

MEDICAL POLICY

Medical Policy Title	Therapies (Speech, Physical and Occupational)
Policy Number	8.01.24
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Our medical policies are based on the assessment of evidence based, peer-reviewed literature, and professional guidelines. Eligibility for reimbursement is based upon the benefits set forth in the member's subscriber contract. (Link to [Product Disclaimer](#))

POLICY STATEMENT(S)

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Initial Therapy Requests

- I. Restorative or habilitative physical therapy (PT), occupational therapy (OT) or speech therapy (ST) are considered **medically appropriate** with **ANY** of the following indications when determined by standardized assessments:
 - A. Functional physical impairment due to disease;
 - B. Trauma/injury;
 - C. Previous therapeutic processes (e.g., traumatic brain injury, cardiovascular accident/stroke);
 - D. Prior therapeutic intervention(s);
 - E. Children exhibiting at least a moderate to severe delay or disability as determined by standardized assessments, resulting from disease, trauma, congenital anomaly, or developmental delay;
 1. A moderate to severe deficit is generally defined as ([Refer to Policy Guideline](#)):
 - a. A score at least 1.5 standard deviations below the mean (i.e., a standard score of 77 or below for most standardized tests that have an average score of 100 with a

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standard deviation of 15). ([Standardized Speech Tests](#))

2. Cross-disciplinary and age equivalency scores may be considered, as well as percentage scores, and standard deviation when determining the severity of the impairment.
- II. In determining the **medical appropriateness** of PT, OT or ST services, consideration will be given to individuals based on **BOTH** of the following criteria:
- A. The degree of limitation/deficit the impairment imposes on the individual; **and**
 - B. Deficit(s) are expected to improve over a short period of time (generally up to two (2) months) with treatment.

Continuation of Services

- III. Continuation of PT, OT, or ST services beyond the initial evaluation and approved therapy sessions will be considered **medically appropriate** if **ALL** of the following criteria have been met:
- A. Maintenance service level has not been achieved ([Refer to Policy Guidelines](#));
 - B. Significant improvement must be demonstrated in objective measures including but not limited to **ANY** of the following:
 1. Standardized assessments;
 2. Non-imaging assessment; **or**
 3. Speech specific testing (e.g., Repeat barium swallow; Fiberoptic endoscopic examination of swallowing (FEES), Weight gain);
 - C. Documentation of **ALL** of the following:
 1. Showing continued improvement within the past treatment period;
 2. An updated treatment plan; **and**
 3. That the member is actively participating in therapy sessions.

Speech Therapy

- IV. Speech Therapy services are considered **not medically necessary** for **ANY** the following indications:
- A. Vocal cord polyps, as the usual recommended treatment is excision of the polyps;
 - B. Untreated conductive hearing loss, as diagnosis of and treatment for the hearing loss should first be provided;
 - C. Individual is receiving maintenance services ([Refer to Policy Descriptions](#));
 - D. Oral myofunctional disorders (e.g., tongue thrust, deviant swallow, reverse swallow, visceral swallow);
 - E. Pragmatic language disorders/impairments.

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Dysphagia and Feeding Difficulties

*For continuation of ST service ([Refer to Policy Statement III](#)).

- V. Dysphagia in children with the potential functional ability to feed by mouth in need of ST is considered **medically appropriate** for and **EITHER** of the following indications:
 - A. Evaluation of and diagnosis of aspiration or laryngeal penetration by a physician with expertise in the diagnosis and treatment of dysphagia;
 - B. The child has a history of or is at high risk for recurrent aspiration or choking or has clinical signs/symptoms of aspiration.
- VI. Feeding difficulties in children in need of ST is considered **medically appropriate** when **ANY** of the following criteria are met:
 - A. Food refusal creating a risk of malnutrition, leading to the required use of enteral feeding or nutritional supplements; ([Refer to Policy Guidelines](#))
 - B. Nutritional status deficiencies that risk diet related diseases (e.g., rickets, scurvy).

Vocal Cord Dysfunction and Voice Therapy

* For continuation of ST service ([Refer to Policy Statement III](#)).

- VII. Vocal Cord Dysfunction (VCD) treatment using ST is considered **medically appropriate**. (Treatment of VCD is not the same as voice therapy).
- VIII. Voice therapy (Voice therapy is not the same as treatment of Vocal Cord Dysfunction) is considered **medically appropriate** for voice disorders when **ALL** of the following criteria has been met:
 - A. When a pathological process has been identified (e.g., anatomic laryngeal/vocal cord abnormality);
 - B. Other methods of treatment have been documented as ineffective.
- IX. Voice therapy is considered **not medically necessary** for **ANY** of the following:
 - A. Intensive behavioral therapy with or without the use of a computerized software program including but not limited to:
 - 1. Lee Silverman Voice Therapy, LSVT LOUD;
 - 2. SPEAK OUT!

