Harvard Pilgrim Health Care | TUFTS Health Plan

Medical Necessity Guidelines:

Speech, Hearing, and Language Services

Effective: December 1, 2025

Prior Authorization Required If REQUIRED, submit supporting clinical documentation pertinent to service request.	Yes* ☒ No ☐
Notification Required IF REQUIRED, concurrent review may apply	Yes ☐ No ☒

***Prior Authorization is required ONLY for plans that limit coverage of speech therapy per condition. Please refer to the member materials for applicability.**

Applies to:

Commercial Products

☒ Harvard Pilgrim Health Care Commercial products; 800-232-0816
☐ Tufts Health Plan Commercial products; 617-972-9409
CareLink℠ – Refer to CareLink Procedures, Services and Items Requiring Prior Authorization

Public Plans Products

☐ Tufts Health Direct – A Massachusetts Qualified Health Plan (QHP) (a commercial product); 888-415-9055
☐ Tufts Health Together – MassHealth MCO Plan and Accountable Care Partnership Plans; 888-415-9055
☐ Tufts Health RITogether – A Rhode Island Medicaid Plan; 857-304-6404
☐ Tufts Health One Care – A dual-eligible product; 857-304-6304

Senior Products

☐ Harvard Pilgrim Health Care Stride Medicare Advantage; 866-874-0857
☐ Tufts Health Plan Senior Care Options (SCO), (a dual-eligible product); 617-673-0965
☐ Tufts Medicare Preferred HMO, (a Medicare Advantage product); 617-673-0965
☐ Tufts Medicare Preferred PPO, (a Medicare Advantage product); 617-673-0965

Note: While you may not be the provider responsible for obtaining prior authorization or notifying Point32Health, as a condition of payment you will need to ensure that any necessary prior authorization has been obtained and/or Point32Health has received proper notification. If notification is required, providers may additionally be required to provide updated clinical information to qualify for continued service.

Overview

The Plan considers outpatient speech/language pathology (SLP) services necessary to assess and treat communication impairments and swallowing disorders as reasonable and medically necessary, including those resulting from injury, trauma, or medically based illness. There must be a reasonable expectation that the member will achieve measurable improvement toward diagnosis-related goals within a reasonable and predictable period of time. In addition, covered services must:

- Provide specific, effective, and reasonable treatment for the member's diagnosis and physical condition.
- Require the judgment, knowledge, and skills of a licensed provider due to the complexity and sophistication of the therapy and the physical condition of the member; and
- Be delivered by a licensed provider performing within the scope of his/her licensure.

Outpatient SLP services are covered to the extent described in the individual member's benefit design. Coverage is consistent with applicable state mandates.

Clinical Guideline Coverage Criteria

General Eligibility Criteria:

The Plan considers outpatient Speech/Language Pathology (SLP) services as reasonable and medically necessary for members with functional speech, hearing, or language disorders when clinical documentation and supportive testing (as appropriate) confirm **ALL** the following:

1. The Member has been diagnosed with a Covered Condition (listed below); **and**
2. There is a defined treatment plan (including frequency and duration of services), and plan for monitoring (at regular intervals) the Member's progress toward established goals; **and**
3. Long- and short-term goals (described in functional terms) can be attained within a reasonable and predictable period of time.

For school-aged children who require both school-based and outpatient services, there must be evidence that the treating SLP clinician is communicating and collaborating with school (or other) therapists to facilitate optimal member progress.

Requests for authorization of on-going treatment must include evidence of periodic re-assessment/re-evaluation (using the same standard clinical tools for comparative purposes) when appropriate, and objective evidence (in functional outcome measures) of progress towards established goals. In addition, there must be documentation confirming the member (and family if applicable) has been compliant with the established treatment plan and updated long- and short-term goals that are objective, measurable, and attainable within a reasonable and predictable period of time with further treatment.

Covered Conditions – Adult and Pediatric

Dysphagia resulting from:

1. Medical Conditions (e.g., CVA, TBI, neurological disease, prematurity); or
2. Oropharyngeal and laryngeal structural abnormalities

Additional Information: Speech/Language Pathology (SLP) services are authorized only when medical record documentation confirms the medical condition, or a structural abnormality adversely impacts his/her ability to safely chew and swallow or move solids or fluids from the mouth down the throat.

