CLINICAL GUIDELINES

Speech Language Pathology (SLP) Services

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EviCore By EVERNORTH

EviCore healthcare Clinical Decision Support Tool Diagnostic Strategies: This tool addresses common symptoms and symptom complexes. Imaging requests for individuals with atypical symptoms or clinical presentations that are not specifically addressed will require physician review. Consultation with the referring physician, specialist, and/or individual's Primary Care Physician (PCP) may provide additional insight.

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Clinical Review Criteria: Speech Language Pathology (SLP) Services (SLP 1.0)

SLP.1.0.A
v1.0.2025

The EviCore clinical review criteria provide guidance regarding the determination of medically necessary care during reviews of requests for skilled speech therapy. EviCore's clinical therapy reviewers consider all clinical information submitted as part of a request as they follow these guidelines in making a determination. Decisions using these criteria determine a reasonable amount of a skilled care benefit (visits) to be authorized for a duration of time specified by the individual's health plan (see **Criteria to Determine Medical Necessity for Skilled Speech Language Pathology Services (SLP-1.2)**). A determination takes into account the "dynamic interaction between a person's health condition, environmental factors, and personal factors," as recommended in the International Classification of Functioning, Disability and Health of the World Health Organization (ICF).[1] Evicore does not determine the specific treatments a provider must use. Providers are responsible to create and follow efficacious and reasonable treatment plans that result in an individual's appropriate responses to care using the amount of visits determined over the time period allowed.

Please be advised:

- Specific health plan policies and local/national rules and mandates may take precedence over these guidelines (see **Rules, Coverage, Benefits, and Mandates (SLP-1.3)**).
- EviCore Clinical Review Criteria Guidelines are not intended to be used as treatment guidelines and should not be considered synonymous with peer-reviewed clinical practice guidelines, systematic reviews or similar published treatment guidelines.
- Treatments and services traditionally thought of as "SLP" treatments may not be exclusive to only speech language therapists/pathologists. There may be other provider types, based on legal scope of practice, that can provide similar treatments that could be considered part of a speech therapy benefit. The following criteria apply in the same way to all skilled speech therapy medical necessity reviews regardless of provider type, as long as the services are within the scope of the licensed provider.

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Definitions (SLP 1.1)

SLP.1.1.A
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The following definitions are provided by EviCore Healthcare only to define key terms and concepts within this guideline to help establish consistent interpretation and understanding. The definitions themselves are NOT criteria for authorization or adverse determination decisions:

Care Levels:

Non-Skilled Care

Non-skilled care includes any services or procedures that are routine and that do not involve complex and sophisticated skill requiring the judgment of a qualified healthcare provider for safety and plan adjustments. This includes any services or procedures being provided that do not address specific, documented, functional deficits in the individual's essential functions of daily living when related to speech, language, swallowing or cognitive deficits. The unavailability of a competent person to provide a non-skilled service (caregiver, tutor, teacher, coach, etc), regardless of the importance of the service to the individual, does not make that service skilled when a healthcare provider furnishes the service.[2]

Skilled Care

Skilled speech therapy care are services provided at such a level of complexity that the services required can only safely and effectively be performed by a qualified healthcare provider. The care is guided by evidence-based practice within the professional scope of the provider, is goal-directed, client-centered, generally occurs within a reasonable period of time, is not routine and results in an appropriate response[2] (See: Response to Skilled Care definition). The services may include formal evaluations/re-evaluations, formal treatments, periodic assessments, home or independent program prescription and caregiver training. The care takes into consideration the individual's activity level and ability to actively participate in their daily tasks in their current environment and role. Skilled therapy care generally falls into one of three types of skilled care: habilitative, maintenance or rehabilitative care.

- **Skilled habilitative** care is generally defined as services that help an individual to keep, learn, or improve functioning required for participation in meaningful daily activities per their individual personal role. Most states have adopted some version of the National Association of Insurance Commissioners (NAIC) definition.[3] This may also include periodic care to educate the individual on progressive debility (i.e. planning for progressive losses due to degenerative conditions) or anticipated functional losses (i.e. dysphagia education prior to radiation treatment).

- **Skilled maintenance** care is service that is required to create, teach and monitor a specific self-maintenance program for an individual (with help from a caregiver if needed) to prevent or slow deterioration of their ability level and condition to allow for "maximal" (realistic) participation in daily activities. Skilled maintenance programs are established by a qualified speech language pathologist (SLP). Skilled care visits are only to establish goals and steps of the program with the individual and caregiver. The actual program would be carried out independently by the individual and their trained caregivers.[2]
- **Skilled rehabilitative** care are services that improve or restore an individual's abilities that are lost or impaired due to injury, disability or illness. Additionally, any limiting environmental or personal factors that are necessary to return the individual to a reasonable activity level required for speech, language, cognition and swallowing to participate in activities of daily living (ADL) and instrumental activities of daily living (IADL)may also be addressed. Care to prevent a future injury or debility in the absence of a current functional limitation is not considered as rehabilitative.[2]

Complexities/Complications

Individuals may present with any variety of situations, impairments or other factors not directly associated with their condition for which they are seeking care but that differentiate them from a “typical” presentation. These complexities may be due (but not limited) to: body function/structure (physical/psycho-social comorbidities), environmental factors (support system, accessibility products and technology) and personal factors (language, cultural factors, age and attitude).

An individual may also experience any variety of new problems or circumstances that directly complicate the current impairment for which they are seeking care. These complications may be due (but not limited) to: adverse healing (infections, chronic swelling/edema, scar tissue or non-closure); neurologic status (extrapyramidal symptoms, changes in level of consciousness/alertness, cognition, myelopathy, dyskinesia, spasticity, rigidity, or tremors); post-procedural sequelae (prolonged procedure, activity limitation or other restriction) or hospitalization.

Determination

A determination is any final decision of a submitted request for skilled care benefit visits. Requests may receive an approval, or an adverse determination (partial denial or full denial determination) based on the review for medical necessity of the information available at the time of the review.

Experimental, Investigational, or Unproven (EIU)[4]

Certain studies, treatments, procedures, or devices may be considered experimental, investigational, or unproven for any condition, illness, disease, or injury being treated if one of the following is present:

- If there is a paucity of supporting evidence;
- If the evidence has not matured to exhibit improved health parameters;
- If the clinical utility has not been demonstrated in any condition;
- It the study, treatment, procedure, or device lacks a collective opinion of support.

Supporting evidence includes standards that are based on credible scientific evidence published in peer-reviewed medical literature (such as well conducted randomized clinical trials or cohort studies with a sample size of sufficient statistical power) generally recognized by the relevant medical community. Collective opinion of support includes clinician specialty society recommendations and the views of clinicians practicing in relevant clinical areas when specialty society recommendations are not available.

Functions of Daily Living

- **Activities of Daily Living (ADLs)** are essential tasks oriented towards taking care of oneself. These activities can include feeding oneself, masticating and safely swallowing and communication during other necessary tasks.
- **Instrumental Activities of daily Living (IADLs)** are activities to support daily life within the home and community that often require more complex interactions such as the care of others, child rearing, driving, household chores, financial management, employment, social interaction, education and essential age related play/task completion.[5]

Communication is integral to effectively performing ADLs/IADLs, especially when expressive interaction is required. It is crucial for tasks such as asking for assistance, following instructions and expressing needs. Speech therapy enhances communication skills, directly impacting the ability to perform ADLs/IADLs independently, and to know when they are contextually appropriate. Speech-language pathology role services address the an individual's specific, documented functional delays/deficits in speech, language, cognitive, feeding or swallowing skills that impact an individual's ability to safely and effectively complete ADLs/IADLs.

Individual

For the entirety of this document, the term "individual" refers to the person for whom services are requested (i.e. patient, client) AND/OR any non-clinical caregivers (aides, restorative staff, parents, guardians, family, friends, etc) that are assisting them.

Medically Necessary[4]

Healthcare services or supplies needed to diagnose, treat, or evaluate a condition or prevent an injury, illness, condition or disease that meets accepted standards of medicine based on evidenced-based clinical standards of care based on supporting evidence and/or collective opinion of support that is:

- Clinically appropriate in terms of type, frequency, extent, site, and duration, and considered effective for the individual's illness, injury, or disease;
- Clinical utility of the technology, drug, device, treatment, or procedure has been demonstrated for a diagnosis, treatment, evaluation or prevention of an illness, condition, or disease based on evidence-based clinical standards of care;
- Not more costly than an alternative service or sequence of services that are at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of a condition;
- Not primarily for the convenience of the individual seeking medical services, health care provider, or other physicians or healthcare providers;
- Supporting evidence and/or collective opinion of support does not demonstrate that there is an alternative that is more appropriate/effective for diagnosis, treatment, or evaluation of a condition.