Physical and Occupational Therapy

- X. Non-skilled therapy services that do not require the expertise of an OT or PT therapist are considered **not medically necessary** and include but are not limited to **ANY** of the following:
 - A. Passive range of motion (PROM) treatment that is not related to restoration of a specific loss of function;
 - B. Treatments, given to an individual who presents without complications, including but not

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limited to **ANY** of the following:

1. Infrared heat;
 2. Whirlpool, paraffin or contrast baths;
 3. Hubbard tank;
 4. Cold, ice or heat packs;
 5. Aquatic exercises;
 6. Transcutaneous Electrical Nerve Stimulation (TENS);
- C. Services that maintain function by using routine, repetitive procedures, exercise, conditioning or gym programs (land- or water-based), for stable, chronic conditions (lasting longer than three months since initial onset), such as fibromyalgia or chronic pain syndrome (chronic low-back pain);
- D. Vasopneumatic compression, when used alone and without the need for skilled monitoring of potential adverse signs and symptoms;
- E. Crutch training.
- XI. The following PT or OT services are considered **not medically necessary** for **ANY** of the following:
- A. Gait analysis;
 - B. Sensory integration therapy (SIT);
 - C. Hippotherapy, equine movement therapy, horseback riding;
 - D. Isokinetic testing with an isokinetic dynamometer (e.g., Biodex, Cybex II, Omnikinetic, Lido Active) in the assessment of muscle strength;
 - E. Programs solely for sports and/or recreational purposes (e.g., conditioning, strength training, and aquatic exercise programs such as water aerobics and water walking);
 - F. Maintenance programs ([Refer to Policy Descriptions](#));
 - G. Work-related or workers' compensation programs ([Refer to Policy Description](#), including but not limited to:
 1. Work evaluation;
 2. Work reconditioning, or work hardening programs;
 3. Sheltered work programs; **or**
 4. Vocational training.
- XII. The following PT or OT Services are considered **investigational** for all indications, including but not limited to:
- A. Dry needling;

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- B. Constraint-induced movement therapy (CIMT), as a sole measure of therapy.

RELATED POLICIES

Corporate Medical Policy

- 1.01.03 Augmentative and Alternative Communication Systems (e.g., Speech Generating Devices)
- 7.01.84 Gender Reassignment and Treatments for Commercial and Medicare Members
- 2.01.13 Computerized Motion Diagnostic Imaging (CMDI)/Gait Analysis
- 7.01.11 Cosmetic and Reconstructive Procedures, which includes iontophoresis
- 10.01.02 Chiropractic Care
- 11.01.03 Experimental or Investigational Services

POLICY GUIDELINE(S)

- I. OT, PT and ST services should be provided by the appropriate licensed therapist operating within their scope of practice. The therapist should address the functional needs of patients with physical impairments resulting from various causes, including disease, trauma, congenital anomalies, or prior therapeutic interventions. Treatment goals should be tailored to the patient's specific diagnosis, with an expectation of measurable improvement within a reasonable and predictable timeframe. The therapy provided should be specific, effective, and appropriate for the patient's diagnosis and physical condition.
- II. Documentation for therapy services must contain a written plan of care, which should include:
 - A. Diagnosis, including severity level of diagnosis;
 - B. Specific statements of long- and short-term functional-based goals;
 - C. Measurable objectives based on standardized outcome measures defined in evaluation and reassessed during follow-up sessions;
 - D. A reasonable estimate of when the goals will be reached;
 - E. The specific treatment techniques and/or activities to be used in treatment (skilled intervention);
 - F. The frequency and duration of treatment; and
 - G. Prior level of function (PLOF), prior treatment, and current level of function (CLOF).
- III. Classification of Impairments According to Severity
 - A. Mild Impairment:
 - 1. Less than one (1) standard deviation from normal,
 - 2. Appropriate for PT one (1) time per week.

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- B. Moderate Impairment:
 - 1. One (1)-to-two (2) standard deviations from normal,
 - 2. Appropriate for PT two (2) times per week.
- C. Severe Impairment:
 - 1. More than two standard deviations from normal,
 - 2. Appropriate for PT three (3) times per week.

Individualized Education Program (IEP)

- I. New York State Department of Health Early Intervention Program defines a developmental delay that has been measured by qualified personnel using clinical opinion, appropriate diagnostic procedures and/or instruments as documented as **ANY** of the following:
 - A. A 12-month delay in one functional area;
 - B. A 33% delay in one functional area or a 25% delay in each of two (2) areas;
 - C. If appropriate standardized instruments are individually administered in the evaluation process, a score of at least 2.0 standard deviations below the mean in one functional area or a score of at least 1.5 standard deviations below the mean in each of two functional areas.
- II. If outpatient therapies requested are in addition to the early intervention services, or school-based services noted in the IEP, or the provider does not feel that the child's needs are being met by the school-based services noted in the IEP, or when there is no IEP provided but it is documented that the child receives school-based services, or documentation must include rationale supporting the medical necessity of the additional outpatient services beyond what the child is already receiving at school as noted in the IEP.
- III. Coverage is not available for services provided by school districts, as stipulated in a child's (preschool, ages 3-5 years, and school, ages 5-21 years) IEP, as the services are generally considered free care or a government program.
 - A. When applicable, an IEP should be completed through the school district before a request for coverage is submitted to the Health Plan. If an IEP is not submitted, the request for speech therapy will be reviewed by the Health Plan for medical necessity in accordance with member's subscriber contract.
 - B. Speech therapy services denied by the school district, including summer services, and not covered in a child's IEP will be reviewed by the Health Plan for medical necessity in accordance with member's subscriber contract.
 - C. If a child is home-schooled, an assessment by the school district should be completed prior to submitting a request to the Health Plan for coverage. Requests for home-schooled children outside NYS will be decided in accordance with NYS laws; however, if an appeal is requested and another state's law is provided or cited, the case should be forwarded for legal review, to determine whether the other state's law should be applied.

