

Home Care - Speech Language Pathology (SLP) Services

Disclaimer

Clinical guidelines are developed and adopted to establish evidence-based clinical criteria for utilization management decisions. Clinical guidelines are applicable according to policy and plan type. The Plan may delegate utilization management decisions of certain services to third parties who may develop and adopt their own clinical criteria.

Coverage of services is subject to the terms, conditions, and limitations of a member's policy, as well as applicable state and federal law. Clinical guidelines are also subject to in-force criteria such as the Centers for Medicare & Medicaid Services (CMS) national coverage determination (NCD) or local coverage determination (LCD) for Medicare Advantage plans. Please refer to the member's policy documents (e.g., Certificate/Evidence of Coverage, Schedule of Benefits, Plan Formulary) or contact the Plan to confirm coverage.

Summary

Members recently discharged from the hospital and/or those diagnosed with certain medical conditions may require short-term skilled care in the home for rehabilitation. When medically necessary, such services can be used to restore or improve functional independence, and help train caregivers and family members in ongoing care of the member. Speech Language Pathology (SLP) or Speech Therapy services are an example of skilled home care and when medically necessary, can be used to improve or restore functional skills of communication (speech production, fluency, language, cognition, voice, resonance, and hearing) and swallowing (oral, pharyngeal, and esophageal, including related feeding behaviors).

Speech therapy is appropriate for specific disorders that affect communication, swallowing, and cognition. A communication disorder as per American Speech-Language-Hearing Association is an impairment in the ability to receive, send, process, and comprehend verbal, nonverbal or symbolic based information. Communication disorders can include speech disorders such as articulation, fluency, or voice, a language disorder including the form (rules that govern how sounds and words are structured), content (meaning of words and sentences) or function (pragmatic/social) of language and hearing disorders including deaf and hard of hearing. Examples of disorders that affect *communication* may include chronic otitis media with conductive hearing loss, vocal cord injuries and/or conditions (e.g., edema, nodules, growths), stroke or cerebrovascular accident (CVA), injury or trauma, cerebral palsy, or encephalopathy. Signs of feeding and *swallowing* disorders may include: difficulty sucking, biting/chewing, moving foods within the mouth, taking a long time to eat, coughing or gagging during

meals, having a gurgly, hoarse, or breathy voice during or after meals, or are losing weight or not gaining weight or growing. Swallowing disorders may result from stroke or cerebrovascular accident (CVA), traumatic brain injury (TBI), cancer, congenital defect, certain genetic syndromes, or certain neurodegenerative disorders such as Parkinson disease (PD), or amyotrophic lateral sclerosis (ALS). Signs of a change in cognition can include reduced awareness and ability to communicate wants and needs, reduced memory, judgment, and ability to share information, reduced ability in problem solving, reasoning, or judging potential consequences.

Speech pathology is generally coordinated by a multidisciplinary team of licensed speech language pathologists, nurses, and prescribing clinicians. Treatments may consist of activities that are tailored to address the functional needs of the member in their own environment. These skilled interventions focus on improving speech, language production, cognitive function, and swallowing. Home SLP therapy requires a prescription and clear documentation of progress, goals, and ongoing medical necessity.

Information about coverage and benefit limitations can be found in the member's plan contract at hioscar.com/forms.

Definitions

"Homebound" refers to members who have normal inability to leave home without considerable and taxing effort (i.e., requires an assistive device or the assistance of another person to leave home) AND one of the following:

- Members who cannot leave home due to a medical condition, chronic disease, or injury; *or*
- Members advised by a treating provider not to leave home for various reasons (e.g., safety, ongoing medical treatment needs, etc.); *or*
- Members who need the aid of supportive devices such as crutches, canes, wheelchairs, and walkers, special transportation (when the member is unable to use common transportation such as private automobile, bus, taxi due to medical condition), or the assistance of others to leave their place of residence.

When the member does leave home, the absence of the member from the home is infrequent or for short periods of time, such as to receive health treatment or adult daycare (non-residential program providing services during the day).

"Speech Language Pathology (SLP)" Therapy or "Speech Therapy" encompasses the diagnosis and treatment of communication and swallowing:

- Communication:
 - Cognitive deficits include problems with memory, executive functioning, attention, problem solving, decision making, organization of thoughts and ideas, and visuospatial processing.
 - A hearing disorder can include hearing loss, deafness, and auditory processing.
 - A language disorder consists of impaired comprehension and/or use of spoken, written, or other symbolic systems. It can include difficulty with phonology, morphology, syntax,

semantics, pragmatics, vocabulary, and word retrieval, including receptive and expressive aphasia.

- A speech disorder is an impairment of the articulation of speech sounds, fluency, and/or voice. It may include deficits such as problems with perception, motor or vocal production articulation, and phonology.
- A fluency disorder includes an interruption in the flow of speaking characterized by atypical rate, rhythm, and disfluencies (e.g., repetitions of sounds, syllables, words, and phrases; sound prolongations; and blocks), which may also be accompanied by excessive tension, speaking avoidance, struggle behaviors, and secondary mannerisms.
- An articulation disorder is the atypical production of speech sounds characterized by substitutions, omissions, additions, or distortions that can impact how well a person is understood.
- A voice disorder is characterized by abnormal production of vocal quality, pitch, loudness, and resonance which is not appropriate for an individual's age or gender. Voice disorders can be caused by vocal cord injuries and conditions (e.g., edema, nodules, growths) resulting in conditions that affect voice quality, pitch, and loudness ranging from aphonia to hoarseness.
- A resonance disorder is a deficit in resonance attributed to having too much or too little nasal and/or oral sound energy in the speech signal. They can result from structural or functional (e.g., neurogenic) causes and occasionally are due to mislearning (e.g., articulation errors that can lead to the perception of a resonance disorder). Resonance disorders include hypernasality, hyponasality, cul-de-sac resonance or mixed resonance.
- Swallowing
 - A feeding and swallowing disorder or dysphagia is characterized by difficulty moving food or liquid from the mouth (oral cavity), throat (pharynx), or esophagus to the stomach. Dysphagia can occur in the oral, pharyngeal, or esophageal stages.

