

Clinical Policy: Physical, Occupational, and Speech Therapy Services

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[Coding Implications](#)

[Revision Log](#)

See [Important Reminder](#) at the end of this policy for important regulatory and legal information.

Description

To provide guidelines for the authorization of outpatient or home care speech therapy, occupational therapy, and/or physical therapy treatment services.

For the purpose of medical necessity review of therapy documentation, it is expected that each request will include all required elements as set forth in this policy, document the safety of the treatment to be delivered, and meet best practice standards of the therapy national associations (AOTA, APTA and ASHA), and State of Texas licensure laws.

This policy applies to the following products: STAR, STAR+PLUS, STAR Health, STAR Kids MMP and CHIP.

I. Policy Criteria

It is the policy of Superior HealthPlan that speech therapy, occupational therapy, and physical therapy **evaluation and treatment** services are considered **medically necessary** when all the following criteria are met:

- A. The member must be clinically stable and exhibit signs and symptoms of physical deterioration or impairment in one or more of the following areas:
 1. Sensory/motor ability
 2. Functional status as evidenced by an inability to perform basic activities of daily living (ADLs)
 3. Cognitive/psychological ability
 4. Cardiopulmonary status
 5. Speech/language/swallowing ability
 6. Integumentary deficits
- B. Member and caregiver must be committed to program participation.
- C. The treatment is ordered by the member's PCP (MD, DO, PA or NP) or appropriate specialist and formal evaluation is conducted by a licensed speech, occupational, or physical therapist.
- D. There is an expectation that within a reasonable and medically predictable period of time the treatment will produce clinically significant and measurable improvement in the member's level of functioning, and prevent or delay further decline.
- E. The treatment program must be individualized and measured by member's progress in achieving anticipated goals or maintenance outcomes.
- F. The treatment requires the judgment, knowledge, and skills of a licensed speech, occupational, or physical therapist or therapy assistant (SLPA, COTA or PTA).
- G. In determining whether a service requires the skill of a licensed physical, occupational, or speech therapist, consideration must be given to the inherent complexity of the service,

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the condition of the member, and the accepted standards of medical and therapy practice guidelines.

- H. Services provided must be within the provider's scope of practice, as defined by state licensure law and regulatory compliance. Physical therapy may be provided by a physician or physical therapist within their licensed scope of practice.
- I. The treatment cannot be reasonably learned and implemented by non-professional or lay caregivers.
- J. The ordered treatment meets accepted standards of discipline-specific clinical practice and is targeted and effective in the treatment of the member's diagnosed impairment or condition.
- K. The treatment does not duplicate services provided by other types of therapy or services provided in multiple settings.
- L. If treatment is part of a medically necessary program to maintain function or prevent significant functional regression, the following criteria must be met:
 - 1. Must be a skilled service that could not reasonably be carried out by a lay person. The absence of a competent person to perform the service does not cause it to become a skilled service **and**,
 - 2. Must include clearly stated maintenance goals directed at a skilled service.
- M. Therapy services must be performed by one of the following: a licensed physical therapist, licensed occupational therapist, licensed speech-language pathologist, a physician within their scope of practice, or one of the following under the supervision of a licensed therapist of the specific discipline:
 - 1. Licensed therapy assistant
 - 2. Licensed speech-language pathology intern (Clinical Fellow)

II. Not Medically Necessary:

It is the policy of Superior HealthPlan that speech therapy, occupational therapy, and/or physical therapy evaluation and treatment services are considered not medically necessary when:

- A. A service that is not skilled is requested.

Note: A service is considered not skilled if the service can safely and effectively be performed by the average non-medical person without the direct supervision of a licensed therapist.
- B. The member's function would not be expected to improve as the member gradually resumes normal activities.

III. Frequency and Duration of Therapy Services

Frequency must always be commensurate with the member's medical and skilled therapy needs, level of disability, and standards of practice; it is not for the convenience of the member or the responsible adult.

Therapy requests above these limits will be reviewed by a SHP medical director on a case-by-case basis.

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Note: Frequency and duration requests should be individualized for the member with consideration of the member's condition and potential to benefit from the formulated treatment plan.

A. High Frequency – duration up to 4 weeks

High frequency (3 times per week) can only be considered for a limited duration (approximately 4 weeks or less) or as otherwise requested by the prescribing provider with documentation of medical need to achieve an identified new skill or recover function lost due to surgery, illness, trauma, acute medical condition, or acute exacerbation of a medical condition, with well-defined specific, achievable goals within the intensive period requested.