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- D. Interim summer programs are provided by school districts for children whose handicapping conditions are severe enough to warrant a structured learning environment of 12 months' duration in order to maintain developmental levels. For preschool children, summer instruction must be available for those whose disabilities are severe enough to exhibit the need for a structured learning environment of 12 months duration to prevent substantial regression.

Speech Therapy Guidelines

- IV. A maintenance program may be established when the response to treatment has plateaued, or restorative potential is judged insignificant after a reasonable period of time. In these situations, coverage is limited to the initial evaluation and the design of an appropriate maintenance program.

Tools for Assessment of Malnutrition:

- The World Health Organization (WHO) provides tools to assess malnutrition
https://www.who.int/health-topics/malnutrition#tab=tab_1
- Based ideal weight for children on National Center for Health Statistics (NCHS) growth charts.
<https://www.cdc.gov/growthcharts/>
- The 2015 Academy of Nutrition and Dietetics/American Society for Parenteral and Enteral Nutrition consensus statement for indicators recommended for the identification and documentation of pediatric malnutrition (undernutrition) listed testing that should be used to assess malnutrition:
 - Food/Nutritional Intake;
 - Assessment of Energy and Protein Needs;
 - Growth Parameters;
 - Mid-Upper Arm Circumference;
 - Weight Gain Velocity;
 - Handgrip Strength; and
 - Documentation of Tanner Stages.

Standardized Tests for Evaluation of Speech Disorders (list is not all inclusive)

- V. A common standard score scale has a mean (average) of 100 and a standard deviation of 15.
- A. Goldman Fristoe Test of Articulation (GFTA)
 - B. Arizona Articulation Proficiency Scale (AAPS)
 - C. Preschool Language Scale (PLS)
 - D. Clinical Evaluation of Language Fundamentals (CELF)
 - E. Clinical Assessment of Articulation and Phonology (CAAP)

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- F. Stuttering Severity Index (SSI)
- G. Recessive Expressive Emergent Language (REEL)
- H. Test of Language Development (TOLD-P)

Feeding Difficulties in Children

VI. Feeding difficulties in children are dependent on the child's specific diagnosis. Typically, up to four (4) visits are allowed for feeding difficulties in neurotypical children. However, additional speech therapy visits may be medically appropriate for neuroatypical children or significant aerodigestive abnormalities with feeding difficulties (e.g., autism).

DESCRIPTION

Maintenance Program

Maintenance program is defined as a program that consists of activities that preserve the patient's present level of function and prevent regression of that function. Maintenance begins when the therapeutic goals of a treatment plan have been achieved or when no additional functional progress is apparent or expected to occur.

Work-Related or Workers' Compensation Programs

- Work-related or workers' compensation are for conditioning primarily for return to work and not treatment of a medical condition.
- When PT or OT services are needed to treat a medical or surgical condition in order for a patient to return to work, services are covered by the New York State Vocational and Educational Services for Individuals with Disabilities (VESID) Program.

Speech Therapy

Speech therapy services are those necessary for the diagnosis and treatment of speech and language impairments/disorders that result in communication disabilities, as well as for the diagnosis and treatment of swallowing disorders, or dysphagia.

Speech disorders refer to those affecting the articulation of speech sounds, the fluency with which speech is produced, or quality.

Speech Disorders

- Articulation disorders are also called phonological disorders and include:
 - Motor speech disorders resulting from damage to the central or peripheral nervous system (e.g., cerebral vascular accident, traumatic brain injury, or neurogenic disorders such as Parkinson's disease, Huntington disease, amyotrophic lateral sclerosis, and perinatal conditions); and
 - Functional articulation disorders, which have no known cause or result from causes other than known neurological insults or physical abnormalities. Functional articulation disorders account for the majority of articulation disorders in children.

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- Fluency disorders are also referred to as stuttering, involve the interruption in the flow of speaking manifested as an atypical rate, rhythm, repetitions in sounds, syllables, words, and phrases; or some combination of these.
- Voice disorders are characterized by abnormal pitch, loudness, resonance, quality, or duration of voice, or by an inability to use voice, or some combination of these, result from overuse or misuse of vocal cords, medical condition or psychological disorder impacting the ability to communicate effectively.
- Language disorders are disorders of impaired comprehension and/or use of spoken, written, and/or other symbol systems used for communication (e.g., aphasia secondary to cerebral vascular accident, dementia, hearing impairment).
- Pragmatics is the system of combining the form (phonology, morphology, and syntax) and content (semantics) of language into functional and socially appropriate communication. A person with a pragmatic language disorder/impairment may say inappropriate or unrelated things during a conversation, tell stories in a disorganized way, or have little variety in the use of language.

Other Common Speech Terms

- Aphasia is defined as the absence or impairment of the ability to communicate through speech, writing, or signs because of brain dysfunction.
- Aphonia is defined as a loss of speech sounds from the larynx.
- Apraxia is defined as the inability to form words or speak, despite the ability to use oral and facial muscles to make sounds.
- Dysarthria is defined as impairments or clumsiness in the uttering of words due to diseases that affect the oral, lingual, or pharyngeal muscles.
- Dysphonia is defined as any impairment of the voice or speaking ability.
- Neurosensory Hearing Loss is defined as a decreased ability to perceive sounds as compared to normal.