"Speech Language Pathologists (SLPs)" work to prevent, assess, diagnose, and treat speech, language, social communication, cognitive-communication, and swallowing disorders in children and adults. This treatment should be delivered by a licensed and certified speech language pathologist.

"Activities of Daily Living (ADLs)" are defined as routine activities that most healthy persons perform daily without requiring assistance: These include but are not limited to: communication and eating.

"Instrumental Activities of Daily Living (IADLs)" are defined as activities that may be performed daily but are not fundamental for daily functioning. These include, but are not limited to: the use of public transportation, balancing a checkbook, community living activities, meal preparation, laundry, leisure activities and sports, and motor vehicle operation.

“Rehabilitative Treatments” are healthcare services and devices with the goal of helping a person keep, get back, or improve skills and functioning for daily living that have been lost or impaired due to illness, injury, or disability.

“Habilitative Treatments” are healthcare services and devices with the goal of helping a person keep, learn, or improve skills and functioning for daily living when they are impaired as a result of injury, disease, or congenital abnormality. This is different from rehabilitative treatment in that habilitative treatments are for individuals that have not developed to the expected level of function or have not yet met a development milestone; an example includes therapy for a child who is not talking at the expected age.

“Custodial Care” or “Long-term Care” are non-skilled, personal care to maintain the member’s ADLs or IADLS over a long-term duration and do not require oversight or skilled services by trained health professionals or technical personnel. These services are not part of a medical treatment plan for recovery, rehabilitation, habilitation, or improvement in sickness or injury. Custodial services may be provided in the home, assisted living facilities, or nursing homes, etc. This type of custodial or long-term care typically does not apply for plan benefits, please see the member’s plan benefit.

Hospice Care / End-of-Life Care - are interdisciplinary and holistic care when curative or life-prolonging treatments are no longer beneficial and services may focus on symptom control, psychosocial and spiritual care, nursing, or short-term acute services. Trained clinicians and support staff support individual and family quality-of-life goals. Hospice care can be provided in the home, skilled nursing facility, or hospital setting (for acute symptom management and stabilization to return to previous level of hospice care).

Palliative Care - is interdisciplinary and holistic care that focuses on symptom management, relieving suffering in all stages of disease, supporting communication, assessing psychosocial and spiritual resources, social and economic resources. Members may receive curative or life-prolonging treatment, and may not choose to receive hospice care or end-of-life care. Furthermore, palliative care provides support for individual and family quality-of-life goals.

Clinical Indications

Speech Language Pathology services in the home are considered medically necessary for initial requests when ALL of the following criteria are met:

1. The treatment plan is prescribed by a licensed provider (MD, DO, NP, or PA) as per individual state law and must be provided by a licensed SLP therapist certified by ASHA (American Speech Language Hearing Association); *and*
2. The member meets the definition of homebound (see *Definitions* section above); *and*
3. Medical necessity criteria in the appropriate MCG Home Care Optimal Recovery Guidelines or MCG Home Care General Recovery Guideline is met; *and/or*

4. For members requesting hospice care/end-of-life care or palliative care (please check plan benefits to verify hospice or palliative care benefit timeframes), the following criteria must be met to meet medical necessity:
 - a. The member is terminally ill, presenting with functional decline, and certified by a medical practitioner for life expectancy less than twelve months for palliative care and less than six months for hospice/end-of-life care; *and*
 - b. The SLP services are rendered as part of a hospice care program; *and*
 - c. The member may receive curative treatment while receiving palliative care; *and/or*
 - d. The member is not receiving curative treatment while in hospice care; *and*
5. The member is motivated, alert and oriented (unless member has cognitive impairment and may not be fully oriented); *and*
6. Therapy is aimed at establishing or restoring function; *and*
7. Rehab potential is evident based on a review of the member's condition, and the member's function is not expected to improve in the absence of therapy; *and*
8. The written plan of care should be sufficient to determine the necessity of SLP therapy and must include the following elements:
 - a. A medical evaluation has been conducted within 30 days of the service dates; *and*
 - b. The diagnosis, the date of onset or exacerbation of the disorder/diagnosis, the duration, the severity, the anticipated course (stable, progressive or, improving), and the prognosis; *and*
 - c. Prior level and current level of communication (including any prior device usage); *and*
 - d. Standardized testing applicable to the member's age and medical condition; *and*
 - e. The goals must be objective and measurable with the specific amount, frequency, and duration of the services. The short-term goals should be attainable in no more than 3 months and long-term goals are attainable within a reasonable period of time (please check plan benefits for coverage); *and*
 - f. Clearly and objectively measured progress over specific time frames; *and*
 - g. The frequency and duration of treatment; *and*
 - h. The specific treatment techniques to be used; *and*
 - i. Discharge plan.
9. Documentation of medical necessity should be reviewed when ANY of the following occur:
 - a. The plan of care exceeds the expected duration and/or estimated frequency of care; *or*
 - b. There is a change in the member's condition that may impact the plan of care; *or*
 - c. The specific goals are no longer expected to be achieved in a reasonable or expected duration of time.