1. Therapy provided three times a week may be considered for two or more of these exceptional situations:
 - a. The member has a medical condition that is rapidly changing.
 - b. The member has a potential for rapid progress (e.g., excellent prognosis for skill acquisition) or rapid decline or loss of functional skill (e.g., serious illness, recent surgery).
 - c. The member's therapy plan and home program require frequent modification by the licensed therapist.
2. On a case-by-case basis, a high frequency requested for a short-term period (4 weeks or less) which does not meet the above criteria may be considered with all of the following documentation:
 - a. Letter of medical need from the prescribing provider documenting the member's rehabilitation potential for achieving the goals identified; and
 - b. Therapy summary documenting all of the following:
 - i. Purpose of the high frequency requested (e.g., close to achieving a milestone)
 - ii. Identification of the functional skill which will be achieved with high frequency therapy
 - iii. Specific measurable goals related to the high frequency requested and the expected date the goals will be achieved
3. A higher frequency (4 or more times per week) may be considered on a case-by-case basis with clinical documentation supporting why three times a week will not meet the member's medical needs.

B. Moderate Frequency – duration of up to 12 weeks for acute conditions or duration up to 24 weeks, not to exceed 180 days, for chronic conditions

Therapy provided two times a week may be considered when documentation shows one or more of the following:

1. The member is making meaningful functional progress toward treatment goals.
2. The member is in a critical period to gain new skills or restore function and is at risk of regression.
3. The licensed therapist needs to adjust the member's therapy plan and home program weekly or more often than weekly based on the member's progress and medical needs.

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4. The member has complex needs requiring ongoing education of the responsible adult.

C. Low Frequency – duration of up to 12 weeks for acute conditions or duration up to 24 weeks, not to exceed 180 days, for chronic conditions

Therapy provided one time per week or every other week may be considered when the documentation shows one or more of the following:

1. The member is making meaningful functional progress toward treatment goals, but the member is nearing discharge where tapering of treatment would be appropriate.
2. Documentation shows the member is at risk of deterioration without therapeutic intervention due to the member's developmental or medical condition.
3. The licensed therapist is required to adjust the member's therapy plan and home program weekly to every other week based on the member's progress.
4. Every other week therapy is supported for members whose medical condition is stable, they are making progress, and it is anticipated the member will not regress with every other week therapy.

Note: As the member's medical need for therapy decreases, it is expected that the therapy frequency will decrease as well.

D. Maintenance Level/Prevent Deterioration - duration up to 3 months

For members who are 20 years of age and younger or STAR+ Waiver members, this frequency level (e.g., every other week, monthly, every 3 months) is used when the therapy plan changes very slowly, the home program is at a level that may be managed by the member or the responsible adult, or the therapy plan requires infrequent updates by the skilled therapist. A maintenance level or preventive level of therapy services may be considered when a member requires skilled therapy for ongoing periodic assessments and consultations and the member meets one of the following criteria:

1. Progress has slowed or stopped, but documentation supports that ongoing skilled therapy is required to maintain the progress made or prevent deterioration.
2. Documentation shows the member and the responsible adult have a continuing need for education, a periodic adjustment of the home program, or regular modification of equipment to meet the member's needs.

Note: The reference to "maintenance" in the above statement is applicable to members who are 20 years of age and younger or for STAR+ waiver members.

IV. Criteria For Discontinuation of Therapy Services

May include, but are not limited to, one or more of the following:

- A. Member no longer demonstrates functional impairment or has achieved goals set forth in the plan of care.
- B. Testing shows member no longer has a developmental delay.
- C. Member has returned to baseline function.
- D. Member can continue therapy with a home treatment program and deficits no longer require a skilled therapy intervention to maintain status.
- E. Member has adapted to impairment with use of compensatory strategies or assistive equipment/devices.

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- F. Member is able to perform ADLs with minimal to no assistance from caregiver.
- G. Member has achieved maximum functional benefit from therapy or is no longer expected to benefit from additional therapy based upon lack of or minimal progress towards treatment goals.
- H. Member is unable to participate in the treatment plan due to medical, psychological, or social complications and responsible adult has had instruction on the home treatment program and the skills of a therapist are not needed to provide or supervise the service.
- I. Non-compliance due to poor attendance with member or responsible adult, and/or non-compliance with therapy and home treatment program.
- J. If therapy no longer appears to be clinically appropriate or beneficial to the member for any reason, including those identified above, a recommendation for discontinuation (denial) should be referred to the medical director for final review and determination.
- K. A full review of the member's complete documented therapy history may be performed. If the therapy documentation does not support appropriate or functionally beneficial skilled services, a denial recommendation may be made to the medical director.
- L. During the denial period, consideration of new requests for the same condition by the same servicing provider would be required to follow the appeals process documented on the Letter of Adverse Determination. If the member has a new illness, injury or true exacerbation of their medical condition, a new request may be considered when objective documentation of the change in medical status is submitted.

V. Exclusions (Non-Covered Services)

Not all treatment modalities are covered benefits. Coverage of specific modalities depends upon their proven efficacy, safety, and medical appropriateness as established by accepted and discipline-specific practice standards.

