Speech-Language Therapy Services
Clinical Coverage Criteria

Description

The Plan covers medically necessary outpatient speech-language therapy services provided by licensed speech-language pathologists, subject to terms and conditions described in the plan member's Evidence of Coverage.

Effective for dates of service on or after November 26, 2021, subject to the supervision requirements set forth in 130 CMR 432.404 (D), MassHealth reimburses the services of speech-language pathology assistants (SLPAs). This applies to both individually enrolled therapy providers and to therapy group practices under 130 CMR 432.404(E) (MassHealth Transmittal Letter THP-27, November 2021). This change in MassHealth policy regarding services rendered by therapy assistants also applies to the Plan's MassHealth ACO members. An SLPA must be currently licensed by and in good standing with the Massachusetts Board of Registration in Speech-Language Pathology and Audiology as an SLPA. An SLPA must work under the supervision of a licensed speech-language pathologist. Supervision of SLPAs must be performed following state regulatory guidance. The supervising speech-language pathologist must be licensed by the Massachusetts Board of Registration in Speech-Language Pathology and Audiology, in good standing, and has practiced for at least two years following licensure. Supervising speech-language pathologists may refer to Massachusetts regulation 260 CMR 10.00: Use and Supervision of Speech-Language Pathology and Audiology Assistant for supervision and documentation requirements.

Services of SLPAs are not eligible for coverage for Medicare members (Medicare Benefit Policy Manual, Chapter 15, Section 230.3 - Practice of Speech-Language Pathology).

Fallon Health does not cover services provided by SLPAs for Community Care members.

A speech-language pathologist may be licensed under State law to perform speech-language therapy services without physician supervision and have the service separately covered and reimbursed by the Plan as a speech-language therapy service. In order to have that same service covered as incident to the services of a physician or nonphysician practitioners (NPP) for Medicare or Community Care plan members, the service must be performed under the direct supervision of the physician/nonphysician practitioner (NPP), as an integral part of the physician/NPP's personal service. Therapy services provided and billed incident to the services of a physician/NPP also must meet all incident-to requirements in Medicare Benefit Policy Manual, Chapter 15, Section 230.5, and also in Chapter 15, Section 60.

MassHealth does not reimburse physicians or midlevel practitioners for the services of speech-language pathologists provided incident to the physician or midlevel practitioner's service. Payment for the services described in 130 CMR 432.000 will be made only to therapists who are contracted with the Plan and participating in MassHealth on the date of service, for services personally rendered by therapists or for services rendered by licensed therapy assistants, subject to the supervision requirements of 130 CMR 432.404(D).

This policy does not apply to speech-language therapy services provided by a home health agency under a home health plan of care. Such services are home health care services.

Definitions

Speech-Language Therapy is defined in MassHealth Program Regulations at 130 CMR 432.402 as therapy services, including diagnostic evaluation and therapeutic intervention, that are designed to improve, develop, correct, rehabilitate, or prevent the worsening of speech/language communication and swallowing disorders that have been lost, impaired, or reduced as a result of acute or chronic medical conditions, congenital anomalies, or injuries. Speech and language disorders are those that affect articulation of speech, sounds, fluency, voice, swallowing (regardless of the presence of a communication disability), and those that impair comprehension, or spoken, written, or other symbol systems used for communication.

Speech-language pathology services are defined in the Medicare Benefit Policy Manual, Chapter 15, Section 230.3 as 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.

Policy

This Policy applies to the following Fallon Health products:

☒ Fallon Medicare Plus, Fallon Medicare Plus Central (Medicare Advantage)
☒ MassHealth ACO
☒ NaviCare HMO SNP (Dual Eligible Medicare Advantage and MassHealth)
☒ NaviCare SCO (MassHealth-only)
☒ PACE (Summit Eldercare PACE, Fallon Health Weinberg PACE)
☒ Community Care (Commercial/Exchange)

Prior authorization requirements for speech-language therapy services varies:

- For Fallon Medicare Plus, Fallon Medicare Plus Central and NaviCare members, prior authorization is required after 35 visits.
- For MassHealth ACO members, prior authorization is required after 30 visits.
- For Community Care members, prior authorization is required after 30 visits.
- For PACE members, with the exception of emergency care and out-of-area urgently needed care, all care and services provided to PACE plan members must be authorized by the interdisciplinary team.