Additional Qualifying Criteria for Dysphagia and Vocal Therapy

SLP therapy indicated for dysphagia must also meet the following criteria:

1. The member is at high risk of recurrent aspiration/choking and inadequate nutrition and hydration as evidenced by the results of a videofluoroscopic swallowing study (VFSS), i.e.,

modified barium swallow study (MBSS), or fiberoptic endoscopic evaluation of swallowing (FEES); *and*

2. The member has retained some swallowing function and shows stimulability to improve swallowing safety and efficiency in therapy as evidenced by the results of an VFSS, MBSS or FEES.

SLP therapy indicated for vocal therapy is appropriate only for the following conditions and must include an ENT evaluation; if available and physically possible, a videostroboscopy should be conducted:

1. Vocal cord dysfunction (paradoxical vocal cord motion); *or*
2. Spastic dysphonia; *or*
3. Vocal cord nodules; *or*
4. Vocal cord paralysis; *or*
5. Following laryngeal cancer; *or*
6. Following surgery or injury to the vocal cords.

Extension Requests

A Plan member who requires continued SLP visits, beyond the original treatment plan of care, may receive extended treatment when the following criteria are met:

1. A re-evaluation has been conducted within 30 days of the service dates; *and*
 - a. The appropriate MCG Home Care Optimal Recovery Guidelines with the Extended Visits criteria are met; *or*
 - b. The appropriate MCG Home Care General Recovery Guideline and the member is still in General Treatment Course Stage 2 or has not met all of the milestones in Stage 3; *or*
2. For an extension request/recertification for hospice or palliative care, please see plan benefits and requirements. The member meets medical necessity when the member continues to meet criteria as listed under Clinical Indications above in criterion 4.

Experimental or Investigational / Not Medically Necessary

Skilled home care, and thus home SLP therapy, should be discontinued when one of the following is present:

- Homebound status is no longer met; *or*
- The member reaches the predetermined goals or skilled treatment is no longer required; *or*
- The member has reached maximum rehab potential; *or*
- The goals will not be met and there is no expectation of meeting them in reasonable time; *or*
- The member can safely and effectively continue their rehabilitation independently or with the help of family or caregivers; *or*
- The member's medical condition prevents further therapy; *or*
- The member refuses treatment; *or*
- The member's behavior or home environment is deemed to be unsafe for effective therapeutic intervention

SLP services are not considered medically necessary for the following:

- Asymptomatic members or those without an identifiable clinical condition; *or*
- Cases of transient or easily reversible loss or reduction in function which could be reasonably expected to improve spontaneously as the member gradually resumes normal activities; *or*
- Chronic illness / chronic flare-ups or exacerbations that did not result in a decline in function or related to an acute exacerbation, *or*
- Long-term maintenance therapy, as it is aimed to preserve the present level of function or to prevent regression below an acceptable level of functioning; *or*
- Custodial care or Long-term care services; *or*
- No expected improvement in functioning over a reasonable and predictable period of time (i.e., a “stable deficit”); *or*
- Duplicative therapy services or programs; *or*
- Treatment modalities that do not require a skilled professional speech language therapy and can safely be conducted by the member alone or with the help of family or caregivers; *or*
- Occupational or recreational requests aiming to augment or improve upon normal human functioning; this includes services considered as routine, conditioning, educational, employment or job training, or as part of a voice training program for singing, public speaking, or fitness; *or*
- Services aimed to identify or screen for members, including screening for hearing acuity; *or*
- As a component of auditory rehab, except for a newly prescribed auditory device (e.g., cochlear implant or BAHA); *or*
- Treatment modalities for which SLP is not adequately supported by peer literature include, but are not limited to:
 - Facilitated communication
 - Altered auditory feedback devices
 - Auditory verbal therapy
 - Vital stim or equivalent electrical stimulation for swallowing disorders
 - Sequential Oral Sensory (SOS) or equivalent therapy
 - Voice amplifiers in the absence of illness or injury do not meet DME requirements; *or*
- Conditions for which SLP is not adequately supported by peer literature include, but are not limited to:
 - Transient ischemic attacks (TIAs), as they are a transient and self-limited deficit.
 - Essential voice tremor
 - Laryngeal hyperadduction
 - Laryngitis
 - Functional dysphonia
 - Supraglottic vocal hyperfunction
 - Altered auditory feedback devices / communication aids for stuttering
 - Members with developmental articulation errors that are self-correcting (e.g., word drills)
 - Sign language training as an augment to primary spoken language
 - Myofunctional disorders (e.g., tongue thrust)

- Chronic conditions flare-ups or exacerbations without acute exacerbation that do not meet the above criteria
- Idiopathic speech delays in members younger than 18 months old is considered experimental as it is unreliable to diagnose speech delays
- Functional feeding disorders

Applicable Billing Codes

Codes considered medically necessary when clinical criteria are met:

<i>Code</i>	<i>Description</i>
92507	Treatment of speech, language, voice, communication, and/or auditory processing disorder; individual
92520	Laryngeal function studies (ie, aerodynamic testing and acoustic testing)
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
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
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
92610	Evaluation of oral and pharyngeal swallowing function
92626	Evaluation of auditory function for surgically implanted device(s) candidacy or postoperative status of a surgically implanted device(s); first hour
92627	Evaluation of auditory function for surgically implanted device(s) candidacy or postoperative status of a surgically implanted device(s); each additional 15 minutes (List separately in addition to code for primary procedure)
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, eg, by Boston Diagnostic Aphasia Examination) with interpretation and report, per hour
96110	Developmental screening (eg, developmental milestone survey, speech and language delay screen), with scoring and documentation, per standardized instrument
96112	Developmental test administration (including assessment of fine and/or gross motor, language, cognitive level, social, memory and/or executive functions by standardized developmental instruments when performed), by physician or other qualified health care professional, with interpretation and report; first hour
96113	Developmental test administration (including assessment of fine and/or gross motor, language, cognitive level, social, memory and/or executive functions by standardized developmental instruments when performed), by physician or other qualified health care professional, with interpretation and report; each additional 30 minutes (List separately in addition to code for primary procedure)
97129	Therapeutic interventions that focus on cognitive function (eg, attention, memory, reasoning, executive function, problem solving, and/or pragmatic functioning) and compensatory strategies to manage the performance of an activity (eg, 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 (eg, attention, memory, reasoning, executive function, problem solving, and/or pragmatic functioning) and compensatory strategies to manage the performance of an activity (eg, 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)
G0153	Services performed by a qualified speech-language pathologist in the home health or hospice setting, each 15 minutes
G0161	Services performed by a qualified speech-language pathologist, in the home health setting, in the establishment or delivery of a safe and effective speech-language pathology maintenance program, each 15 minutes [not to be billed when exceeding 3 months with every 30-day evaluation]
S9128	Speech therapy, in the home, per diem
S9152	Speech therapy, re-evaluation
V5336	Repair/modification of augmentative communicative system or device (excludes adaptive hearing aid)
V5362	Speech screening
V5363	Language screening

V5364	Dysphagia screening
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Codes not considered medically necessary for indications listed in this Guideline:

<i>Code</i>	<i>Description</i>
43229	Esophagoscopy, flexible, transoral; with ablation of tumor(s), polyp(s), or other lesion(s) (includes pre- and post-dilation and guide wire passage, when performed) [not considered medically necessary for ERBE electrocautery]
64550	Application of surface (transcutaneous) neurostimulator (eg, TENS unit)
64612	Chemodenervation of muscle(s); muscle(s) innervated by facial nerve, unilateral (eg, for blepharospasm, hemifacial spasm)
64616	Chemodenervation of muscle(s); neck muscle(s), excluding muscles of the larynx, unilateral (eg, for cervical dystonia, spasmodic torticollis)
90867	Therapeutic repetitive transcranial magnetic stimulation (TMS) treatment; initial, including cortical mapping, motor threshold determination, delivery and management
90868	Therapeutic repetitive transcranial magnetic stimulation (TMS) treatment; subsequent delivery and management, per session
90869	Therapeutic repetitive transcranial magnetic stimulation (TMS) treatment; subsequent motor threshold re-determination with delivery and management
95873	Electrical stimulation for guidance in conjunction with chemodenervation (List separately in addition to code for primary procedure)
95874	Needle electromyography for guidance in conjunction with chemodenervation (List separately in addition to code for primary procedure)
97014	Application of a modality to one or more areas; electrical stimulation (unattended)
97032	Application of a modality to one or more areas; electrical stimulation (manual), each 15 minutes
97810 - 97814	Acupuncture
E0720	Transcutaneous electrical nerve stimulation (TENS) device, two lead, localized stimulation
E0730	Transcutaneous electrical nerve stimulation (TENS) device, four or more leads, for multiple nerve stimulation
E0745	Neuromuscular stimulator, electronic shock unit
E1399	Durable medical equipment, miscellaneous [when billed for altered auditory feedback devices for stuttering]

G0283	Electrical stimulation (unattended), to one or more areas for indication(s) other than wound care, as part of a therapy plan of care
J0585	Injection, onabotulinumtoxinA, 1 unit
J0587	Injection, rimabotulinumtoxinB, 100 units
L8510	Voice amplifier

References

1. Ahern R, Lippincott LH, Wisdom G. Voice rehabilitation after laryngectomy: An overview. *J La State Med Soc.* 2002;154(3):118-120.
2. Alper BS, Manno CJ. Dysphagia in infants and children with oral-motor deficits: Assessment and management. *Semin Speech Lang.* 1996;17(4):283-310.
3. Alamer A, Melese H, Nigussie F. Effectiveness of Neuromuscular Electrical Stimulation on Post-Stroke Dysphagia: A Systematic Review of Randomized Controlled Trials. *Clin Interv Aging.* 2020 Sep 3;15:1521-1531. doi: 10.2147/CIA.S262596. PMID: 32943855; PMCID: PMC7481288.
4. American Speech-Language-Hearing Association. (2004). Admission/Discharge Criteria in Speech-Language Pathology. Retrieved from: <https://www.asha.org/policy/gl2004-00046/>
5. American Speech-Language-Hearing Association. (2022). Evidence Mapping for Stuttering Treatment. Available from: <http://www2.asha.org/evidencemaplanding.aspx?id=8589936429&recentarticles+false&year+undefined&tab=all>. Accessed March 11, 2022.
6. American Speech-Language-Hearing Association. (n/a). Stuttering. Retrieved 3/7/23 from <https://www.asha.org/public/speech/disorders/stuttering/>
7. American Speech-Language-Hearing Association. (2022). ASHA Evidence Maps. Summary of the Systematic Review. Stuttering Interventions for Children, Adolescents, and Adults: A Systematic Review as a Part of Clinical Guidelines. *Journal of Communication Disorders*, 99, 106242. Retrieved from <https://apps.asha.org/EvidenceMaps/Articles/ArticleSummary/fadff17d-ae32-ed11-8137-0050568382a5>
8. American Speech-Language-Hearing Association. Feeding and Swallowing Disorders in Children. Retrieved from: <https://www.asha.org/public/speech/swallowing/feeding-and-swallowing-disorders-in-children/>. Accessed March 11, 2022.
9. American Speech-Language-Hearing Association. Cognitive-Communication Referral Guidelines for Adults. Retrieved from: <https://www.asha.org/slp/cognitive-referral/>. Accessed March 11, 2022.
10. American Speech-Language-Hearing Association. (2016). Scope of practice in speech-language pathology [Scope of Practice]. Available from www.asha.org/policy/.
11. American Speech-Language-Hearing Association. (n.d.). Adult Dysphagia. (Practice Portal). Retrieved March 12, 2022, from www.asha.org/Practice-Portal/Clinical-Topics/Adult-Dysphagia/