Response to Skilled Care

An appropriate and significant response to *skilled rehabilitative care* may be demonstrated through a documented combination of:

- Marked improvement in the impairment based goals that is meaningful both clinically and statistically.The improvement should be shown through the change in standard outcome measure scores. Improvement in standard outcome measure scores should be over a reasonable period of time similar to those published during the research-based validation process of the chosen outcome. Standard outcome measures are any measure that has been validated through research and has a standardized method of obtaining scores. These could be patient-reported outcome surveys (i.e. the individual completes a survey about their current ability and a score is tabulated from their responses) and/or performance-based measures (i.e. the individual performs a standard set of tasks that are scored by the observing clinician). Standard outcomes measures is a general term and may include many types of measures, such as standard deviations, percentile rankings, percent of delay, or quotient scores.
- Marked improvement in clinical assessment-based standard measures appropriate for the individual's specific problem as it relates to their daily life. This may include reliably quantified levels of task completion, clinically observed progressive changes in language components (e.g. syntax, pragmatics, sematics), clinically observed progressive changes in articulation (e.g. percent consonant correct, test of stimulability) or other quantifiable changes over a reasonable period of time.
- Marked improvement in multiple measures of participation in ADLs/IADLs related to the individual's documented limitations and/or appropriate and quantifiable goals over a reasonable period of time (e.g. observational assessments, quality of life indicators).

An appropriate response to *skilled maintenance care* may be demonstrated through any of the following:

- The individual and/or caregivers being able to reasonably follow the established maintenance program to maintain or slow decline of the present present functional impairments or participation limitations due to training and education provided as part of skilled care.
- A documented need for additional skilled care by a provider to monitor the effectiveness and safety of the established maintenance program and make periodic changes to the plan to allow the individual and caregivers to be independent with the program.

An appropriate response to *skilled habilitative care* may be demonstrated through any of the following:

- A documented need for skilled care by a qualified provider based upon appropriate improvement from norm-referenced standardized testing, criterion-referenced standardized testing and/or functional performance.
- Clear documentation of newly gained acquisition of skills or independence of tasks directly associated with the established goals in the plan of care.

Please reference the **Clinical Considerations (SLP-2.0)** section below for additional information regarding the use of standardized outcome and performance-based measures to help demonstrate an individual's response to skilled care.

Severity

Severity of an individual's impairments related to speech is a measure of how severe, or bad, the impairment impacts daily life. Severity encompasses several variables which can include, but are not limited to, frequency, duration, intensity and subjective personal and environmental factors. Severity ratings, or grading, can be used to help describe an overall condition or diagnosis, or it can be used to describe individual impairments (e.g. articulation, weakness, coordination, loss of motion). A common way to categorize severity level is through the use of "mild, moderate or severe" nomenclature. One such example comes from the World Health Organization.[1] It is well-established and easily applied when reviewing cases for medical necessity, as illustrated below:

- **Mild problem -**the impairment is present less than 25% of the time (approximately), with a tolerable intensity, and infrequently interferes with daily life. The impairment minimally inhibits communication, education, or social and vocational skills. Swallowing related impairments may present with minimal oral or pharyngeal dysfunction, but could require some diet modification or swallowing precautions.
- **Moderate problem -** the impairment is present between 25%-50% of the time (approx), with an intensity that sometimes interferes with daily life. The impairment moderately inhibits communication and usually impacts some skill acquisition resulting in loss of education, social and vocational skills. Swallowing related impairments may present with moderate oral and pharyngeal dysfunction that inhibit nutrition and increase safety concerns due to aspiration risk.

- **Severe problem -**the impairment is present between 50%-95% of the time (approx), with an intensity that occurs frequently and partially alters daily life. The impairment significantly limits functional communication and always interferes with skill acquisition resulting in loss of educational, social and vocational skills. Swallowing related impairments may present with significant dysfunction resulting in more frequent aspiration and inadequate oropharyngeal transit.
- **Permanent problem -** The problem is present all the time (96% or greater) and frequently alters daily life. A chronic problem that always significantly limits functional communication and interferes with skill acquisition.

The results of formal assessments can help to categorize the severity of an individual's problem. Formal assessments are recommended when appropriate. There are multiple assessments that utilize normal bell-curve standard deviation ranges.[6] Formal assessments can be helpful in tracking severity and how it changes in a standard, repeatable, fashion. The typical bell curve deviation severity ranges are as follows:

- Mild: -1 to 1.5 Standard deviations (SD) below the mean
- Moderate: -1.5 to -2 SD below the mean
- Severe: -2 or more SD below the mean

There are various ways to grade severity and each individual system will have limitations. Severity grading helps to provide context to the impairments and limitations the individual is facing as part of a review for medical need of skilled care. Severity will be based on all information provided for review, including any specific rating or grading provided. However, it does not guarantee medical need or authorization of care.

Standards of Practice

For these purposes, standards of practice are widely accepted clinical practices supported by recommendations in published peer-reviewed evidence-based clinical practice guidelines. In the absence of such guidelines for a specific area of practice, a collection of high-level established peer-reviewed literature (such as systematic reviews, meta-analysis or collection of trial research) may also be generally recognized by the relevant healthcare community. Lower-level research (cohort studies, non-randomized studies, case studies, expert opinion) may be helpful in establishing a standard of practice if there is no higher-level research established. The **Clinical Considerations (SLP-2.0)** in this publication provides additional context in reference to usual and reasonable care for common areas of practice within speech pathology.

Criteria to Determine Medical Necessity for Skilled Speech Language Pathology Services (SLP-1.2)

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Due to the complex nature of an individual's diagnosis, complexities and complications, and environmental and personal factors, decisions of medical necessity will be based on all the clinical information submitted and available to review at the time a case is considered. Each request submitted for review must have clinical information that, at a minimum, demonstrates the individual's current impairments and limitations in ADLs/ IADLs demonstrated through standard quantifiable measures. For the convenience of the provider when going to submit clinical information for review EviCore has clinical worksheets available at www.EviCore.com. The worksheets show what information should be submitted with a request. The worksheets also provide examples of some common standard measures. Not all possible measures are listed on the worksheets. Providers are responsible to choose appropriate standard measures for the individual's situation. There are multiple worksheets available and a provider may choose the most appropriate form based on the individual's type of impairment or concern.

If subsequent requests for an individual are submitted, these requests should be accompanied by clinical information that, at a minimum, demonstrates how the individual has responded to the care provided according to changes in standard quantifiable measures and goals, and that significant limitations remain that have not yet been addressed. Formal re-evaluations may be necessary when an individual presents with significant changes in their impairments. Changes may be due to new complications, complexities or significant gaps in care requiring the skilled assessment of a provider. This can lead to an updated plan of care. This does not necessitate that a provider do a formal re-evaluation for every request, as clinical measures should be taken and goals updated periodically throughout a course of an individual's care. It is the provider's responsibility to provide the clinical information they feel best demonstrates the level of medical necessity of the care being requested. EviCore Healthcare reviews all information submitted.

The following criteria is applicable to all requests regardless of client populations, provider types or specialties. Please notice that some criteria are specific to the type of skilled care being provided (habilitative, maintenance, rehabilitative). Please refer to **section 2.0** for information on how variability in clinical presentation is considered during the review process.