The following services are not a benefit of Texas Medicaid under this policy:

- A. Therapy services that are provided after the member has reached the maximum level of improvement or is now functioning within normal limits.
- B. Repetitive therapy services that are designed to maintain function once the maximum level of improvement has been reached, which no longer require the skills of a therapist to provide or oversee.
- C. Therapy services related to activities for the general good and welfare of members are not considered medically necessary because they do not require the skills of a therapist, such as:
 - 1. General exercises to promote overall fitness and flexibility,
 - 2. Activities to provide diversion or general motivation,
 - 3. Supervised exercise for weight loss,
 - 4. Instruction of English as a second language,
 - 5. Treatment of behavioral issues as a replacement for behavioral therapy.
- D. Hippotherapy, equine therapy, and therapeutic riding are not covered benefits and may not be billed in conjunction with speech, occupational, or physical therapy services.
- E. Massage therapy that is the sole therapy and is not part of a comprehensive therapeutic treatment plan to address an acute condition.

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- F. Separate reimbursement for VitalStim® therapy for dysphagia is not medically necessary. VitalStim® must be a component of a comprehensive feeding treatment plan to be considered a benefit.
- G. Treatment solely for the instruction of other agency or professional personnel in the member's PT, OT, or ST program.
- H. Emotional support, adjustment to extended hospitalization or disability, and behavioral readjustment.
- I. Therapy not expected to result in practical functional improvements in the member's level of functioning.
- J. Treatments that do not require the skills of a licensed therapist to perform in the absence of complicating factors (i.e., massage, general range of motion exercises, repetitive gait, activities and exercises that can be practiced by the member on their own or with a responsible adult's assistance).
- K. Therapy requested for general conditioning or fitness, or for educational, recreational or work-related activities that do not require the skills of a therapist
- L. Therapy equipment and supplies used during therapy visits are not reimbursed separately; these would be considered part of the therapy services provided.
- M. Therapy prescribed primarily as an adjunct to psychotherapy.
- N. Treatments not supported by medically peer reviewed literature, including, but not limited to, investigational treatments such as sensory integration, vestibular rehabilitation for the treatment of attention deficit hyperactivity disorder, anodyne therapy, craniosacral therapy, interactive metronome therapy, cranial electro stimulation, low-energy neuro-feedback, and the Wilbarger brushing protocol.
- O. Therapy services provided by a licensed therapist who is the member's responsible adult (e.g., biological, adoptive, foster parent, guardian, court-appointed managing conservator, or other family members by birth or marriage).
- P. Auxiliary personnel (aide, orderly, student, or technician) may participate in physical therapy, occupational therapy, or speech therapy sessions when they are appropriately supervised according to each therapy discipline's scope of practice and provider licensure requirements. Providers may not bill Texas Medicaid for therapy services provided solely by auxiliary personnel.

VI. Children's Therapy Services: Members birth through 20 years of age

A. Acute PT, OT, and ST Services

Acute PT, OT, and ST services are benefits of Texas Medicaid for the medically necessary short term treatment of an acute medical condition or an acute exacerbation of a chronic medical condition.

Treatments are expected to significantly improve, restore, or develop physical functions diminished or lost as a result of a recent trauma, illness, injury, disease, surgery, or change in medical condition, in a reasonable and generally predictable period of time, based on the prescribing provider's and therapist's assessment of the members' restorative potential.

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Note: Recent is defined as occurring within the past 90 days of the prescribing provider's evaluation of condition.

Treatments are directed towards restoration of, or compensation for, lost function.

Acute is defined as an illness or trauma with a rapid onset and short duration.

A medical condition is considered chronic when 120 days have passed from the start of therapy, or the condition is no longer expected to resolve or may be slowly progressive over an indefinite period of time.

With documentation of medical need, physical, occupational, and speech therapy may continue for a maximum of 120 days for an acute medical condition or an acute exacerbation of a chronic medical condition.

Once the member's condition is no longer considered acute, continued therapy for a chronic condition will only be considered for members who are 20 years of age or younger.

B. Chronic Services

Chronic physical, occupational, and speech therapy services are benefits of Texas Medicaid for the medically necessary treatment of chronic medical conditions and developmental delay when a medical need is established for the developmental delay. All eligible members who are birth through 20 years of age may continue to receive all medically necessary therapy services, with documentation proving medical necessity. The goals of the services provided are directed at maintaining, improving, adapting, or restoring functions which have been lost or impaired due to a recent illness, injury, loss of body part, congenital abnormality, degenerative disease, or developmental delay.

Treatment for chronic medical conditions and developmental delay will only be considered for members who are birth through 20 years of age.