12. American Speech-Language-Hearing Association (n.d.). Fluency Disorders (Practice Portal). Retrieved March 12, 2022, from www.asha.org/practice-portal/clinical-topics/fluency-disorders/.
13. American Speech-Language-Hearing Association (n.d.) Speech Sound Disorders: Articulation and Phonology. (Practice Portal). Retrieved March 12,, 2022, from www.asha.org/Practice-Portal/Clinical-Topics/Articulation-and-Phonology/
14. American Speech-Language-Hearing Association (n.d.). Spoken Language Disorders. (Practice Portal). Retrieved March 12, 2022, from www.Practice-Portal/Clinical-Topics/Spoken-Language-Disorders.
15. American Speech-Language-Hearing Association. (2003). Evaluating and treating communication and cognitive disorders: approaches to referral and collaboration for speech-language pathology and clinical neuropsychology [Technical Report]. Available from www.asha.org/policy.
16. American Speech-Language-Hearing Association. (n.d.). Voice Disorders. (Practice Portal). Retrieved March 12, 2022 from www.asha.org/Practice-Portal/Clinical-Topics/Voice-Disorders/.
17. American Speech-Language-Hearing Association. (n.d.). Resonance Disorders. (Practice Portal). Retrieved March 12, 2022 from www.asha.org/Practice-Portal/Clinical-Topics/Resonance-Disorders/.
18. Arvedson JC. Management of pediatric dysphagia. *Otolaryngol Clin North Am*. 1998;31(3):453-476.
19. Bowen A, Hesketh A, Patchick E, et al. Effectiveness of enhanced communication therapy in the first four months after stroke for aphasia and dysarthria: A randomised controlled trial. *BMJ*. 2012;345:e4407.
20. Brady MC, Kelly H, Godwin J, Enderby P. Speech and language therapy for aphasia following stroke. *Cochrane Database Syst Rev*. 2012;5:CD000425.
21. Brennan-Jones CG, White J, Rush RW, Law J. Auditory-verbal therapy for promoting spoken language development in children with permanent hearing impairments. *Cochrane Database Syst Rev*. 2014;3:CD010100.
22. Burke D, Alexander K, Baxter M, et al. Rehabilitation of a person with severe traumatic brain injury. *Brain Inj*. 2000;14(5):463-471.
23. Brignell, A., Krahe, M., et al. (2021). Interventions for Children and Adolescents Who Stutter: A Systematic Review, Meta-Analysis, and Evidence Map. *Journal of Fluency Disorders*, 70, 105843. Retrieved from: <https://www2.asha.org/articlesummary.aspx?id=8589987807>
24. Brignell, A., Krahe, M., et al. (2020). A Systematic Review of Interventions for Adults Who Stutter. *Journal of Fluency Disorders*, 64, 105766. Retrieved from: <https://www2.asha.org/articlesummary.aspx?id=8589986670>
25. Chen X, et al. Types and timing of therapy for vocal fold paresis/paralysis after thyroidectomy: a systematic review and meta-analysis. *Journal of Voice* 2014;28(6):799-808. DOI: 10.1016/j.jvoice.2014.02.003.
26. CMS Medicare Benefit Policy Manual Chapter 7 - Home Health Services. CMS.gov. <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c07.pdf> Revised 05/7/2021.
27. Centers for Medicare & Medicaid Services. Medicare Benefit Policy Manual Chapter 9 - Coverage of Hospice Services Under Hospital Insurance. <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c09.pdf>

28. CMS Coverage Guidelines. <http://www.cms.gov/mcd/index>. Accessed on Feb 27, 2016.
 - a. National Coverage Determination (NCD) for SPEECH-LANGUAGE Pathology Services for the Treatment of Dysphagia (170.3)
 - b. Local Coverage Article: Coding Guidelines for Home Health SPEECH-LANGUAGE Pathology (A53052)
 - c. Local Coverage Article: SPEECH LANGUAGE Pathology (SLP) Services: Communication Disorders (A54111)
 - d. Local Coverage Article: SPEECH-LANGUAGE Pathology – Supplemental Instructions Article (A52866)
 - e. Local Coverage Determination (LCD): Home Health SPEECH-LANGUAGE Pathology (L34563)
 - f. Local Coverage Determination (LCD): Medicine: SPEECH LANGUAGE Pathology - Outpatient (L34311)
29. Druker KC, Mazzucchellie TG, Beilby JM. (2019). An evaluation of an integrated fluency and resilience program for early developmental stuttering disorders. *Journal of Communication Disorders*; 78: 69-83. Doi: <https://doi.org/10.1016/j.jcomdis.2019.02.002>
30. Local Coverage Determination (LCD): Outpatient SPEECH LANGUAGE Pathology (L34429) Casper JK, Murry T. Voice therapy methods in dysphonia. *Otolaryngol Clin North Am*. 2000;33(5):983-1002.
31. Connery A, Galvin R, McCurtin A. (2021). Effectiveness of Nonpharmacological Stuttering Interventions on Communication and Psychosocial Functioning in Adults: A Systematic Review and Meta-Analysis of Randomized Controlled Trials. *Journal of Evidence-Based Medicine*, 14(1), 17-26. Retrieved from: <https://www2.asha.org/articlesummary.aspx?id=8589987110>
32. Craig J, Tomlinson C, Stevens K, et al. Combining voice therapy and physical therapy: A novel approach to treating muscle tension dysphonia. *J Commun Disord*. 2015;58:169-178.
33. Davies S. An interdisciplinary approach to the management of dysphagia. *Prof Nurse*. 2002;18(1):22-25.
34. Dejonckere PH. Clinical implementation of a multidimensional basic protocol for assessing functional results of voice therapy. A preliminary study. *Rev Laryngol Otol Rhinol (Bord)*. 2000;121(5):311-313.
35. ECRI. Diagnosis and treatment of swallowing disorders (dysphagia) in acute-care stroke patients. Evidence Report/ Technology Assessment No. 8. Prepared by ECRI for the Agency for Health Care Policy and Research (AHCPR). AHCPR Pub. No. 99-E024. Bethesda, MD: AHCPR; July 1999.
36. Enderby P, Emerson J. Speech and language therapy: does it work? *BMJ*. 1996; 312(7047):1655-1658.
37. Enderby PM, John A. Therapy outcome measures in speech and language therapy: comparing performance between different providers. *Int J Lang Commun Disord*. 1999;34(4):417-429.
38. Frigerio-Domingues CE, Gkalitsiou Z, Zezinka A, et al. (2019). Genetic factors and therapy outcomes in persistent developmental stuttering. *Journal of Communication Disorders*; 80: 11-17. Doi: <https://doi.org/10.1016/j.jcomdis.2019.03.007>