Voice Therapy

Vocal cord dysfunction (VCD), also known as paradoxical vocal fold movement- is a respiratory disorder characterized by paradoxical closure of the vocal cords during the respiratory cycle that leads to airway obstruction. Symptoms can range from wheezing to stridor. VCD can be mistaken for asthma and is distinguished from asthma by the performance of a pulmonary function test and laryngoscopy. VCD is often treated with speech therapy, relaxation techniques, or psychotherapy.

Lee Silverman Voice Therapy, LSVT LOUD has been proposed as an intensive behavioral voice therapy program for individuals with Parkinson disease and other neurological disorders and is aimed at improving the vocal loudness of these patients. The LSVT Companion System may be used as a technical adjunct to the program, to complement person-to-person voice therapy. The sound produced by a patient's voice is received by a calibrated microphone and converted to a visual display

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that consists of different visual and auditory feedback. The patient is given a target range of both vocal intensity (loudness) and fundamental frequency (pitch) and instructed to maintain a given loudness and or pitch for a given duration.

SPEAK OUT! is a program designed for individuals with Parkinson's disease to improve speech (speaking with intent) and swallowing. The exercises used target vocal function and speech clarity and moving it from an automatic function to an intentional task.

Dysphagia

Dysphagia is defined as difficulty swallowing. It is a frequently occurring impairment for children with disabilities because many disabling conditions are associated with oropharyngeal or esophageal dysfunction. The workup for dysphagia usually includes an evaluation by a speech therapist and may also include a video fluoroscopic barium study (often referred to as a cookie swallow) or a fiber-optic endoscopic evaluation of swallow. Speech and occupational therapists often collaborate in feeding therapy for children with poor oral motor and swallowing skills on the basis of the child's needs and the expertise of the providers involved.

Nutritional status deficiency refers to an imbalance in the intake of essential nutrients required by the body.

Physical Therapy

PT is the treatment of disease or injury by the use of therapeutic exercise and other interventions that focus on improving posture, locomotion, strength, endurance, balance, coordination, joint mobility, flexibility, and the ability to perform the functional activities of daily living, as well as the relief of pain. PT is a short-term therapy that is expected to result in significant, measurable improvements.

Baseline objective measurement(s) is/are essential to determine clinical effectiveness of all PT interventions. Clinical assessment of the patient's strength, prior to the initiation of PT, is essential to determining the therapeutic effectiveness of PT. Assessment data is obtained through a variety of standardized tests (e.g., measurement, functional performance, and manual or isokinetic muscle evaluation).

Hippotherapy (Equine-Assisted Therapy) is a treatment strategy that uses the movement of horses to engage sensory, neuromotor, and cognitive systems to achieve functional outcomes. It has been proposed as a therapy for individuals with impaired walking or balance.

Isokinetic exercise involves muscle use in an action that results in a movement without changing angular velocity. It involves the accommodation of resistance throughout the range of motion, to closely resemble normal action of muscle. Dynamometers are pieces of equipment that use hydraulics to maintain constant velocity and are controlled by a computer and associated software to measure joint flexion and extension via torque, typically of the knee, but can be adapted for other joints.

Dry needling refers to a procedure whereby a fine needle is inserted into the trigger point, to induce a twitch response and relieve pain. Research suggests that dry needling may improve pain control and reduce muscle tension in neck and/or shoulder pain, plantar heel pain, temporomandibular myofascial pain, and other conditions. Dry needling can be deep or superficial. Deep dry needling is

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believed to inactivate trigger points by eliciting contraction and subsequent relaxation of the muscle via a spinal cord reflex. Superficial needling is believed to activate mechanoreceptors and have an indirect effect on pain by inhibiting C-fiber pain impulses.

Sensory integration therapy (SIT) is a form of PT that has been investigated as a method of treatment for developmental disorders in patients with established sensory processing dysfunction, as in autism spectrum disorder (ASD). Sensory integration therapy is aimed at improving the way the brain processes and organizes sensations, as opposed to teaching higher-order skills. Therapy usually involves activities that provide vestibular, proprioceptive, and tactile stimuli, which are selected to match specific sensory processing deficits of the child. For example, swings are commonly used to incorporate vestibular input, while trapeze bars and large foam pillows or mats may be used to stimulate somatosensory pathways of proprioception and deep touch. Tactile reception may be addressed through a variety of activities and surface textures involving light touch.

Occupational Therapy (OT)

Occupational Therapy (OT) is a short-term form of rehabilitation therapy involving the treatment of individuals of all ages with functional deficits resulting from injury, disease, or birth. Occupational therapists assess all components of function (strength, range of motion, sensation, coordination, cognition, perception, vision, memory, judgment, safety, etc.) and work with the individual through the use of goal-directed, graded activity and exercise to improve skills.

Sensory Integration Therapy (SIT) is a form of OT that has been investigated as a method of treatment for autism, intellectually disabled, or learning disabilities. Sensory integration therapy is aimed at improving the way the brain processes and organizes sensations, as opposed to teaching higher-order skills.

Constraint-Induced Movement Therapy (CIMT) is proposed as a method of therapy to help patients with neurological disorders (e.g., cerebral palsy, congenital hemiplegia, stroke) regain the use of dysfunctional limb(s). CIMT involves restraint of the unaffected limb and intensively engaging the affected limb in repetitive exercises, which results in the new neural pathways being generated in the brain.