Medical Conditions Impacting Speech or Language

1. Apraxia, or expressive or receptive aphasia resulting from central nervous system injury
2. Dysarthria from central or peripheral nervous system injury (e.g., CVA, TBI, CP, Parkinsonism, MS, ALS, Myasthenia Gravis)
3. Poor speech intelligibility due to oral/pharyngeal structure abnormalities (e.g., partial or total glossectomy)

Additional Information: SLP services are authorized when medical record documentation confirms a reasonable expectation of significant improvement(s) in a reasonable and generally predictable period of time.

Voice Disorders

1. Chronic (4-6 weeks duration) hoarseness or laryngitis due to a structural abnormality, or medical condition (e.g., laryngopharyngeal reflux, GERD)
2. Hyper-nasal Voice secondary to cleft palate, or velopharyngeal insufficiency
3. Restricted use of voice secondary to dysfunction including:
4. Irritable Larynx Syndrome/Chronic Cough
5. Muscle Tension Dysphonia
6. Puberphonia/Mutational Falsetto
7. Spasmodic Dysphonia
8. S/P Laryngectomy- Partial or Total
9. Vocal cord dysfunction (i.e., laryngospasm or Paradoxical Vocal Fold Movement/PVFM)
10. Vocal cord paralysis/paresis/hypomobility
11. Vocal fatigue
12. Vocal Tremor

Additional Information: Documentation of evaluation by otolaryngologist is required in most cases. In cases where vocal cord surgery is needed, services may be medically necessary pre- and post-operatively.

Gender Dysphoria

Additional Information: Refer to the Gender Affirming Medical Policy for clinical coverage criteria for voice modification and communication therapy

Covered Conditions – Pediatric (Children Under Age 18 Years)

Articulation/Phonological Processing Disorders

1. SLP services are authorized when medical record documentation confirms member has at least two phonological processes that are not developmental age appropriate; **EITHER** of the following:
    a. Fair to poor intelligibility (i.e., it is difficult for the listener to understand when the child speaks in words, sentences, or conversation); **or**
    b. Good intelligibility but errors (e.g., distortions, substitutions, omissions) are atypical or not age appropriate.

Autism Spectrum Disorder and Pervasive Developmental Disorders

1. SLP services are authorized for assessment and treatment of ASD/PDD when medical record documentation confirms ANY of the following:
    a. Loss of any language or social skills at any age;
    b. No babbling by age 12 months;
    c. No gesturing (e.g., pointing, waving bye-bye) by age 12 months;
    d. No single words by age 16 months;
    e. No two-word spontaneous phrases (not just echolalic) by age 24 months.

Childhood Apraxia of Speech

1. SLP services are authorized when medical record documentation confirms member has ALL:
    a. Difficulty with sequencing sounds, syllables and words; AND
    b. Poor intelligibility measured using a standard tool.

Cleft Lip/Cleft Palate

1. SLP services are authorized when the attending physician or surgeon determines services are medically necessary and consequent to the treatment of cleft lip and/or cleft palate

Developmental Language Delays

1. SLP services are authorized when medical record documentation confirms a delay in receptive, expressive, or pragmatic language:
    a. Significantly impacts the child's ability to effectively communicate his/her wants and needs; **or**
    b. Significantly impacts the child's ability to be understood by family/caregivers (i.e., patient scores at or below the 16th percentile on standardized measures)

Dysfluency/Stuttering

(Requests are reviewed on a case-by-case basis)

1. SLP services are authorized when medical record documentation confirms the child has ANY of the following:
    a. Primary symptoms (phonemic, part-word, whole word, and phrase repetitions; prolongations; inaudible or audible blocks);
    b. Secondary symptoms (facial grimaces, eye blinking/eye closing, decreased eye contact, head/body movements);
    c. Family history of dysfluency.

Note: Certified speech/language pathologists are trained and qualified in the management of dysfluency

Orofacial Myofunctional Disorder and Tongue Thrust Swallow Pattern

(Requests for oral-myofunctional therapy are reviewed on a case-by-case basis. Factors including member/family motivation, and member needs are considered)

1. Improvements are expected within four visits (in most cases); re-evaluation is required before additional visits are authorized.

a. Additional visits are not authorized if there is no objective evidence of progress after four visits.

Post Cochlear Implant

1. SLP services are authorized when medical record documentation confirms progress towards established goals, and member/family compliance with outpatient treatment plan (including consistent attendance) and home carryover.