39. Glade MJ. Diagnostic and therapeutic technology assessment: speech therapy in patients with a prior history of recurrent or chronic otitis media with effusion. *Amer Med Assoc.* Jan 5, 1996.
40. Gillman, A., Winkler, R., et al. (2016). Implementing the Free Water Protocol Does Not Result in Aspiration Pneumonia in Carefully Selected Patients With Dysphagia: A Systematic Review. *Dysphagia*, 1-17. Epub ahead of print retrieved November 28, 2016 from <http://dx.doi.org/10.1007/s00455-016-9761-3>.
41. Goldberg DM, Flexer C. Auditory-verbal graduates: Outcome survey of clinical efficacy. *J Am Acad Audiol.* 2001;12(8):406-414.
42. Greaver L, Eskridge H, Teagle HF. Considerations for pediatric cochlear implant recipients with unilateral or asymmetric hearing loss: Assessment, device fitting, and habilitation. *Am J Audiol.* 2017;26(2):91-98. doi: 10.1044/2016_AJA-16-0051
43. Hazlett DE, Duffy OM, Moorhead SA. Review of the impact of voice training on the vocal quality of professional voice users: Implications for vocal health and recommendations for further research. *J Voice.* 2011;25(2):181-191.
44. Herd CP, Tomlinson CL, Deane KH, et al. Comparison of speech and language therapy techniques for speech problems in Parkinson's disease. *Cochrane Database Syst Rev.* 2012b;8:CD002814.
45. Herd CP, Tomlinson CL, Deane KH, et al. Speech and language therapy versus placebo or no intervention for speech problems in Parkinson's disease. *Cochrane Database Syst Rev.* 2012;(8):CD002812.
46. Kaneoka, A., Pisegna, J. M., et al. (2017). A Systematic Review and Meta-Analysis of Pneumonia Associated With Thin Liquid vs. Thickened Liquid Intake in Patients Who Aspirate. *Clinical Rehabilitation*, 31(8), 1116-1125.
47. Koch WM. Swallowing disorders. Diagnosis and therapy. *Med Clin North Am.* 1993;77(3):571-582.
48. Kosko JR, Moser JD, Erhart N, Tunkel DE. Differential diagnosis of dysphagia in children. *Otolaryngol Clin North Am.* 1998;31(3):435-451.
49. Laiho A, Elovaara H, Kaisamatti K, et al. (2022). Stuttering interventions for children, adolescents, and adults: a systematic review as a part of clinical guidelines. *Journal of Communication Disorders*; 99:106242. Doi: <https://doi.org/10.1016/j.jcomdis.2022.106242>
50. Landers S, Madigan E, Leff B, Rosati RJ, McCann BA, et al. The Future of Home Health Care. A Strategic Framework for Optimizing Value. *Home Health Care Manag Pract.* 2016; 28(4): 262–278. doi: 10.1177/1084822316666368
51. Langmore SE. Issues in the management of dysphagia. *Folia Phoniatr Logop.* 1999;51(4-5):220-230.
52. Limbo AJ. Oropharyngeal dysphagia: Clinical features, diagnosis, and management. UpToDate Inc., Waltham, MA. Accessed February 27, 2016.
53. Liang Y, Lin J, Wang H, et al. (2021). Evaluating the Efficacy of VitalStim Electrical Stimulation Combined with Swallowing Function Training for Treating Dysphagia following an Acute Stroke. *Clinics.* 76: e3069. Doi: <https://doi.org/10.6061/clinics/2021/e3069>