Initiation of Skilled Rehabilitation/Habilitation Care

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The initiation of an episode of speech language pathology services for skilled habilitation/rehabilitation will be considered medically necessary when current information is submitted to demonstrate that ALL of the following criteria have been met. Failure to meet ANY of these criteria would indicate skilled care is not necessary:

1. The services to be provided meet the definition of "Medically Necessary" as defined previously in **Definitions (SLP 1.1)**
2. The skills of a qualified provider are required to address a documented impairment related to speech in functioning that creates a limitation in body functions, structures, and/or activity participation (e.g. ADL/IADLs) that require care of such complexity and sophistication that only a qualified provider can address them safely. Merely providing services by a qualified provider do not, alone, make them necessary. The services must meet the required level of complexity for skilled care as defined in **Definitions (SLP 1.1)**.
   a. The functional deficit shall be quantified using formal and/or informal speech-language assessments to establish the type, characteristics, and severity of the disorder.[7] Individuals with exposure to more than one language must receive culturally and linguistically adapted standardized testing in all languages exposed to in order to compare potential impairments fairly. When standardized testing is not available in all languages alternative informal measures such as dynamic assessment, language sampling and additional documentation to support the medical necessity of services is considered.
   b. The skilled care requested is NOT specifically related to reading, writing, studying and spelling in the absence of significant functional deficit in developmental language. Standardized testing must show a functional deficit in receptive and/or expressive language given comprehensive spoken language testing. The functional deficit(s) must be quantified as per criteria in 1a above.
   c. The skilled care requested is NOT specifically related to continued participation in elective, recreational, or hobby activities; or would NOT be considered preventive care as per the definition in **Definitions (SLP 1.1)**.
   d. The care is not primarily routine or can reasonably be done by the individual on their own, or with help from caregivers or other non-skilled professionals (i.e. teachers, resource staff, family, tutors, community services).
3. The recommended plan of care is reasonable and generally accepted as within the standard of practice of the provider to be effective for the individual's documented limitations and would not be considered experimental, investigational or unproven (EIU).
   - Central auditory processing disorders and aural habilitation/rehabilitation require a formal diagnosis by an audiologist.
4. There is an expectation that the individual will respond appropriately and favorably to the plan of care in a reasonable and generally predictable period of time resulting in discharge to an independent program (with or without help from caregivers)

5. There is an expectation that the individual will be actively compliant with all aspects of the recommended plan of care, including regular participation in their home program. Non-compliance with a home program due to a lack of specific clinic-based equipment or facilities is not a reason for continued skilled care. Home programs can be tailored to the individual's situation and capability.

Initiation of Skilled Maintenance Care

When covered by the health plan, the initiation of an episode of speech language pathology skilled services will be considered medically necessary to create a maintenance program when current information is submitted that demonstrates ALL of the following criteria have been met. Failure to meet ANY of this criteria would indicate skilled maintenance care is not necessary:

1. The services to be provided meet the definition of "Medically Necessary" as defined previously in **Definitions (SLP 1.1)**
2. The maintenance program/care requires such complexity and sophistication that only a qualified provider can address them safely. The skills of a qualified provider are required to:
   a. Establish or design a customized maintenance program to be carried out by the individual and their caregivers appropriate to their capacity and tolerance. The individual’s current functional status is no longer rapidly changing, but should be maintained to promote safety, current ability level or slow deterioration, but there has not yet been a reasonable opportunity to establish a program, OR
   b. The individual is experiencing special medical complications that require the skills of a provider to address the best course of management until they are more stable or can follow a home program.
3. The recommended plan to establish the maintenance program is reasonable and generally accepted as within the standards of practice specific to the individual’s condition [See **Definitions (SLP 1.1)**].
4. There is an expectation that the individual and or caregivers will follow through on their own with the established program and goals are appropriate in regards to maintaining a program versus goals for rehabilitation/habilitation.

Continuation of Skilled Care

Consideration of the need for continued skilled care (habilitation, rehabilitation, maintenance), including potential formal re-evaluations or assessments, beyond the initial determination involves determining that an individual is responding appropriately to the type of care or program being provided, yet still requires additional skill from a provider. Failure to meet ANY of the criteria for continued care would indicate skilled care is no longer necessary, or not necessary as requested.

In addition to the criteria for initiation of skilled care, requests for continuation of treatment (those beyond the initial request) must also include current information that demonstrates that all of the following are MET:

1. An individual is responding appropriately to their plan of care or established program [Refer to **Response to Skilled Care** in **Definitions (SLP 1.1)**] but the skills of a qualified provider are still required to address some remaining documented significant, specific, functional impairments.

   -OR-

   The individual has a significant acute decline in their function related to impairments that have not previously been addressed during the current episode of care (exacerbation of condition, flare-up, etc.) that has resulted in a statistically meaningful deficit in daily speech tasks/participation and that requires a change to the plan of care of such complexity and sophistication that only a qualified provider can address it, such as:

   a. There has been an acute exacerbation of deficits despite adherence to a care plan, but the individual was otherwise responding appropriately.
   b. Progression of limitations has occurred despite adherence to a care plan and skilled care is needed to modify or alter the care plan to address changes.
   c. There has been a significant complication that was not previously present [refer to complexities definition in **Complexities/Complications** in **Definitions (SLP 1.1)**]
2. The services being provided continue to meet the definition of "medically necessary" as previously outlined.
3. The services provided continue to be at an appropriate skill level and are progressive in their programming according to the following:
   a. The services are not routine and continue to be of such complexity and sophistication that only a qualified provider can provide them safely. The services are NOT to maintain participation in elective activities, reading, writing, or spelling in the absence of specific functional impairments. New functional skills are being addressed as the plan of care is progressed over the episode.
   b. The individual's maintenance program is no longer effective, and they now require specific changes, modification or training of such complexity that they can only be addressed by a qualified provider. The general lack of a competent caregiver, the unwillingness or inability of the individual to arrange for a caregiver, or the unwillingness of the individual and/or a caregiver to carry out a care program does not apply.
4. The individual continues to be compliant with the recommended plan of care or program and is consistently making an effort to participate in all aspects of their care. This would include adherence to their home program, attendance to and being an active participant in scheduled care, utilizing appropriate caregivers and assistive devices, and modifying activities to avoid continued harm or exacerbations.

Determination of Dosage of Skilled Care

The number of skilled care visits authorized as part of an individual's health care benefit will be influenced by many factors. Individual clinical presentations will vary; as will the medical need for a certain dosage of visits. Individual health plan policies and visit limitations will vary and must be followed. A dose of skilled care visits should be based on medical need; not specific to a diagnosis, procedure, protocol or treatment method. It is EviCore's intent that the amount of services authorized for a request are reasonably sufficient for the entire duration of that request's time period.

The following is meant to apprise clinicians of the general (but not limited to) considerations involved in deciding on a reasonable number of medically necessary visits to authorize for a request. It serves as background guidance into dosage and is subject to some variability. The exact number of visits authorized per request may vary based on these factors and is not predictive. The following does not supersede or take place of the medical necessity criteria just established. All medical necessity determinations will be made based on the clinical information available at time of the review:

Response/Likelihood of Response - Skilled care must drive an appropriate response by the individual. It is reasonable that, in general, individuals responding rapidly to care would be ready for more frequent skilled progression and updated than those that respond more slowly. Clinical based treatments and programming should be commensurate with the individual's readiness for significant progressions. A reasonable number of clinical visits will take into account reasonable time between visits for the individual to sufficiently practice their home/self-care program, on their own, so they are ready for new updates or modifications during a subsequent skilled care visit. A consistent lack of progress or decline (not to be confused with an acute complication) may indicate treatment is becoming ineffective. Once care is no longer effective, continuing with the same plan of care would not be reasonable.

It is generally accepted that physiological adaptations to skilled care take at a minimum several weeks and require an appropriate intensity of skill performance. Reasonable plans of care would involve programmed skills that are progressive so that intensity is maintained. However, repetition of activities or skills is also a key component to progress. Individuals are responsible to practice said programs consistently outside of clinical visits. Practice need not always be perfect or require extensive feedback. Decisions on the number of skilled care visits takes into account that individuals need time between clinic visits to practice and adapt to the program they were given.

Severity - Individuals with more severe limitation presentations (moderate to severe) may benefit from more skilled care than those with less severe limitations (minimal to mild). The severity of an individual's speech impairment is of primary concern when considering the need for the use of a skilled care benefit; as the purpose of a skilled care benefit is to manage activity and participation levels. Individual complexities,

complications and personal and environmental factors may make for more severe functional problems and those identified in the submitted clinical information will be a consideration in dosage decisions.

Chronicity - Chronic conditions, outside of acute exacerbations, are more constant and change very slowly or not at all. Reasonable skilled care for chronic conditions can involve infrequent episodes of care where a small number of visits are used for a short time to address acute impairments and establish a self-care program. The individual (with any caregivers) can then focus on the practice of their program and maintaining healthy habits on their own for a time.

Caregiver Training - Many individuals receiving skilled care will require varying levels of assistance from a caregiver to complete basic daily tasks. It is reasonable that some clinical time will be needed to provide caregiver training. A reasonable amount of caregiver training will vary by case, but it does not always require extensive or intensive clinical time. Continued care due to a lack of a caregiver does not meet the definition of skilled care.