SUPPORTIVE LITERATURE

Speech Therapy

Sackley et al (2024) conducted a multicenter, three arm, unblinded, randomized controlled trial involving 388 people with Parkinson's and dysarthria to assess the clinical effectiveness of two speech and language therapy approaches versus no speech and language therapy. Participants were randomly assigned to one of three groups: Lee Silverman Voice Treatment (LSVT LOUD, n=130), NHS speech and language therapy (n=129), or no therapy (n=129). The primary outcome was self-reported Voice Handicap Index (VHI) at three months. Participants receiving LSVT LOUD reported lower VHI scores at three months than those who did not receive speech and language therapy (-8.0 points; 99% CI -13.3 to -2.6). NHS therapy showed no significant difference from no therapy (1.7 points; CI -3.8 to 7.1). Patients in the LSVT LOUD group also reported LVH index scores than did those randomized to NHS speech and language therapy (-9.6 points; CI -14.9 to -4.4). Adverse

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events, mainly vocal strain, were reported in 93 LSVT LOUD participants and 46 NHS therapy participants; none were serious. LSVT LOUD was more effective than both NHS therapy and no therapy in reducing voice-related disability. NHS therapy showed no clear benefit over no treatment.

Namasivayam et al (2021) conducted a two-arm randomized control trial studying the effectiveness of Prompts for Restructuring Oral Muscular Phonetic Targets (PROMPT) in children with severe speech motor delays (SMD). The study was comprised of 49 children with SMD. The intervention group received 45min of PROMPT intervention two times a week for 10 weeks or were waitlisted for the same duration and received only home training instructions. Outcome measures for speech motor control, articulation, speech intelligibility, and functional communication were assessed at baseline and at 10 weeks. PROMPT interventions were found to be clinically effective intervention for children with SMD.

Behrman et al (2020) conducted a prospective study on 40 individuals with idiopathic Parkinson's disease (PD) to assess the outcome of the SPEAK OUT! and the LOUD Crowd therapy programs. Of the 40 individuals, 12 received 40 minute sessions, 3 times per week of SPEAK OUT!, for 4 weeks. Assessments were conducted at baseline, within one week and 6 weeks after completion of the SPEAK OUT! sessions, while also participating in LOUD Crowd. 25 adults without communication disorders were assessed at the same schedule as the SPEAK-OUT! recipients. In the PD group reading and monologue intensity increased significantly. The mean values of intensity for the PD group were lower than those of the control group at baseline, but posttherapy values for the two groups were equivalent. Posttherapy, it was determined that there is evidence of effectiveness of this program on hypokinetic dysarthria secondary to PD.

Hippotherapy

The literature regarding hippotherapy consists of systematic reviews, randomized trials, and case series involving individuals with cerebral palsy, multiple sclerosis, stroke or gait and balance disorders. The randomized trials are generally small, can be described as having significant methodologic problems, and have not demonstrated that hippotherapy is superior to alternative therapies. Therefore, the evidence is insufficient to determine that it results in an improvement in the net health outcome.

Isokinetic Testing

Several isokinetic dynamometers have received FDA approval. Published literature suggests that due to the large variations in testing methods, isokinetic dynamometry has not been medically proven to improve net health outcomes or to be more effective than established methods of assessment of muscle strength. The effectiveness of isokinetic dynamometry has not been demonstrated outside the investigational setting.

Dry Needling

Dry needling has been investigated in randomized controlled trials (RCTs) and systematic reviews. Reviewers have summarized that studies have not associated dry needling with reductions in shoulder or neck pain compared to other modalities.

Young et al (2024) conducted a randomized, single blinded, multicenter, parallel group trial

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comparing the effects of adding thrust spinal manipulations and electrical dry needling to conventional physical therapy in patients with lumbar spinal stenosis (LSS). Over 34 months, 128 patients from 12 outpatient clinics in eight states were assessed using Numeric Pain Rating Scale (NPRS) and the Oswestry Disability Index (ODI) (primary outcomes) and the Roland Morris Disability Index (RMDI), Global Rating of Change (GROC), and medication intake (secondary outcome) at 2 and 6 weeks and 3 months. At 3 months, the MEDNCPT group experienced greater reductions in overall pain and related disability compared to the conventional physical therapy (CPT) group. At 3 months, significantly more patients in the MEDNCPT group reported a successful outcome ($GROC \geq +5$) than the CPT group. No significant differences were observed at earlier follow-ups. Limitations included the lack of sham-needling comparison group, the MEDNCPT group received additional treatments compared to the CPT group, the use of separate region-specific pain scores.

Sensory Integration Therapy (SIT)

There is insufficient evidence to permit conclusions regarding the effectiveness of SIT or whether SIT improves the net health outcome in children with autism and developmental impairments. Only one study was published for SIT in autistic children, and three studies were published for SIT in developmentally delayed children; the validity of all four studies is questionable. The evidence indicates that SIT does not improve the net health outcome in learning-disabled children when compared to alternative treatments or no treatment at all.