54. Lowell SY, Kelley RT, Colton RH, et al. Position of the hyoid and larynx in people with muscle tension dysphonia. *Laryngoscope*. 2012;122(2):370-377.
55. Momosaki, R. (2017). Rehabilitative Management for Aspiration Pneumonia in Elderly Patients. *Journal of General and Family Medicine*, 18(1), 12-15.
56. Meier DE, McCormick E & Lagman RL. (Dec 7, 2020). *Hospice: Philosophy of care and appropriate utilization in the United States*. UpToDate.com. Accessed March 4, 2022.
57. Meier DE, Back AL, Berman A, Block SD, Corrigan JM, Morrison RS. A National Strategy For Palliative Care. *Health Affairs (Millwood)*. 2017 Jul 1;36(7):1265-1273. doi: 10.1377/hlthaff.2017.0164.
58. Miller S. Voice therapy for vocal fold paralysis. *Otolaryngol Clin North Am*. 2004;37(1):105-119.
59. Momosaki R, Abo M, Watanabe S, et al. Repetitive peripheral magnetic stimulation with intensive swallowing rehabilitation for poststroke dysphagia: An open-label case series. *Neuromodulation*. 2015;18(7):630-634; discussion 634-635.
60. Natke U, Kalveram KT. Effects of frequency-shifted auditory feedback on fundamental frequency of long stressed and unstressed syllables.. *J Speech Lang Hear Res*. 2001;44(3):577-584.
61. National Association for Home Care & Hospice. *What is Hospice and Palliative Care?* <https://www.nahc.org/about/faq/#111> Accessed: March 8, 2022.
62. National Hospice and Palliative Care Organization. (2021). *NHPCO Facts and Figures Report, 2021 edition*. <https://www.nhpco.org/hospice-care-overview/hospice-facts-figures/> Accessed March 8, 2022.
63. National Institutes for Health. National Institute on Deafness and Other Communication Disorders (NIDCD). Stuttering. (2017). Retrieved on April 29, 2022 from <https://www.nidcd.nih.gov/health/stuttering>
64. Okon TR, Christensen A. (Nov 29, 2021). Overview of comprehensive patient assessment in palliative care. UpToDate.com. Accessed March 4, 2022.
65. Pennington L, Goldbart J, Marshall J. Speech and language therapy to improve the communication skills of children with cerebral palsy. *Cochrane Database Syst Rev*. 2003;(3):CD003466.
66. Perez HR, Stoeckle JH. (2016). Stuttering. *Canadian Family Physician*, 62 (6) 479-484. Retrieved from: <https://www.cfp.ca/content/62/6/479.full>
67. Peters HF, Hulstijn W, Van Lieshout PH. Recent developments in speech motor research into stuttering. *Folia Phoniatr Logop*. 2000;52(1-3):103-119.
68. Pisegna JM, Kaneoka A, Pearson WG Jr, et al. Effects of non-invasive brain stimulation on post-stroke dysphagia: A systematic review and meta-analysis of randomized controlled trials. *Clin Neurophysiol*. 2016;127(1):956-968.
69. Prelock P. Understanding autism spectrum disorders: The role of speech-language pathologists and audiologists in service delivery. ASHA Leader Online. Rockville, MD: American Speech-Language-Hearing Association (ASHA); 2001. Available at: <http://www.asha.org/about/publications/leader-online/>. Accessed Feb 27, 2017
70. Romeiser, Sarah A.; Kiley, Sullivan J.; and Nocella, Nicholas J., "The Effects of Altered Auditory Feedback (AAF) on Fluency in Adults Who Stutter: A Systematic Review" (2019). *Communication Sciences and Disorders: Systematic Review Publications*. <https://scholarworks.uvm.edu/csdms/10>

71. Roy N. Functional dysphonia. *Curr Opin Otolaryngol Head Neck Surg.* 2003;11(3):144-148.
72. Rubin JS, Blake E, Mathieson L. Musculoskeletal patterns in patients with voice disorders. *J Voice.* 2007;21(4):477-484.
73. Sama A, Carding PN, Price S, et al. The clinical features of functional dysphonia. *Laryngoscope.* 2001;111(3):458-463.
74. Samlan RA, Webster KT. Swallowing and speech therapy after definitive treatment for laryngeal cancer. *Otolaryngol Clin North Am.* 2002;35(5):1115-1133.
75. Scarborough HS, Dobrich W. Development of children with early language delay. *J Speech Hear Res.* 1990; 33(1):70-83.
76. Sellars C, Hughes T, Langhorne P. Speech and language therapy for dysarthria due to non-progressive brain damage. *Cochrane Database Syst Rev.* 2005;(3):CD002088.
77. Shortland, H. L., Hewat, S., et al. (2021). Orofacial Myofunctional Therapy and Myofunctional Devices Used in Speech Pathology Treatment: A Systematic Quantitative Review of the Literature. *American Journal of Speech-Language Pathology.* Retrieved from https://doi.org/10.1044/2020_ajslp-20-00245.
78. Sneed RC, May WL, Stencel C. Physicians' reliance on specialists, therapists, and vendors when prescribing therapies and durable medical equipment for children with special health care needs. *Am Acad Pediatr.* 2001; 107(6):1283-1290.
79. Sommers RK, Logsdon BS, Wright JM. A review and critical analysis of treatment research related to articulation and phonological disorders. *J Commun Disord.* 1992; 25(1):3-22.
80. Stepp CE, Merchant GR, Heaton JT, Hillman RE. Effects of voice therapy on relative fundamental frequency during voicing offset and onset in patients with vocal hyperfunction. *J Speech Lang Hear Res.* 2011;54(5):1260-1266.
81. Vaezi MF, Pandolfino JE, Vela MF. ACG clinical guideline: Diagnosis and management of achalasia. *Am J Gastroenterol.* 2013;108(8):1238-1249.
82. Van Demark DR, Hardin MA. Effectiveness of intensive articulation therapy for children with cleft palate. *Cleft Palate J.* 1986; 23(3):215-224.
83. van Gogh CD, Verdonck-de Leeuw IM, Boon-Kamma BA, et al. The efficacy of voice therapy in patients after treatment for early glottic carcinoma. *Cancer.* 2006;106(1):95-105.
84. Wambaugh JL, Kalinyak-Fliszar MM, West JE, Doyle PJ. Effects of treatment for sound errors in apraxia of speech and aphasia. *J Speech Lang Hear Res.* 1998; 41(4):725-743.
85. Watts CR, Hamilton A, Toles L, et al. A randomized controlled trial of stretch-and-flow voice therapy for muscle tension dysphonia. *Laryngoscope.* 2015a;125(6):1420-1425
86. Yamashita M, Yamashita H, Shibata S, et al. Symptom relief effect of palliative high dose rate intracavitary radiotherapy for advanced esophageal cancer with dysphagia. *Oncol Lett.* 2015;9(4):1747-1752.
87. Zeitels SM, Casiano RR, Gardner GM, et al. Management of common voice problems: Committee report. *Otolaryngol Head Neck Surg.* 2002;126(4):333-348.
88. Zheng YQ, Zhang BR, Su WY, et al. Laryngeal aerodynamic analysis in assisting with the diagnosis of muscle tension dysphonia. *J Voice.* 2012;26(2):177-181.