Post-procedural Care - More frequent skilled care visits may be needed initially following major surgical procedures. The resultant functional activity and participation level of the individual following the procedure is a key component to dosage decisions. As recovery progresses, the individual (and caregivers) typically becomes more independent with basic speech related tasks and their home program thus reducing the need for frequent skilled intervention. A dosage of visits authorized for any request will not be based on just a procedure, post-procedural protocol or similar, but on a case by case basis.

Evidence Based Recommendations - Currently, research on establishing the most efficacious dosages of skilled therapy is minimal. Research is adequate to show that skilled care can be generally effective. It is not adequate to show what number of visits is a superior dosage in most clinical situations. Some published research and guidelines may give recommended visit ranges, however these are often quite wide and vary by source so can only be used as general starting points to consider. EviCore does review current research literature annually, but must consider all individual clinical factors when deciding upon a range of visits to authorize.

National Practice Patterns - National skilled care visit data can reveal usage patterns, including average visit dosages. These averages can function similar to recommended visit ranges from clinical research and help provide consistent visit numbers to consider while all the clinical information in a request is reviewed.

Initial Requests - It is reasonable to expect that starting a new treatment plan (not re-evaluation or continuation after lapse in care) can be more involved and may require additional attention from a skilled provider. It is assumed initial visits will be used to start care, educate the individual, start a home program, and train caregivers. It is also

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assumed that there will be a reasonable block of visits for clinical sessions to monitor how the individual responds to the plan of care. For some clinical presentations it is reasonable that the initial block of visits could be sufficient to complete the entire episode of care. It is reasonable to expect that initial authorized visits are used judiciously.

Subsequent Requests (AKA follow-up requests) - Where criteria is met for continued skilled care, an individual may still demonstrate medical necessity for care. However, the individual should now be more familiar with their self-care program and their functional impairments should be less severe, or have been addressed through some taught adaptations. It is reasonable to expect that the frequency of skilled care visits will be adjusted as the severity of the individual's limitations change, or as adaptations have been taught. As an individual or caregiver responds appropriately to care over a reasonable timeframe their ability to self-manage should increase, thereby decreasing the overall need for skilled care.

Health Equity - Health equity is the highest level of health for all people; health inequity is the avoidable difference in health status or distribution of health resources due to the social conditions in which people are born, grow, live, work and age. Social determinants of health are conditions in the environment that affect a wide range of health, functioning, and quality of life outcomes and risks. Examples include safe housing, transportation, and neighborhoods; racism, discrimination and violence; education, job opportunities and income; access to nutritious foods and physical activity opportunities; access to clean air and water; and language and literacy skills.

All efforts are made to consider any documented social determinants of health of the individual along with all other clinical information submitted with a request for skilled benefits. Providers are responsible to clearly document those factors affecting the health equity of the individual and how they are impacting the established plan of care.

Discontinuation of Skilled Care

Requests for speech language pathology services that do not meet the criteria for initiation or continuation of skilled care would be considered not medically necessary.

Rules, Coverage, Benefits, and Mandates (SLP-1.3)

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EviCore is required to follow any applicable exclusions, rules, policies or mandates set forth by a health plan or governing bodies when processing requests for skilled care. The final determination of reimbursement for skilled therapy services is at the discretion of the health plan. Providers and individuals need to reference health plan policies and rules, federal or state health mandates, and any other applicable policies for any concerns about covered and non-covered skilled care services.

Health plans may be administered privately (commercial) or through state or national administrators (e.g. Medicare, Medicaid). Specific rules pertinent to submitting a request for skilled care will vary by health plan. Health plan rules, policies, any applicable medical necessity criteria and member coverage benefits pertaining to each health plan will take precedence over EviCore's medical necessity criteria. Private health plans may have specific limitations on how skilled care benefits are administered which dictate aspects of a request such as time frames allowed for submitting requests, when an authorization will expire, how long an episode of care may have coverage, benefit maximums, non-covered exclusions, and how a request can be submitted to EviCore.

When Evicore completes completes a case review for an individual that is covered by a Centers for Medicare and Medicaid Services (CMS) health plan, the CMS medical necessity policies take precedence over Evicore's criteria. CMS coverage and plan type may vary by national and/or state policies. In any instances where there is not a national and/or state CMS medical necessity policy for a specific jurisdiction of a CMS covered individual, then Evicore's criteria may apply. For any questions regarding CMS medical necessity criteria for skilled therapy, please refer to the applicable Medicare online benefit manual or state specific Medicaid policy.[8]

All determinations completed by EviCore will be communicated to the appropriate stakeholders as dictated by the health plan or policy in force. While there may be some variation, this typically includes at least the requesting provider, the member and referring provider if applicable. The determination letters should provide any authorized number of visits or denial of visits, a rationale for the decision and the guideline/policy that applies to the decision. The determination letters will also communicate any additional rights and points of contact for that decision. It is the provider's responsibility to read determination letters.

Clinical Considerations (SLP-2.0)

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To demonstrate the need for skilled care, the previously established criteria in **Criteria for the Provision of Speech Language Pathology (SLP) Services (SLP 1.0)** must be met. However, there are many variations in conditions, diagnoses and functional limitations and environmental factors as to why an individual could seek skilled care and be authorized for a reasonable amount of care. There are different areas of discipline, concentration or specialty within skilled care that may cater to these variations. Effective treatment options vary from case to case. This section and its subsections provide supplementary language to help establish what can be considered as reasonable evidence-based care and an appropriate response to that care, while keeping in mind possible variations.

Determining an individual has a limitation that requires skilled care or planning is essential to meeting the criteria established in **Criteria to Determine Medical Necessity for Skilled Speech Language Pathology Services (SLP-1.2)**. Demonstrating an appropriate and significant response to skilled care is required to show a continued need for care. Standard validated outcome measure scores and condition specific measures are recommended to be used to quantify levels of impairment and response to care [**Definitions (SLP 1.1)**]. Standard measures should be used throughout an episode of care to track progress. Measures used should reflect the limitations and goals of the individual. There are many validated standard measures available for a variety of impairments, conditions, ability levels, and population groups. It is the skilled provider's responsibility to choose appropriate measures specific to the needs and goals of the individual under their care. It is the provider's responsibility to know how to appropriately administer, score, track and document the standard measures they have chosen. In rare instances where standard measures are not appropriate, it is the provider's responsibility to document these reasons and to provide alternative quantifiable measures of progress.

It is acknowledged that standard measures are not free from some levels of subjectivity, bias and error. Additional clinical information beyond standard scores (subjective reports, observations, non-standard measures, etc) can help inform on the individual's complete situation and problems. All pertinent and applicable clinical information documenting an individual's progress is considered during the review process. [**Definitions (SLP 1.1)**].

EviCore takes into account current scientific evidence-based recommendations when evaluating a request for an appropriate need for skilled care. Generally accepted standards of practice [**Definitions (SLP 1.1)**] are recommendations based on published, credible, high-level, peer-reviewed evidence-based clinical practice guidelines and

systematic reviews of applicable research; they help define what is considered to be reasonable care. Episodes of skilled care and the treatments provided can vary for similar diagnoses and/or patient groups yet still result in an appropriate clinical response. Therefore, an individual's need for skilled care is evaluated based more so on the individual's presentation, response to the plan of care, and their ability for self-care than on specific treatments or techniques. An individual clinical trial may show a particular treatment or technique is effective for a specific problem and population, however just using a researched treatment is not what determines if an episode of skilled care is medically necessary.

Cognitive Communication Disorders Considerations (SLP-2.1)

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Cognitive communication disorders are typically characterized by any aspect of communication that disrupts cognitive processes. Some cognitive processes that can be disrupted may include, but are not limited to, memory, attention, problem solving, reasoning, planning, self-monitoring/self-advocacy, executive function, and time management. Problems in these areas may be verbal or nonverbal. Cognitive communication disorders can impact an individual's ability to safely and efficiently perform activities of daily living. Common etiologies of cognitive communication disorders include but are not limited to dementia, concussion, brain tumors, stroke and traumatic brain injury. Individuals with cognitive communication disorders can present with varied complexities and complications during an episode of care (**Definitions (SLP 1.1)**) which will be considered along with all clinical information.