Occupational Therapy

García-Pérez et al (2024) conducted a prospective, randomized controlled clinical trial in 60 adults who have suffered a stroke and were discharged home and what the effectiveness of an early OT intervention programs (EOTIPS). Participants were assigned to the experimental group ($n=30$) were included in EOTIPS and were compared to a control group ($n=30$). Evaluations assessed quality of life (Stroke and Aphasia Quality of Life Scale [SAQOL-39]), functional independence (Modified Rankin Scale [mRS]), perceptual-cognitive skills (Montreal Cognitive Assessment [MoCA]), upper limb function (Fugl Meyer Assessment [FMA]), mobility (Berg Balance Scale [BBS] and Timed Up & Go [TUG]), communication skills (Communicative Activity Log [CAL]) and mood disorders (Beck Depression Inventory–II [BDI-II]); completed within two weeks post-stroke and at three month follow-up. Intent-to-treat analysis, considering all participants (dropouts as failures), and efficacy analysis, considering only end-of-treatment participants. Participants in the intervention group showed a significant better evolution in the main outcome measure of quality of life (SAQOL-39 $p = .029$), as well as for independence ($mRSp = .004$), perceptual-cognitive skills (MoCA $p = .012$) and symptoms of depression (BDI-II $p = .011$) compared to the control group. The study supports EOTIPS as effective in improving post-stroke recovery. Limitations included lack of therapist blinding, inclusion of only mild-to-moderate stroke cases, variability in rehab sessions, and inconsistent caregiver support.

Sensory Integration Therapy (SIT)

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intellectually disabled children; the validity of all four studies is questionable. The evidence indicates that SIT does not improve the net health outcome in learning-disabled children when compared to alternative treatments or no treatment at all.

Randall et al (2024) conducted a two-arm RCT to assess the clinical and cost-effectiveness of manualized Sensory Integration Therapy (SIT) for autistic children with sensory processing difficulties. They recruited 138 children and carers (92% of those screened), with retention rates of 77.5% at 6 months and 69.9% at 12 months. Intervention fidelity was high, with 78.3% receiving a sufficient dose, though session attendance varied. Descriptive statistics covered recruitment, demographics, adherence, and adverse effects—none were reported. Qualitative interviews with carers and therapists found the intervention generally acceptable, despite logistical barriers like scheduling, travel, and COVID-19. The process evaluation highlighted contextual factors affecting effectiveness and emphasized the importance of caregiver involvement and individualized outcomes in future research.

Constraint-Induced Movement Therapy (CIMT)

There is insufficient evidence to permit conclusions regarding the effectiveness of CIMT for any indication. The majority of studies address the utilization of CIMT in either cerebral palsy, congenital hemiplegia, or stroke rehabilitation. Several studies, systematic reviews and meta-analyses have recently been published. They conclude that further rigorous, well-designed, randomized, controlled studies addressing CIMT are needed, to determine the efficacy of its use.

Reddy et al (2022) conducted a systematic review and meta-analysis aiming to delineate the effect of various lower extremity CIMT (LECIMT) protocols on gait speed, balance, and cardiovascular outcomes. For this study, clinical trials involving stroke populations in different stages of recovery, greater than 18 years old, and treated with LECIMT were considered, only ten studies were included. CIMT, when compared to controlled interventions, showed superior or similar effects. The effect of LECIMT on gait speed and balance were non-significant, with mean differences (SMDs) of 0.13 and 4.94 and at 95% confidence intervals (Cis) of (-0.18–0.44) and (-2.48–12.37), respectively. In this meta-analysis, the authors observed that despite the fact that several trials claimed the efficacy of LECIMT in improving lower-extremity functions, gait speed and balance did not demonstrate a significant effect size favoring LECIMT. Therefore, CIMT treatment protocols should consider the patient's functional requirements, cardinal principles of CIMT, and cardiorespiratory parameters.

PROFESSIONAL GUIDELINE(S)

In the American Speech-Language-Hearing Association (ASHA) 2015 Speech-Language Pathology Medical Review Guidelines they state that "eligibility for services or evaluation is indicated if one or more of the following factors are present:

- "When a referral is made from a teacher, family member, or a professional in hearing, speech and language.
- Failure to pass a screening assessment for function of communication and/or swallowing.
- Individual is unable to communicate functionally or optimally across environments.

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- Individual is unable to swallow to maintain adequate nutrition or hydration.
- Evaluation by ASHA-certified speech-language pathologist shows the presence of a speech or swallowing disorder.
- Individual's communications skills are not comparable to others of the same age, gender, ethnicity, or cultural and linguistic background.
- Communication skills are negatively affecting health, safety, social, emotional, educational or vocational status.
- Swallowing skills negatively affect his or her nutritional health or safety.
- Family or guardian want to achieve and/or maintain optimal communication and/or swallowing skills.
- Individual or family is looking for services to enhance communications skills."

The 2016 Guidelines for Adults Stroke Rehabilitation and Recovery by the American Heart Association (AHA) and American Stroke Association (ASA) (Winstein et al 2016), which were accepted by the ASHA state:

- "Speech and language therapy is recommended for individuals with aphasia. (class I, level of evidence A)
- Computerized treatment may be considered to supplement treatment provided by a speech language pathologist." (class IIb, level of evidence A)

In June 2012, the American Academy of Pediatrics (AAP) issued a policy statement indicating that treatment "with the use of sensory-based therapies may be acceptable as one of the components of a comprehensive treatment plan. However, parents should be informed that the amount of research regarding the effectiveness of sensory integration therapy is limited and inconclusive."