Limitations

The Plan considers speech, hearing and language services as not medically necessary for all other indications. In addition, The Plan does not cover:

2. Maintenance activities intended to preserve the member's present level of function or prevent regression of that function; or
3. Educational/school-based services that are not part of a defined medical treatment plan for disorders resulting from injury, trauma, or medically based illness or disease.
4. School-based services, or services that are primarily academic or educational in nature (e.g., services to enhance writing skills), and not part of a defined medical treatment plan.
5. SLP services requested for psychosocial, behavioral, or conceptual problems encountered in school settings (including speech or developmental delays, and/or attention disorders) when services are not part of a defined medical treatment plan.
6. Outpatient SLP services for disorders that are self-correcting (e.g., natural dysfluency or developmental articulation disorders in young children).
7. SLP services that do not require the skills of a qualified SLP provider, and/or may be effectively performed by a non-skilled caregiver (e.g., practicing word drills for developmental articulation disorders).
8. SLP services designed to preserve present level of function or prevent regression after therapeutic goals of the treatment plan have been achieved, or in situations where no further functional progress is apparent or expected to occur.
9. SLP services for treatment of dialect and accent reduction, or whose purpose is vocationally or recreationally based

Codes

The following code(s) require prior authorization:

Table 1: CPT/HCPCS Codes

Code	Description
92507	Treatment of speech, language, voice, communication, and/or auditory processing disorder (includes aural rehabilitation); individual
92508	Treatment of speech, language, voice, communication, and/or auditory processing disorder; group, 2 or more individuals

References:

1. Commonwealth of Massachusetts. Chapter 111G: Early Childhood Intervention Services
2. American Speech-Language-Hearing Association (2015). *Speech-Language Pathology Medical Review Guidelines.* American Speech-Language Hearing Association. https://www.asha.org/practice/reimbursement/slp-medical-review-guidelines/. Accessed August 21, 2025.
3. Commonwealth of Massachusetts. (2000) Chapter 345: An Act Providing that Certain Health Care Plans and Policies Shall Cover Payment for Costs Arising from Speech, Hearing, and Language Disorders
4. Commonwealth of Massachusetts (2012) Chapter 234: An Act Relative to the Treatment of Cleft Palate and Cleft Lip

Approval And Revision History

October 20, 2020: Reviewed by the Medical Policy Approval Committee (MPAC); renewed without changes

Subsequent endorsement date(s) and changes made:

- November 17, 2021: Reviewed by MPAC; renewed without changes
- December 21, 2021: Reviewed by MPAC; criteria updated to include gender dysphoria
- November 16, 2022: Reviewed by MPAC; renewed without changes
- September 20, 2023: Reviewed by MPAC; renewed without changes
- December 2023: Rebranded Unify to One Care effective January 1, 2024

- October 17, 2024: Reviewed by MPAC, added clarifying prior authorization statement effective December 1, 2024
- October 15, 2025: Reviewed by MPAC, renewed without changes effective December 1, 2025
- November 12, 2025: Fax number for Senior Care Options, Tufts Medicare Preferred HMO and Tufts Medicare Preferred PPO updated; language for Carelink removed; Harvard Pilgrim Health Care Stride Medicare Advantage removed as an applicable product from the template

Background, Product and Disclaimer Information

Medical Necessity Guidelines are developed to determine coverage for benefits and are published to provide a better understanding of the basis upon which coverage decisions are made. We make coverage decisions using these guidelines, along with the Member's benefit document, and in coordination with the Member's physician(s) on a case-by-case basis considering the individual Member's health care needs.

Medical Necessity Guidelines are developed for selected therapeutic or diagnostic services found to be safe and proven effective in a limited, defined population of patients or clinical circumstances. They include concise clinical coverage criteria based on current literature review, consultation with practicing physicians in our service area who are medical experts in the particular field, FDA and other government agency policies, and standards adopted by national accreditation organizations. We revise and update Medical Necessity Guidelines annually, or more frequently if new evidence becomes available that suggests needed revisions.

For self-insured plans, coverage may vary depending on the terms of the benefit document. If a discrepancy exists between a Medical Necessity Guideline and a self-insured Member's benefit document, the provisions of the benefit document will govern. For Tufts Health Together (Medicaid), coverage may be available beyond these guidelines for pediatric members under age 21 under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefits of the plan in accordance with 130 CMR 450.140 and 130 CMR 447.000, and with prior authorization.

Treating providers are solely responsible for the medical advice and treatment of Members. The use of this guideline is not a guarantee of payment or a final prediction of how specific claim(s) will be adjudicated. Claims payment is subject to eligibility and benefits on the date of service, coordination of benefits, referral/authorization, utilization management guidelines when applicable, and adherence to plan policies, plan procedures, and claims editing logic.