Consideration of the need for the skilled care of cognitive communication disorders necessitates determining that an individual presents with a specific problem that limits their abilities while performing ADLs/IADLs. Baseline functional cognition should be assessed at the initiation of an episode of care and regularly throughout an episode. Standard function and performance-based measures are recommended for baseline and continued tracking of an individual's ability (**Clinical Considerations (SLP-2.0)**). Literature indicates clinicians should use standardized, valid assessment tools to evaluate impairments, functional activity limitations, participation levels, environmental restrictions, and mood/behavioral changes. Cognitive impairments should be assessed by healthcare professionals with competence in neurocognitive functioning.[9]

An individual may be seeking skilled care for a cognitive communication disorder secondary to a sentinel event such as a stroke or traumatic brain injury. Individuals may develop a gradual decline in cognition due to chronic neurological disorders such as Parkinson's disease or Multiple Sclerosis. An individual's needs and treatments may vary significantly from one to another.[10] Adults with cognitive dysfunction associated with acquired brain injury (ABI) should receive holistic, integrated cognitive rehabilitation that is clinician directed, person centered, and evidence based.[11] An individual's need for speech related skilled care will be assessed based on all clinical information presented that meet the indications for care (**Criteria to Determine Medical Necessity for Skilled Speech Language Pathology Services (SLP-1.2)**) in consideration of associated complexities and complications.

Published clinical practice guidelines for cognitive communication disorders recommend that interventions to address cognitive dysfunction in individuals should be: tailored

to daily communication needs, promote generalization and maintenance with self-management, metacognitive skills, anticipatory awareness, and be practiced in natural environments and engagement with the patient's network in a variety of settings. Interventions should identify and incorporate specific occupational or school tasks into treatment with the goal of returning to pre-morbid levels of impairment when appropriate through self-efficacy and independent management of compensatory systems. Effective management of cognitive-communication impairments may include domain-specific treatment approaches targeting impaired memory, attention, executive function and/or social communication skills and include one or more treatment approaches for the management of generalized cognitive dysfunction.[11] It is recommended that metacognitive strategy training, especially for those with mild to moderate attention deficits, utilize training that incorporates everyday activities of the individual.[12] Goals should be patient-centered aimed at mastering specific activities and the provider should ensure that the patient has requisite motivation and attention skills to participate prior to initiating treatment.[10,13] Goals should be set in collaboration with the patient and family/caregiver and should be well-defined, specific and challenging.[13]

When addressing pediatric individuals, recommended treatments should be meaningful, engaging, progressively adapted, age-appropriate, task-specific, and goal-oriented for the child and family. Interventions may target educational habilitation/rehabilitation, classroom function and safety, developmentally relevant play, and leisure skills appropriate for their home, school, and/or community environments.[10] Children and adolescents with cognitive impairments benefit from a holistic approach to habilitation/rehabilitation which incorporates developmental, cognitive, social, and emotional considerations.[15]

Hearing and Auditory Processing Disorders Considerations (SLP-2.2)

SLP.2.2.A
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Hearing and auditory processing disorders are typically characterized by an inability or decreased ability to perceive, discriminate, and integrate speech and non-speech sounds, resulting in functional communication deficits during activities of daily living. Generalized hearing loss can impact an individual's ability to safely function within their environment, as well as ability to understand speech and discourse. Hearing and auditory processing disorders may present in combination with congenital defects of the auditory mechanism, or may result from injury, trauma, neurological conditions or presbycusis. A licensed audiological evaluation is required for the differential diagnosis of hearing and/or auditory processing disorders, as well as the need for appropriate amplification, prior to referral for SLP intervention. Individuals with hearing and/or auditory processing deficits can present with varied complexities and complications during an episode of care [**Definitions (SLP 1.1)**] which will be considered along with all clinical information.

Considering the need of skilled care for a hearing and/or auditory processing deficit necessitates that an individual presents with a specific problem that significantly limits their functional communication ability during ADLs/IADLs. Baseline level of functioning should be assessed at the initiation of an episode of care and regularly throughout an episode. Standard function and performance based outcomes are recommended for baseline and continued tracking of an individual's communication ability [**Clinical Considerations (SLP-2.0)**]. It is expected that an individual will respond appropriately to skilled care in an appropriate and predictable amount of time.

An individual may be seeking skilled care for a hearing and/or auditory processing problem impacting acquisition of communication skills, or to improve hearing or processing due to an injury, surgery, neurological event or congenital abnormality. Assistive hearing/listening devices and/or environmental modifications may be appropriate in conjunction with skilled therapy. Early detection and intervention for these disorders is recommended for speech and language acquisition and functional communication abilities across the lifespan. There is a growing body of research suggesting that therapists should also be aware that auditory processing deficits may result from age-related changes in the auditory system[16]. The approaches, devices and strategies will vary and each individual will respond differently. The need for skilled care will be assessed based on all clinical information presented that meets the indications for care [**Criteria to Determine Medical Necessity for Skilled Speech Language**

Pathology Services (SLP-1.2)] in consideration of associated complexities and complications.

Published clinical practice guidelines for hearing and auditory processing disorders recommend clinicians develop a management plan based on assessment findings unique to the individual and family that is focused on maximizing communication participation and independence.[15,16,17] The treatment model must consider the specific clinical, social, educational, vocational, and community needs in order to promote autonomy. Speech-language therapy is recommended for those with processing difficulties impacting attention, memory and organization of auditory information. Incorporating evidence-based auditory training is recommended. Language-based treatment should involve the use of compensatory metacognitive and metalinguistic strategies, communication repair strategies, and educating caregivers and educators, as well as targeting classroom/environmental factors such as reducing distance and background noise.[15,16] Auditory habilitation/rehabilitation and processing treatments may include use of assistive listening devices or other technologies. Approaches may target listening, discrimination, identification and localization of sounds in noise as well as functional language skills, including vocabulary, grammar, and conversation. Educating the individual to use visual aids and repetition to aid in communication exchanges is recommended.[7] Further recommendations specific to hearing loss in the adult population suggest that clinicians should make the following resources available as part of an individual-centered approach: multicomponent AR interventions including informational counseling (regarding communication strategies, hearing aid handling, care, environmental modification, assistive technology and consequences of hearing loss and hearing aid use) and personal adjustment counseling, such as direct or indirect perceptual training to improve understanding of speech.[18]

Language Disorders Considerations (SLP-2.3)

SLP.2.3.A
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Language disorders are typically characterized by impairment in the acquisition and/or use of language for listening, speaking, reading, writing, thinking, reasoning, and/or engaging in social communication.[7] Language disorders can be congenital or acquired. Individuals with language impairment may demonstrate deficits in understanding or expression in any of the domains of language including phonology, morphology, syntax, semantics, and/or pragmatics/social communication. A language disorder may be diagnosed in the absence of any other medical or mental condition; however, a spoken language disorder in children will often accompany other conditions such as autism, hearing loss, intellectual disability, or global delay.[19] In adults, acquired language disorders, such as aphasia or apragmatism often result from stroke, head injury, brain tumors, and other infectious, toxic, metabolic, or degenerative diseases.[20] Additionally, individuals who demonstrate language impairments may have difficulty in areas of reading and writing. Language impairments can range from very mild to severe. The level of deficit may be related to whether the impairment includes receptive and expressive language, expressive language alone, and/or comorbid mental or medical conditions.[21]

It is important to note that bilingualism does not cause or in any way contribute to a language disorder. A bilingual individual may present with a language impairment, but it is essential to differentiate a language difference from a language disorder. If a language impairment is present, it will be found in both/all the languages the individual understands and uses.[22]

Consideration of the need for skilled intervention for language disorders necessitates determining that an individual presents with a deficit that limits ability to understand and/or use language effectively to communicate, thereby impairing the ability to participate in social, educational, and vocational activities.[7] A comprehensive assessment, including standardized receptive/expressive language testing, is essential for diagnosing a language disorder [**Clinical Considerations (SLP-2.0)**]. Other objective assessment procedures including, language sample, dynamic measures, parent/caregiver report/questionnaires, examination of reading and writing, and systematic observation are also considered when diagnosing language impairments and when determining baseline skills.[19,23] Treatment is usually supported when an individual performs at least one standard deviation below the mean on standardized testing or demonstrates significant deficits through objective skills assessments.[24] Additional information including level of impairment and comorbid conditions should also be considered when determining

need relative to skilled intervention. When evaluating a bilingual/multilingual individual, assessment must be conducted in all languages spoken.[22]