Becker et al (2015) presented The Academy of Nutrition and Dietetics/American Society for Parenteral and Enteral Nutrition consensus statement for indicators recommended for the identification and documentation of pediatric malnutrition (undernutrition). The recommendations are as follows:

- "Food/Nutritional Intake- Completed by history and/or direct observation for food and/or nutrients consumed.
- Assessment of Energy and Protein Needs- measured by indirect calorimetry (most precise) or estimated through the use of standard equations.
- Growth Parameters-Growth should be monitored at regular intervals and are typically expressed and reported in comparison with population data (normally in percentiles). Standard deviation comparisons are recommended for tracking and assessing nutritional status:
 - In children less than 36 months of age- measures of growth include length-for-age, weight-for-age, head circumference-for-age, and weight-for-length.

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- In children ages 2–20 years, standing height-for-age, weight-for-age, and body mass index (BMI)-for-age.
- Weight Gain Velocity- defined as the rate of change in weight or length/height over time.
- Mid-Upper Arm Circumference- has been correlated to BMI in children and adults. It is important measurement in individuals whose weight may be affected by fluid retention (edema, ascites or steroids).
- Handgrip Strength- using a handheld dynamometer, it measures the maximum strength of the hand and the forearm muscles.
- Documentation of Tanner Stages-Because of the variability in genetic determinants for the onset of puberty, using the Tanner staging is limited (Becker 2015)."

REGULATORY STATUS

As of January 1, 2014, the Patient Protection and Affordable Care Act (PPACA) required all health insurers to provide coverage for essential health benefits, including habilitative services. Under PPACA, habilitative services are health care services that help a person keep, learn or improve skills and functioning for daily living and include the management of limitations and disabilities, including services or programs that help maintain or prevent deterioration in physical, cognitive, or behavioral function.

Under federal law, all health insurers must provide essential health benefits in the individual and small group markets, including habilitative services. The law defines habilitative services as health care services that help a person keep, learn or improve skills and functioning for daily living and include the management of limitations and disabilities, including services or programs that help maintain or prevent deterioration in physical, cognitive, or behavioral function.

Certain contracts only cover short-term therapy services for a limited number of visits per condition, per lifetime, or per contract year. These limits generally apply to all therapies combined (PT, OT and ST). The visit limits do not apply when PT, OT or ST are for the treatment of a Mental Disorder (including autism spectrum disorder). Mental Disorder is defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders.

New York State Laws

Under New York State law, all insured contracts providing physician services, or providing medical, major medical, or similar comprehensive-type coverage, must provide coverage for the screening, diagnosis, and treatment of autism spectrum disorders when prescribed or ordered by a licensed physician or a licensed psychologist for medically necessary services. Treatment includes services provided by a licensed or certified speech therapist, occupational therapist, physical therapist, and social worker, when the policy generally provides such coverage. Therapeutic treatment must include care that is deemed habilitative or non-restorative.

New York State law restricts the practice of PT to licensed physical therapists or certified physical therapist assistants. Individuals who are not licensed or certified may not provide PT services. Athletic trainers are not licensed or otherwise authorized in New York State to practice PT.

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The New York State Vocational and Educational Services for Individuals with Disabilities (VESID) Program covers PT or OT services that are needed to treat a medical or surgical condition for a patient to return to work.

CODE(S)

- Codes may not be covered under all circumstances.
- Code list may not be all inclusive (AMA and CMS code updates may occur more frequently than policy updates).
- (E/I)=Experimental/Investigational
- (NMN)=Not medically necessary/appropriate

CPT Codes

Code	Description
20560 (E/I)	Needle insertion(s) without injection(s); 1 or 2 muscle(s)
20561 (E/I)	Needle insertion(s) without injection(s); 3 or more muscle(s)
92507	Treatment of speech, language, voice, communication, and/ or auditory processing disorder; individual
92508	Treatment of speech, language, voice, communication, and/ or auditory processing disorder; group, Two (2) or more individuals
92521	Evaluation of speech fluency (e.g., stuttering, cluttering)
92522	Evaluation of speech sound production (e.g., articulation, phonological process, apraxia, dysarthria)
92523	Evaluation of speech sound production (e.g., articulation, phonological process, apraxia, dysarthria); with evaluation of language comprehension and expression (e.g., receptive and expressive language)
92524	Behavioral and qualitative analysis of voice and resonance
92526	Treatment of swallowing dysfunction and/or oral function for feeding
92610	Evaluation of oral and pharyngeal swallowing function

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Code	Description
96105	Assessment of aphasia (includes assessment of expressive and receptive speech and language function, language comprehension, speech production ability, reading, spelling, writing, e.g., by Boston Diagnostic Aphasia Examination) with interpretation and report, per hour
97010	Application of a modality to 1 or more areas; hot or cold packs
97012	traction, mechanical
97014	electrical stimulation (unattended)
97016	vasopneumatic devices (NMN when used without skilled monitoring)
97018	paraffin bath
97022	whirlpool
97024	diathermy (e.g., microwave)
97026	infrared
97028	ultraviolet
97032	electrical stimulation (manual), each 15 minutes
97033	iontophoresis, each 15 minutes
97034	contrast baths, each 15 minutes
97035	ultrasound, each 15 minutes
97036	Hubbard tank, each 15 minutes
97110	Therapeutic procedure, 1 or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility
97112	neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing activities
97113	aquatic therapy with therapeutic exercises
97116	gait training (includes stair climbing)

