 bytes)

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