There is an established body of guidelines and reviews that provide recommendations for reasonable and effective care for language disorders. These recommendations suggest that early diagnosis and treatment support a higher prevalence of positive outcomes. Research findings support a combination of explicit and implicit treatment. Explicit care often consists of individual or group therapy sessions with the clinician, while implicit care typically involves training parents/caregivers to provide care in the home.[25] Parent-implemented interventions have been found to be very effective in supporting improvements in language for children given the consistent access parents have on a daily basis.[26-29] For adults, services should also include healthcare providers and family members with caregiver involvement in the rehabilitation process.[10,30] Speech language therapy providers should implement evidence-based treatment approaches which include: language stimulation, vocabulary intervention, scaffolding, prompting, cloze, use of visual supports, errorless teaching, semantic/syntactic programs (such as semantic feature analysis and concept mapping), word finding, literacy intervention, high level language skills (such as inferencing), functional communication (including social skills training), melodic intonation therapy, and/or augmentative and alternative communication (such as use of sign language, communication boards, picture exchange, and speech-generating devices).[20,30,31] When treating individuals with aphasia or persistent language impairments, treatment may involve compensatory training and/or introduction to augmentative/alternative methods of communication.[30,32,33]

It is important to note that when treating language impairment in multilingual individuals, treatment should occur in all languages by a bilingual/multilingual speech-language pathologist or with a trained interpreter.[22,32] The goal should be to achieve, regain, or maintain bilingualism/multilingualism. The primary language (L1) should never be abandoned in order to focus on an additional language.[22] For aphasic bilingual individuals it is important to note that parallel recovery occurs in most cases; however in some cases there may be selective recovery in that one language that remains impaired while the other is recovered. Repetition and practice are critical and care may become episodic with a shift toward the targeting of functional skills to meet a specific need. Skilled care for language disorders should empower individuals and their caregivers to become independent in carryover of skills taught and parents/caregivers should be educated on the reality of the individual's language disorder, and goals should be reasonable and realistic.[33, 34]

Speech Production Disorders Considerations (SLP-2.4)

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Speech production disorders refers to any combination of difficulty with speech production, including problems with making sounds and sound patterns.[7] Characteristics may include difficulty with tongue/lip posture or movement and speech sound distortions. Disruptions in speech motor planning and execution can result in abnormalities of the strength, range of motion, tone, or precision of movements required for appropriate control of the speech subsystems (i.e. , articulatory, respiratory, phonatory, resonatory, and fluency). These abnormalities may affect speech sound production (e.g., articulation, apraxia, dysarthria), resonance (e.g., hypernasality, hyponasality), voice (e.g., phonation quality, pitch, loudness, and respiration), and fluency (e.g., stuttering).[7] Speech production disorders may lead to deficits in functional daily communication and can present in combination with developmental and neurological conditions, prematurity, genetic syndromes, trauma, cancer, structural anomalies, etc. Individuals with speech production disorders can present with varied complexities and complications during an episode of care, which will be considered along with all clinical information during a review for need of skilled care.

The need for skilled care for a speech in managing production disorders arises when an individual demonstrates significant limitations in their ability to communicate through speech. Objective assessments including standardized testing, speech samples, parent/caregiver questionnaires and examination of oral motor structure and function should be performed initially and regularly throughout an episode of care. Accurate and regular assessments are essential to identify specific problems and track progress. Objective acoustic data can validate the auditory and visual perceptions of the skilled care professionals and the patient self-reports. There is also evidence that selected acoustic, laryngeal imaging–based, auditory–perceptual, functional, and aerodynamic measures may be used as effective components in a clinical voice evaluation. Instrumentation (i.e. laryngeal function or velopharyngeal function studies) may also be considered when determining baseline skills. Standardized, valid, functional and performance based measures are recommended to be used throughout an episode of care to demonstrate levels of a deficit and that an individual is responding appropriately to the care provided [**Clinical Consideration (SLP-2.0)**]. In special situations where these measures cannot be performed, clinical observation and objective information may be provided to demonstrate the level of functional deficit. Additional clinical details about speech concerns and standard scores will be considered during a review for medical necessity. It is expected that an individual will respond appropriately to skilled care in a generally predicted timeframe.[35]

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An established body of peer-reviewed guidelines and systematic reviews recommend on reasonable and effective care for speech production disorders. These recommendations support using sensory-motor treatments as effective in the remedying of persistent speech errors. Speech therapy that encourages intense practice of misarticulated speech sounds or correct movement patterns of phonological structures is effective. Outcomes may be maximized by employing specialized procedures for each subtype of speech sound disorders.[22]

The current literature supports the importance of speech therapy in individuals with dysarthria and dysphonia.[24,36] It is also recommended that the core of vocal rehabilitation includes both indirect and direct approaches. There is high level evidence to support recommendations for using motor learning principles in skilled care for childhood apraxia of speech, including recommendations that high frequency of sessions may sometimes be supported. The current literature recommends early intervention skilled care for children who demonstrate fluency disorders (i.e stuttering) during pre-school.[37,38] Early intervention for fluency should help not only improve speech, but activity and participation of the young individual.[38] It is recommended that only a few treatment sessions for sound production in individuals with acquired apraxia/ aphasia are needed to achieve initial positive changes. Mastery of articulation, for individuals that showed an initial positive response to skilled care, may occur within an average of 12-14 sessions for most individuals.[39] Attention to effort methods have also been recommended to improve speech and communication, primarily when dysarthria may be related to Parkinsonism or similar conditions.[40]

It is recommended that individuals receiving skilled care for speech production disorders be provided with progressive home and self-care programs to regularly work on the repetitive aspects of their care plan on their own or with a caregiver. Skilled care should empower individuals and their caregivers to become independent once a home program is established. For children, one way to achieve greater treatment intensity is to include a home program that is implemented by the child's parents or primary caregiver.[24]

Swallowing and Feeding Disorders Considerations (SLP-2.5)

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Swallowing and feeding disorders are typically characterized by impaired oral intake that is not age appropriate, creates a health risk and negatively impacts quality of life. These disorders can also present in combination with developmental and neurological conditions, such as prematurity and low birth weight, genetic syndromes, trauma, cancer, oral structural abnormalities, etc. The severity of a swallowing or feeding disorder is related to nutrition/growth and safety concerns and the need for supplemental/enteral nutrition.[41]

Consideration of the need for skilled care for a swallowing and/or feeding disorder necessitates determining that an individual presents with a specific problem that impacts swallowing function, significantly limits oral intake and/or is a safety concern. Baseline feeding skills should be assessed at the initiation of an episode of care. Standardized, valid, functional and performance based measures are recommended to be used throughout an episode of care to demonstrate levels of feeding deficit and appropriate response to care being provided [**Clinical Considerations (SLP-2.0)**]. Additional information specific to swallowing and feeding concerns will be considered along with standard scores. This may include food/drink types, textures, quantities; oral motor skills; growth/nutrition concerns of medical professionals; functional imaging assessments (such as fluoroscopic swallowing studies); supplemental nutrition; caregiver participation; and any additional complexities of the individual's situation. It is expected that an individual will respond appropriately to skilled care in a predicted amount of time.

An established body of published high-level guidelines and reviews provide recommendations on reasonable care for swallowing and feeding disorders. These recommendations suggest that skilled care for swallowing and feeding should focus on treatment strategies that are task-specific. Skilled care should primarily be active in nature, including tongue and pharyngeal exercise with education and transition to a home program as soon as possible.[42-45] Evidence supports care that incorporates multiple exercise strategies such as chin-tuck, Shaker, and expiratory muscle training along with traditional dysphagia treatment.[46] Individuals and caregivers can learn a home program and repeat their program between direct skilled care sessions. As the individual's needs change, skilled care may become episodic to address specific needs. It is also recommended that individuals and their caregivers be educated on the reality of their feeding disorder and be given realistic goals and expectations.

For pre-term infants, recommended strategies include pacing, positioning, non-nutritive suck and oral motor stimulation to improve suck-swallow-breathe coordination, latching, and suction strength and endurance for improved oral feeding.[44,47-48] Oral stimulation and oral support increases volume intake, feeding efficiency, and weight gain while decreasing oral feed time, transition time to full oral feeding, and hospital stay length.[49-51] Neurostimulation therapies, such as transcranial magnetic stimulation can be effective for post-stroke dysphagia.[52] It is recommended that nutritional concerns be addressed through a combination of treatments that address food intake such as task oriented training, behavioral interventions, peer modeling, sensory activities, and parent/caregiver education.[42,43,46,,50,53-55] It has been recommended that individuals weaning from tube feeding can benefit from hunger provocation and behavioral programs.[56] Skilled care for swallowing and feeding should empower an individual and their caregiver to become independent once a home program is established.