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Code	Description
97140	Manual therapy techniques (e.g., mobilization/ manipulation, manual lymphatic drainage, manual traction), 1 or more regions, each 15 minutes
97150	Therapeutic procedure(s), group (2 or more individuals)
97161	Physical therapy evaluation: low complexity
97162	Physical therapy evaluation: moderate complexity
97163	Physical therapy evaluation: high complexity
97164	Re-evaluation of physical therapy established plan of care
97168	Re-evaluation of occupational therapy established plan of care, requiring these components: An assessment of changes in patient functional or medical status with revised plan of care; An update to the initial occupational profile to reflect changes in condition or environment that affect future interventions and/or goals; and A revised plan of care. A formal reevaluation is performed when there is a documented change in functional status or a significant change to the plan of care is required. Typically, 30 minutes are spent face-to-face with the patient and/or family.
97530	Therapeutic activities, direct (one-on-one) patient contact (use of dynamic activities to improve functional performance), each 15 minutes
97533 (NMN)	Sensory integrative techniques to enhance sensory processing and promote adaptive responses to environmental demands, direct (one-on-one) patient contact, each 15 minutes
97535	Self-care/home management training (e.g., activities of daily living (ADL) and compensatory training, meal preparation, safety procedures and instructions in use of assistive technology devices/adaptive equipment) direct one-on-one contact, each 15 minutes
97537 (NMN)	Community/work reintegration training (e.g., shopping, transportation, money management, avocational activities and/or work environment/modification analysis, work task analysis), direct one-on-one contact, each 15 minutes
97542	Wheelchair management (e.g., assessment, fitting, training), each 15 minutes
97545 (NMN)	Work hardening/conditioning; initial two hours

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Code	Description
97546 (NMN)	each additional hour
97750	Physical performance test or measurement (e.g., musculoskeletal, functional capacity), with written report, each 15 minutes Note: Considered NMN when used for isokinetic testing or vibromyography.
97760	Orthotic(s) management and training (including assessment and fitting when not otherwise reported), upper extremity (ies), lower extremity(ies) and/or trunk, initial orthotic(s) encounter, each 15 minutes
97761	Prosthetic(s) training, upper and/or lower extremity(ies), initial prosthetic(s) encounter, each 15 minutes
97763	Orthotic(s)/prosthetic(s) management and/or training, upper extremity (ies), and/or trunk, subsequent orthotic(s)/prosthetic(s) encounter, each 15 minutes

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Modifier Code

Code	Description
96	Habilitative Services
97	Rehabilitative Services

HCPCS Codes

Code	Description
S9128	Speech therapy; in the home, per diem (This policy does not address home care services, please refer to InterQual for review.)
S9152	Speech therapy, re-evaluation
G0129	Occupational therapy requiring the skills of a qualified occupational therapist, furnished as a component of a partial hospitalization treatment program, per session (45 minutes or more)

ICD10 Codes

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Code	Description
Multiple Codes	

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SEARCH TERMS

Not Applicable

CENTERS FOR MEDICARE AND MEDICAID SERVICES (CMS)

Speech Therapy

[Speech-Language Pathology Services for the Treatment of Dysphagia \(NCD 170.3\)](#) [accessed 2025 Feb 02]

[Speech-Language Pathology \(LCD L33580\)](#) [accessed 2025 Feb 02]

[Billing and Coding: Speech-Language Pathology \(LCA A52866\)](#) [accessed 2025 Feb 02]

Physical and Occupational Therapy

[Outpatient Physical and Occupational Therapy Services \(LCD L33631\)](#) [accessed 2025 Jun 25]

[Outpatient Physical and Occupational Therapy Services \(LCA Billing and Coding A56566\)](#) [accessed 2025 Jun 25]

[Acupuncture for Chronic Lower Back Pain \(cLBP\) \(NCD 30.3.3\)](#) [accessed 2025 Jun 25]

[Pain Management - Injection of tendon sheaths, ligaments, ganglion cysts, carpal and tarsal tunnels \(LCD L33622\)](#) [accessed 2025 Jun 25]

[Peripheral Nerve Blocks \(LCD L36850\)](#) (Applicable to dry needling) [accessed 2025 Jun 25]
2025 Jun 25]

PRODUCT DISCLAIMER

- Services are contract dependent; if a product does not cover a service, medical policy criteria do not apply.
- If a commercial product (including an Essential Plan or Child Health Plus product) covers a specific service, medical policy criteria apply to the benefit.
- If a Medicaid product covers a specific service, and there are no New York State Medicaid guidelines (eMedNY) criteria, medical policy criteria apply to the benefit.
- If a Medicare product (including Medicare HMO-Dual Special Needs Program (DSNP) product)

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covers a specific service, and there is no national or local Medicare coverage decision for the service, medical policy criteria apply to the benefit.

- If a Medicare HMO-Dual Special Needs Program (DSNP) product DOES NOT cover a specific service, please refer to the Medicaid Product coverage line.

POLICY HISTORY/REVISION	
Committee Approval Dates	
11/20/25	
Date	Summary of Changes
11/20/25	<ul style="list-style-type: none">• New Policy created from the content merger of CMPs #8.01.13, #8.01.12 and #8.01.17
11/20/25	<ul style="list-style-type: none">• Original effective date