Fallon Health Clinical Coverage Criteria

Fallon Health Clinical Coverage Criteria apply to Community Care members.

For Community Care members, prior authorization is required after 30 visits.

Fallon Health considers speech-language therapy services medically necessary when all of the following criteria are met:

- The member must have a documented speech disorder showing their performance is less than previous levels or below age appropriate speech milestones.
- The member's clinical record supports measurable improvement can be achieved over a specific timeframe and is reasonable based on the member's diagnosis.
- The complexity of the therapy can only be safely and effectively done by a licensed speech and language pathologist.

Medicare Variation

Medicare statutes and regulations do not have coverage criteria for speech therapy. Medicare has an NCD for Speech-Language Pathology Services for the Treatment of Dysphagia (170.3). National Government Services, Inc. has an LCD for Speech-Language Pathology (L33580) (Medicare Coverage Database search 10/28/2025).

Additionally, Medicare Benefit Policy Manual, Chapter 15, Sections 220 and 230.3 describe conditions of coverage for speech-language pathology services.

Link: NCD Speech-Language Pathology Services for the Treatment of Dysphagia (170.3)
Link: LCD Speech-Language Pathology (L33580)
Link: Medicare Benefit Policy Manual, Chapter 15, Sections 220 and 230.3

Coverage criteria for speech-language pathology services provided within the scope of practice of speech-language pathologists for the diagnosis and treatment of speech and language disorders, are fully established by Medicare in NCD Speech-Language Pathology Services for the Treatment of Dysphagia (170.3), and National Government Services, Inc. LCD Speech-Language Pathology (L33580), and therefore, the Plan's Clinical Coverage Criteria are not applicable.

MassHealth Variation

MassHealth has Guidelines for Medical Necessity Determination for Speech and Language Therapy, therefore the Plan's Clinical Coverage Criteria are not applicable to MassHealth ACO members.

Link: MassHealth Guidelines for Medical Necessity Determination for Speech and Language Therapy

All speech-language therapy services provided to MassHealth ACO members must meet clinical coverage criteria in the MassHealth Guidelines for Medical Necessity Determination for Speech and Language Therapy.

The Plan reviews requests for coverage of speech-language therapy services on a case-by-case basis in accordance with 130 CMR 450.204: Medical Necessity. The Plan bases its determination on clinical documentation that demonstrates the potential for measurable and objective progress and the potential impact of factors that would complicate or affect the efficacy of treatment.

Requests for prior authorization for speech-language therapy services beyond the 30th visit must be submitted by a speech-language pathologist and accompanied by clinical documentation supplied by a licensed physician or licensed nurse practitioner that supports the need for the services being requested. Clinical information from a licensed physician or licensed nurse practitioner must be submitted by the licensed, certified speech-language pathologist who is requesting PA.

Documentation supporting medical necessity must include all of the following:

1. The primary diagnosis name and ICD-CM code for which treatment is being requested;
2. The secondary diagnosis name and ICD-CM code specific to the medical condition;
3. The severity of the signs and symptoms pertinent to the communication or swallowing disorder;
4. A written comprehensive evaluation by a licensed, certified speech-language pathologist of the member's condition containing the following:
    a. Background information including underlying medical diagnosis, description of the medical condition, medical status, disability, previous functional level (if relevant) and psychosocial status. Treatment history and documented progress with past treatment should be included;
    b. Findings of the comprehensive speech and language evaluation, including the communication or swallowing disorder diagnosis as well as the underlying etiology with date of onset or exacerbation of the condition;
    c. Results of standardized assessment and a subjective description of the member's current level of communicative functioning or swallowing functioning;
    d. Interpretation of the results, including need for intervention, further assessment or referral, prognosis, and expectation for change in level of functioning with and without intervention;
    e. The member's rehabilitation potential, including any risk factors or comorbid conditions affecting the treatment plan.