Evidence exists that neuromuscular electrical stimulation (NMES) in conjunction with exercise and behavioral swallowing treatment can be an effective method of treatment for swallowing function in individuals with oropharyngeal dysphagia of different etiologies.[57] The addition of NMES to skilled care for swallowing impairments in progressive neurological disease such as Parkinson's is recommended as it may be more beneficial than care alone to help reduce the risk of aspiration.[58]There is insufficient evidence in the published, peer-reviewed scientific literature to conclude that NMES/electrical stimulation by itself is effective in the treatment of dysphagia.

References (SLP)

Guideline Page

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References

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1. World Health Organization. How to use the ICF: A practical manual for using the International Classification of Functioning, Disability and Health (ICF). Exposure draft for comment. October 2013. Geneva. https://www.who.int/publications/m/item/how-to-use-the-icf---a-practical-manual-for-using-the-international-classification-of-functioning-disability-and-health Accessed 7/15/23.
2. Centers for Medicare and Medicaid Services. *Medicare Benefit Policy Manual Publication* 100-02, Chapter 15 – Covered medical and other health services rev. 10880, 08-06-21. Section 220.2. Baltimore, MD.
3. National Association of Insurance Commissioners. *Glossary of Health Insurance and Medical Terms*. https://content.naic.org/sites/default/files/inline-files/committees_b_consumer_information_ppaca_glossary.pdf Accessed 5/13/22
4. Evicore Healthcare. Clinical Guidelines: Guideline Definitions v 1.0.2023. Accessed Jan 2024: eviCore Guideline Definitions Guidelines - V1.0.2024 - Effective 2/1/24. https://www.evicore.com/provider/clinical-guidelines-details?solution=supplemental%20information&hPlan=EviCore%20by%20Evernorth
5. American Occupational Therapy Association. (2020). *Occupational therapy practice framework: Domain and process* (4th ed.). American Journal of Occupational Therapy, 74(Suppl. 2), 7412410010. doi:10.5014/ajot.2020.74S2001.
6. American Speech-Language Hearing Association Statistics Refresher. www.ASHA.org. https://www.asha.org/research/ebp/statistics-refresher/#:~:text=Standard%20deviation%20estimates%20the%20variability,of%20the%20bell%2Dshaped%20curve. Accessed 8/19/2023.
7. American Speech-Language-Hearing Association. Speech-Language Pathology Medical Review Guidelines, 2015. https://www.asha.org/practice/reimbursement/SLP-medical-review-guidelines/. Accessed 7/1/22.
8. Centers for Medicare and Medicaid Services. Medicare Coverage Determination Process. https://www.cms.gov/Medicare/Coverage/DeterminationProcess. Page last modified 3/3/2022. Accessed 3/23/22.
9. General Standards for Neurological Care and Support. Healthcare Improvement Scotland. Edinburgh (United Kingdom): Healthcare Improvement Scotland. 2019; 1-44. https://www.healthcareimprovementscotland.org/our_work/standards_and_guidelines/stnds/neurological_care_standards.aspx . Accessed 7/1/22.
10. Lindsay MP, Mountain A, Gubitz G, Dowlatshahi D, Casaubon L, and Smith EE. (eds.), on behalf of the Canadian Stroke Best Practices and Quality Advisory Committee. *Canadian Stroke Best Practice Recommendations Sixth Edition*, 2018; Toronto, Ontario Canada: Heart and Stroke Foundation. https://www.strokebestpractices.ca/ . Accessed 7/1/22.
11. Guideline Development Panel, Brown, J, Kaelin, D, Mattingly, E, et al. American speech-language-hearing association clinical practice guideline: Cognitive rehabilitation for the management of cognitive dysfunction associated with acquired brain injury.American journal of speech-language pathology,2022. 31(6), pp.2455-2526.
12. Ponsford, Jennie et al. "INCOG 2.0 Guidelines for Cognitive Rehabilitation Following Traumatic Brain Injury, Part II: Attention and Information Processing Speed."*The Journal of head trauma rehabilitation*vol. 38,1 (2023): 38-51. doi:10.1097/HTR.0000000000000839.
13. American Speech-Language-Hearing Association. *Summary of the Clinical Practice Guideline: Cognitive rehabilitation for service members and veterans following mild to moderate traumatic brain injury clinical recommendations*. Defense and Veterans Brain Injury Center 2019. ASHA Evidence Maps. https://apps.asha.org/EvidenceMaps/Articles/ArticleSummary/dfd13009-31b6-4e78-b8c7-b6f91e0ccd6d. Accessed 7/1/22.
14. Stroke Foundation (2022). *Clinical Guidelines for Stroke Management*. Melbourne Australia. https://informme.org.au/Guidelines/Clinical-Guidelines-for-Stroke-Management. Accessed 7/1/22.
15. Shaw DR. A systematic review of pediatric cognitive rehabilitation in the elementary and middle school systems. NeuroRehabilitation. 2016 Jun 18;39(1):119-23. doi: 10.3233/NRE-161343.
16. College of Speech and Hearing Health Professionals of British Columbia. *Clinical Practice Guideline: Auditory Processing Disorder in Children and Adults*. Adopted 2019. Vancouver, Canada. https://www.cshbc.ca/wp-content/uploads/2019/02/CSHBC-ACPG-01-Auditory-Processing-Disorders-in-Children-Adults-EN.pdf. Accessed 7/1/22.

17. Keith WJ, Purdy SC, Baily MR, Kay FM. *New Zealand Guidelines on Auditory Processing Disorder*. New Zealand Audiological Society. https://www.audiology.org.nz/. Accessed 7/1/22.
18. Basura G, Cienkowski K, Hamlin L et al. American Speech-Language-Hearing Association Clinical Practice Guideline on Aural Rehabilitation for Adults With Hearing Loss. American Journal of Audiology, 2023. 32(1):1-51. Doi: 10.1044/2022_AJA-21-00252.
19. American Speech-Language-Hearing Association. *Clinical Topics: Spoken Language Disorders*. https://www.asha.org/practice-portal/clinical-topics/spoken-language-disorders/guage Disorders/ Accessed 8/14/22.
20. Mattioli F. The clinical management and rehabilitation of post stroke aphasia in Italy: evidences from the literature and clinical experience. *Neurological Sciences*. 2019;40(7):1329-1334. doi:10.1007/s10072-019-03844-0
21. American Speech-Language-Hearing Association. *Clinical Topics: Late Language Emergence*. https://www.asha.org/practice-portal/clinical-topics/late-language-emergence/ Accessed 8/14/22.
22. Pert S, Bradley B. Clinical Guidelines for Speech and Language Therapists: Bilingualism: working with bilingual clients/patient with speech, language and communication needs. *Royal College of Speech and Language Therapists*. https://www.rcslt.org/clinical_resources/bilingualism/bilingualism_overview. Accessed 8/14/22.
23. Koenig-Bruhin M, Kolonko B, At A et al. Aphasia following a stroke: recovery and recommendations for rehabilitation. *Swiss Archive for Neurology and Psychiatry*. 2013; 164(08):292-298. doi:10.4414/sanp.2013.00209
24. Damico JS, Mueller N, Ball MJ. *The Handbook of Language and Spech Disorders*, 2nd ed. Hoboken NJ, Wiley-Blackwell 2021. ISBN: 978-1-119-60696-3
25. Frizelle P, Tolonen AK, Tulip J et al. The Impact of Intervention Dose Form on Oral Language Outcomes for Children With Developmental Language Disorder. *Journal of Speech, Language, and Hearing Research*. 2021;64(8):3253-3288. doi:10.1044/2021_jslhr-20-00734.
26. Tosh R, Arnott W, Scarinci N. Parent-implemented home therapy programmes for speech and language: A systematic review. *International Journal of Language & Communication Disorders*. 2016;52(3):253-269. doi:10.1111/1460-6984.12280.
27. DeVeney SL, Hagaman JL, Bjornsen AL. Parent-implemented versus clinician-directed interventions for late-talking toddlers: A systematic review of the literature. *Communication Disorders Quarterly*. 2017;39(1):293-302. doi:10.1177/1525740117705116.
28. Parsons L, Cordier R, Munro N, Joosten A, Speyer R. A systematic review of pragmatic language interventions for children with autism spectrum disorder. *PLOS ONE*. 2017;12(4). doi:10.1371/journal.pone.0172242.
29. Lamego DT da C, Moreira MCN, Bastos OM. Guidelines for child health: language development on focus. *Ciência & Saúde Coletiva*. 2018;23(9):3095-3106. doi:10.1590/1413-81232018239.04892016.
30. Simmons-Mackie N, Worrall L, Murray LL, et al. The top ten: best practice recommendations for aphasia. *Aphasiology*. 2016;31(2):131-151. doi:10.1080/02687038.2016.1180662.
31. Morgan A, Mei C, Anderson V, Waugh M-C, Cahill L, & the TBI Guideline Expert Working Committee. *Clinical Practice Guideline for the Management of Communication and Swallowing Disorders following Paediatric Traumatic Brain Injury*. Melbourne: Murdoch Childrens Research Institute; 2017
32. American Speech-Language-Hearing Association. *Clinical Topics: Aphasia*. https://www.asha.org/practice-portal/clinical-topics/aphasia/. Accessed 8/14/22.
33. Law J, Dennis JA, Charlton JJV. Speech and language therapy interventions for children with primary speech and/or language disorders. *Cochrane Database of Systematic Reviews*. 2017. doi:10.1002/14651858.cd012490.
34. Speech Pathology Australia (2020). *Augmentative and Alternative Communication Clinical Guideline*. Melbourne: Speech Pathology Australia.
35. Baker J, Barnett C, Cavalli L, et al. Management of functional communication, swallowing, cough and related disorders: consensus recommendations for speech and language therapy. *J Neurol Neurosurg Psychiatry*. 2021;92(10):1112-1125. doi:10.1136/jnnp-2021-326767.
36. Chiaramonte R, Pavone P, Vecchio M. Speech rehabilitation in dysarthria after stroke: a systematic review of the studies. *Eur J Phys Rehabil Med*. 2020;56(5):547-562. doi:10.23736/S1973-9087.20.06185-7.
37. Sjögreen L, Gonzalez Lindh M, Brodén M, et al. Oral Sensory-Motor Intervention for Children and Adolescents (3-18 Years) with Developmental or Early Acquired Speech Disorders Secondary to Congenital or Early-Acquired Disabilities: A Review of the Literature, 2000 to 2016. *Annals of Otology, Rhinology & Laryngology*. 2018;127(12):978-985. doi:10.1177/0003489418803963.