89. Zimmerman S, Kalinowski J, Stuart A, Rastatter M. Effect of altered auditory feedback on people who stutter during scripted telephone conversations. *J Speech Lang Hear Res.* 1997;40(5):1130-1134.
90. American Psychology Association (APA) - Facilitated Communication: Sifting the Psychological Wheat from the Chaff. Accessible from <http://www.apa.org/research/action/facilitated.aspx>. November 20, 2003.
91. Moore, S., Donovan, B., & Hudson, A. (1993). Facilitator-suggested conversational evaluation of facilitated communication. *Journal of Autism and Developmental Disorders* 23, 541-551.
92. Mostert, M.P. (2001). Facilitated communication since 1995: A review of published studies. *Journal of Autism and Developmental Disorders* 31, 287-313.
93. Szempruch, J., & Jacobson, J.W. (1993). Evaluating the facilitated communications of people with developmental disabilities. *Research in Developmental Disabilities* 14, 253-264.
94. Ingham RJ, Ingham JM. No evidence-based data on SpeechEasy. *Letters. The ASHA Leader Online.* Rockville, MD: American Speech-Language-Hearing Association (ASHA); April 15, 2003. Available at: <http://www.asha.org/about/publications/leader-online/letters2/ltr030415a.htm>. Accessed June 28, 2004.
95. Natke U, Kalveram KT. Effects of frequency-shifted auditory feedback on fundamental frequency of long stressed and unstressed syllables.. *J Speech Lang Hear Res.* 2001;44(3):577-584.
96. Natke U, Glosser J, Kalveram KT. Fluency, fundamental frequency, and speech rate under frequency-shifted auditory feedback in stuttering and nonstuttering persons. *J Fluency Disord.* 2001;26(3):227-241.
97. Brennan-Jones CG, White J, Rush RW, Law J. Auditory-verbal therapy for promoting spoken language development in children with permanent hearing impairments. *Cochrane Database Syst Rev.* 2014.
98. Roy N. Functional dysphonia. *Curr Opin Otolaryngol Head Neck Surg.* 2003;11(3):144-148.
99. Ruotsalainen JH, Sellman J, Lehto L, et al. Interventions for treating functional dysphonia in adults. *Cochrane Database Syst Rev.* 2007;(3).
100. Speyer R. Effects of voice therapy: A systematic review. *J Voice.* 2008;22(5):565-580
101. American Speech-Language-Hearing Association. (n.d.). Practice Portal. Available from <http://www.asha.org/practice-portal/>.
102. American Speech-Language-Hearing Association. (2005). Evidence-based practice in communication disorders [Position statement]. Available from www.asha.org/policy/.
103. American Speech-Language-Hearing Association. Comprehensive Assessment of Speech Sound Production in Preschool Children. *Perspectives of the ASHA Special Interest Groups*, June 2016, Vol. 1, 39-56. doi:10.1044/persp1.SIG1.39. Available from <https://perspectives.pubs.asha.org/article.aspx?articleid=2529456>.
104. American Speech-Language-Hearing Association. Essential Coverage: Rehabilitative and Habilitative Services and Devices. Available from www.asha.org/uploadedFiles/Rehabilitative-Habilitative-Services-Devices.pdf
105. American Speech-Language Hearing Association. 2017 Coding and Billing for Audiologists and Speech-Language Pathology.

106. American Speech-Language-Hearing Association. (2015). Speech-Language Pathology Medical Review Guidelines. Available from <http://www.asha.org/practice/reimbursement/SLP-medical-review-guidelines/>.
107. Atkinson-Clement C, Sadat J, Pinto S. Behavioral treatments for speech in Parkinson's disease: meta-analyses and review of the literature. *Neurodegenerative Disease Management* 2015;5(3):233-48. DOI: 10.2217/nmt.15.16.
108. Committee on the Evaluation of the Supplemental Security Income (SSI) Disability Program for Children with Speech Disorders and Language Disorders; Board on the Health of Select Populations; Board on Children, Youth, and Families; Institute of Medicine; Division of Behavioral and Social Sciences and Education; National Academies of Sciences, Engineering, and Medicine; Rosenbaum S, Simon P, editors. *Speech and Language Disorders in Children: Implications for the Social Security Administration's Supplemental Security Income Program*. Washington, DC: National Academies Press (US); 2016 Apr 6. 3, Treatment and Persistence of Speech and Language Disorders in Children. Available from: <https://www.ncbi.nlm.nih.gov/books/NBK356271/>
109. Paul-Brown D, Ricker JH. Evaluating and treating communication and cognitive: Approaches to referral and collaboration for speech-language pathology and clinical neuropsychology [Technical report]. Asha.org. doi:10.1044/policy.TR2003-00137
110. Krug H, Turkstra LS. Assessment of Cognitive-Communication Disorders in Adults with Mild Traumatic Brain Injury. *Perspectives on Neurophysiology and Neurogenic Speech and Language Disorders*. 2015; 25: 17-35. [doi:10.1044/nnsld25.1.17](https://doi.org/10.1044/nnsld25.1.17)

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