5. A written treatment plan that incorporates all of the following:
    a. Specific short and long term measurable functional treatment goals;
    b. Treatment types, techniques and interventions to be used to achieve goals;
    c. Amount, frequency and duration of treatment;
    d. Estimate of time required to reach goals;
    e. Education of the member and primary caregiver to promote awareness and understanding of diagnosis, prognosis, and treatment;
    f. A summary of all treatment provided, and results achieved (response to treatment, changes in the member's condition, documentation of measurable progress toward previously defined goals, problems encountered, and goals met) during previous periods of therapy;
    g. For members receiving speech-language therapy in another setting, requests for additional services must be for substantially different treatment from that currently being received. Justification for additional therapy must include not only the medical basis for the services, but also the goals for the additional therapy.

Exclusions

- Speech Therapy that does not meet the above criteria
- Services that are primarily educational or vocational in nature
- Maintenance therapy once further improvement is not expected
- Treatment related to accent or dialect reduction
- Treatment for self-correcting disorders (natural dysfluency or articulation errors that are self-correcting)

Coding

The following codes are included below for informational purposes only; inclusion of a code does not constitute or imply coverage or reimbursement.

Note: The Plan follows Subchapter 6 of the MassHealth Provider Manual for MassHealth ACO members. Payable codes and modifiers for speech-language therapy services are listed in Subchapter 6, Section 604 of the MassHealth Therapist Manual.

CPT code 92605 (Evaluation for prescription for non-speech generating AAC device, face-to-face with the patient; first hour) is not reimbursed by the Plan for Medicare Advantage, Fallon Health Weinberg PACE or Community Care members.

CPT code 92606 (Therapeutic service(s) for the use of non-speech-generating device, including programming and modification) is not reimbursed by the Plan.

CPT 92618 (Evaluation for prescription for non-speech generating AAC device, face-to-face with the patient; each additional 30 minutes is not reimbursed by the Plan.

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
92521	Evaluation of speech fluency (eg, stuttering, cluttering)
92522	Evaluation of speech sound production (eg, articulation, phonological process, apraxia, dysarthria)
92523	Evaluation of speech sound production (eg, articulation, phonological process, apraxia, dysarthria) with evaluation of language comprehension and expression (eg, receptive and expressive language)
92524	Behavioral and qualitative analysis of voice and resonance

92605	Evaluation for prescription for non-speech generating AAC device, face-to-face with the patient; first hour
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
92609	Therapeutic services for the use of speech-generating device, including programming and modification
92610	Evaluation of oral and pharyngeal swallowing function (per hour, maximum of one hour)
92618	Evaluation for prescription for non-speech generating AAC device, face-to-face with the patient; each additional 30 minutes (list separately in addition to code for primary procedure)

References

1. Massachusetts General Law (M.G.L) Chapter 176G Section 4N Coverage for speech, hearing, and language disorders.
2. Massachusetts Legislature Chapter 234 Acts of 2012: An Act Relative To The Treatment Of Cleft Palate And Cleft Lip.
3. Medicare National Coverage Determination (NCD). Speech-Language Pathology Services for the Treatment of Dysphagia (170.3). Original Effective Date 08/28/1989. Effective Date of this Version 10/01/2006. Available at: https://www.cms.gov/medicare-coverage-database/view/ncd.aspx?NCDId=192&NCDver=2. Accessed 08/26/2024.
4. National Government Services, Inc. Local Coverage Determination (LCD) Speech-Language Pathology (L33580). Original Effective Date For services performed on or after 10/1/2015. Revision Effective Date For services performed on or after 12/19/2019. Available at: https://www.cms.gov/medicare-coverage-database/view/lcd.aspx?LCDId=33580. Accessed 10/27/2025.
5. National Government Services, Inc. LCD Reference Article Billing and Coding: Speech-Language Pathology (A52866). Original Effective Date 10/01/2015. Revision Effective Date 01/01/2025. Available at: https://www.cms.gov/medicare-coverage-database/view/article.aspx?articleid=52866. Accessed 10/27/2025.
6. MassHealth. Guidelines for Medical Necessity Determination for Speech and Language Therapy. Revised Date: March 30, 2017. Policy Effective Date: July 1, 2005. Available at: https://www.mass.gov/guides/masshealth-guidelines-for-medical-necessity-determination-for-speech-and-language-therapy. Accessed 10/27/2025.
7. American Speech-Language-Hearing Association (ASHA). Speech-Language Pathology Medical Review Guidelines. Copyright © 2015 American Speech-Language-Hearing Association. Available at: https://www.asha.org/practice/reimbursement/slp-medical-review-guidelines/. Accessed 08/26/2024.
8. ASHA. Preferred Practice Patterns for the Profession of Speech-Language Pathology. Approved by the ASHA Legislative Council, November 2004. Available at: https://www.asha.org/policy/. Accessed 08/26/2024.