38. Brignell A, Krahe M, Downes M, Kefalianos E, Reilly S, Morgan A. Interventions for children and adolescents who stutter: A systematic review, meta-analysis, and evidence map. *J Fluency Disord*. 2021;70:105843. doi:10.1016/j.jfludis.2021.105843.
39. Wambaugh JL, Kallhoff L, Nessler C. Sound Production Treatment for Acquired Apraxia of Speech: An Examination of Dosage in Relation to Probe Performance. *Am J Speech Lang Pathol*. 2021;30(1S):425-440. doi:10.1044/2020_AJSLP-19-00110.
40. Grimes D, Fitzpatrick M, Gordon J, et al. Canadian guideline for Parkinson disease. *CMAJ*. 2019;191(36):E989-E1004. doi:10.1503/cmaj.181504.
41. Shune SE, Karnell LH, Karnell MP, Van Daele DJ, Funk GF. Association between severity of dysphagia and survival in patients with head and neck cancer. Head & Neck. 2012;34(6):776-784. doi:https://doi.org/10.1002/hed.21819.
42. Yang S, Park JW, Min K, Lee YS et al. Clinical Practice Guidelines for Oropharyngeal Dysphagia. Ann Rehabil Med. 2023 Jul;47(Suppl 1):S1-S26. doi: 10.5535/arm.23069.
43. Cahill SM, Beisbeir S. Practice Guidelines—Occupational therapy practice guidelines for children and youth ages 5–21 years. *American Journal of Occupational Therapy*. 2020; 74, 7404397010.
44. Frolok CG, Kingsley KL. Practice Guidelines—Occupational therapy practice guidelines for early childhood: Birth–5 years. *American Journal of Occupational Therapy.* 2020; 74, 7403397010.
45. Morgan C, Fetters L, Adde L et al. Early intervention for children aged 0 to 2 years with or at high risk of cerebral plasy Internation clinical practice guideline based on systematic reviews. *JAMA Pediatrics*. 2021;175(8):846-858. doi:10.1001/jamapediatrics.2021.0878.
46. Lee CL, Banda KJ, Chu YH, Liu D, Lee CK, Sung CM, Arifin H, Chou KR. Efficacy of swallowing rehabilitative therapies for adults with dysphagia: a network meta-analysis of randomized controlled trials. Geroscience. 2024 Oct 23. doi: 10.1007/s11357-024-01389-5.
47. Chen D, Yang Z, Chen C, Wang P. Effect of oral motor intervention on oral feeding in preterm infants: A systematic review and meta-analysis. *American Journal of Speech-Language Pathology.* 2021 Sep 23;30(5):2318-28.
48. Racyznksa A, Gulczyńska E, Talar T. Advantages of side-lying position. A comparative study of positioning during bottle-feeding in preterm infants (≤34 weeks GA). Journal of Mother and Child.2022; 25(4): 269–276.
49. Rodriguez Gonzalez P, Perez-Cabezas V, Chamorro-Moriana G, Ruiz Molinero C, Vazquez-Casares AM, Gonzalez-Medina G. Effectiveness of Oral Sensory-Motor Stimulation in Premature Infants in the Neonatal Intensive Care Unit (NICU) Systematic Review. *Children*. 2021; 8(9):758. https://doi.org/10.3390/children8090758.
50. Gronski M, Doherty M. Interventions within the scope of occupational therapy practice to improve activities of daily living, rest, and sleep for children ages 0–5 years and their families: A systematic review. *American Journal of Occupational Therapy*. 2020 Mar 1;74(2):7402180010p1-33.
51. Calk P. Best Practices for Oral Motor Stimulation to Improve Oral Feeding in Preterm Infants: A Systematic Review. *Ann Physiother Occup Ther*. 2019, 2(4): 000143.
52. Chiang CF, Lin MT, Hsiao MY, Yeh YC, Liang YC, Wang TG. Comparative efficacy of noninvasive neurostimulation therapies for acute and subacute poststroke dysphagia: a systematic review and network meta-analysis. *Archives of Physical Medicine and Rehabilitation*. 2019 Apr 1;100(4):739-50.
53. Clark GF, Kingsley KL. Occupational therapy practice guidelines for early childhood: Birth–5 years. *American Journal of Occupational Therapy*. 2020 May 1;74(3):7403397010p1-42.
54. Malzacher A, Slocum S, Ausderau K. Dietary Intake Outcomes of Feeding Interventions for Children With Autism Spectrum Disorder (ASD)—A Systematic Review. *American Journal of Occupational Therapy*. 2020 Aug 1;74(4_Supplement_1):7411515342p1-.
55. Diaz J, Cosbey J. Supporting Parents' Occupations: A Systematic Review of Feeding Interventions for Children With Autism Spectrum Disorder. *American Journal of Occupational Therapy*. 2017 Jul 1;71(4_Supplement_1):7111520292p1-.
56. Zwaigenbaum L, Bauman M, Choueiri R, et al. Early intervention for children with autism spectrum disorder under 3 years of age: recommendations for practice and research. *Pediatrics*. 2015;136(1)60-81. https://pediatrics.aappublications.org/content/pediatrics/136/Supplement_1/S60.full.pdf. Accessed July 21, 2020.
57. Wang Z, Xiao Z, Shen Q, Zhao N, Zhang W. Neuromuscular Electrical Stimulation for Post-Stroke Dysphagia Treatment: A Systemic Evaluation and Meta-Analysis of Randomized Controlled Trials. Dysphagia. 2024 Jun;39(3):424-432. doi: 10.1007/s00455-023-10626-6.

58. Cheng I, Sasegbon A, Hamdy S. Dysphagia treatments in Parkinson's disease: A systematic review and meta-analysis. Neurogastroenterology & Motility. 2023;35:e14517. doi: 10.1111/nmo.14517.