Policy history

Origination date:	11/28/2006
Review/Approval(s):	Technology Assessment Subcommittee: 11/28/2006 Technology Assessment Committee: 04/10/2007, 12/03/2014 (updated criteria and references) 12/15/2015 (added code 92524), 12/07/2016 (annual review, no updates), 12/6/2017 (updated references), 02/01/2018 (clarified authorization language regarding initial visits, not reviewed via committee), 12/05/2018 (annual review, no updates) 12/04/2019 (annual review, no

updates), 02/10/2022 (Added clarifying language related to Medicare Advantage, NaviCare and PACE under policy section), 08/27/2024 (annual review, updated regulatory language under Policy section, updated Coding and References sections), 10/28/2025 (annual review, no changes to coverage criteria, created new sections for Medicare and MassHealth variation).
Utilization Management Committee: 11/18/2025 (annual review, approved with no changes to coverage criteria).

Instructions for Use

Fallon Health complies with CMS's national coverage determinations (NCDs), local coverage determinations (LCDs) of Medicare Contractors with jurisdiction for claims in the Plan's service area, and applicable Medicare statutes and regulations when making medical necessity determinations for Medicare Advantage members. When coverage criteria are not fully established in applicable Medicare statutes, regulations, NCDs or LCDs, Fallon Health may create internal coverage criteria under specific circumstances described at § 422.101(b)(6)(i) and (ii).

Fallon Health generally follows Medical Necessity Guidelines published by MassHealth when making medical necessity determinations for MassHealth members. In the absence of Medical Necessity Guidelines published by MassHealth, Fallon Health may create clinical coverage criteria in accordance with the definition of Medical Necessity in 130 CMR 450.204.

For plan members enrolled in NaviCare, Fallon Health first follows CMS's national coverage determinations (NCDs), local coverage determinations (LCDs) of Medicare Contractors with jurisdiction for claims in the Plan's service area, and applicable Medicare statutes and regulations when making medical necessity determinations. When coverage criteria are not fully established in applicable Medicare statutes, regulations, NCDs or LCDs, or if the NaviCare member does not meet coverage criteria in applicable Medicare statutes, regulations, NCDs or LCDs, Fallon Health then follows Medical Necessity Guidelines published by MassHealth when making necessity determinations for NaviCare members.

Each PACE plan member is assigned to an Interdisciplinary Team. PACE provides participants with all the care and services covered by Medicare and Medicaid, as authorized by the interdisciplinary team, as well as additional medically necessary care and services not covered by Medicare and Medicaid. With the exception of emergency care and out-of-area urgently needed care, all care and services provided to PACE plan members must be authorized by the interdisciplinary team.

Not all services mentioned in this policy are covered for all products or employer groups. Coverage is based upon the terms of a member's particular benefit plan which may contain its own specific provisions for coverage and exclusions regardless of medical necessity. Please consult the product's Evidence of Coverage for exclusions or other benefit limitations applicable to this service or supply. If there is any discrepancy between this policy and a member's benefit plan, the provisions of the benefit plan will govern. However, applicable state mandates take precedence with respect to fully insured plans and self-funded non-ERISA (e.g., government, school boards, church) plans. Unless otherwise specifically excluded, federal mandates will apply to all plans