C. Developmental Delay Criteria Using Standardized Testing

1. Standardized Tests must be age-appropriate for the member. Providers should use the same testing instrument utilized in the initial evaluation when deemed appropriate. If reuse of the initial testing instrument is not appropriate (i.e. due to change in member status, restricted age range of the testing instrument, or the instrument is no longer a valid means of testing), the provider must explain the reason for selecting a different method of assessment.
2. If standardized testing is not appropriate for a member, a description of the member's current functional deficits and their severity level may be documented using objective data. Documentation may include current age equivalents, and percentage of functional delay, criterion-referenced scores or other objective information as appropriate for the member's condition or impairment.
3. When a standardized test is documented, standardized scores greater than or equal to one-and-a-half standard deviations (SD) below the mean (except where state requirements are more stringent) may indicate medical necessity when considered in conjunction with the overall treatment plan and stated functional goals.

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4. One and a half SD below the mean for a standardized test wherein the mean is 100 would equal a standard score of 78.

D. Adjusting Score for Children with a History of Prematurity

From birth to age 2 ½ years, impairments in development must be determined based on the member's corrected age as calculated using the member's gestational age at birth and not on the member's actual age at the time of the testing. Full term is considered 40 weeks. Correct age in weeks is calculated by subtracting the number of weeks the member was premature from the number of weeks of the member's actual age. For example: if a member was born at 28 weeks gestation, the member is 12 weeks (3 months) premature. If the member is now 48 weeks old (12 months old), his corrected age is 48 weeks minus 12 weeks or 36 weeks (9 months old). This member's development may be expected to be on par with a 9 month old rather than a 12 month old.

E. Additional treatment plan documentation for speech therapy requests

The member's language knowledge and exposure must be established through a thorough case history and relevant caregiver interview.

1. The documentation must include all of the following that apply:
 - a. Home language(s)
 - b. School, daycare and community language(s) of instruction or exposure
2. If child is exposed to more than one language, an appropriate assessment of speech and language abilities should be performed.
3. If no standardized tool is available, then results should be reported using appropriate objective assessment methods. Examples may include criterion-referenced tests, probes, language samples, dynamic assessment, or MLU, etc. in order to differentiate a language disorder from a language difference as well as the severity of that disorder, should it be identified.
4. If a standardized bilingual language test is utilized as part of the objective assessment, documentation of its type of administration must be stated for either dual language administration or monolingual administration use only.

VII. Adult Services: Benefits and Limitations

Physical therapy (PT), occupational therapy (OT), and speech therapy (ST) services are benefits of Texas Medicaid for the medically necessary short term treatment of an acute medical condition or an acute exacerbation of a chronic medical condition for members who are 21 years of age and older.

Treatments are expected to significantly improve, restore, or develop physical functions diminished or lost as a result of a recent trauma, illness, injury, disease, surgery, or change in medical condition, in a reasonable and generally predictable period of time based on the prescribing provider's and therapist's assessment of the member's restorative potential.

Note: Recent is defined as occurring within the past 90 days of the prescribing provider's evaluation of condition.

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Treatments are directed towards restoration of, or compensation for, lost function.

Acute is defined as an illness or trauma with a rapid onset and short duration.

Adult therapy services are limited to a maximum of 120 days per identified acute medical condition or acute exacerbation of a chronic medical condition requiring therapy or whenever the maximum benefit from therapy has been achieved, whichever comes first.

A medical condition is considered chronic when 120 days have passed from the start of therapy, or the condition is no longer expected to resolve or may be slowly progressive over an indefinite period of time.

Physical and occupational therapy services for acute conditions are benefits of Texas Medicaid for adult members in the office, outpatient, and home settings.

Speech therapy services for acute conditions are benefits of Texas Medicaid for adult members in the office and outpatient setting only.

VIII. STAR+PLUS Waiver Members/Home and Community Based Services (HCBS) Program

Therapy services provided through the STAR+PLUS Home and Community Based Services (HCBS) program are long term services (waiver benefit) and do not replace a member's acute care benefit. Therapy services include the evaluation, examination and treatment of physical, functional and speech disorders and limitations. Therapy services include the full range of activities under the direction of a licensed therapist within the scope of her or his state licensure. Therapy services are provided directly by licensed therapists or by assistants under the supervision of licensed therapists in the member's home, or the member may receive the therapy in an outpatient center or clinic.

Occupational therapy (OT), physical therapy (PT), and speech therapy (ST) are covered by the STAR+PLUS HCBS program (waiver benefit) only after the member has exhausted her or his therapy benefit under Medicare, Medicaid or other third-party resources (TPRs).

IX. STAR+PLUS Nursing Facility (NF) Add-On Services

Acute OT, PT and ST are covered benefits of the nursing facility add-on services. These services may not be covered under the nursing facility daily unit rate. Medicaid nursing facility members may not be eligible for Medicare or other insurance. These services will not be processed for members that are dual eligible (have both Medicare and Medicaid) unless member is enrolled in SHP's STAR+PLUS MMP Plan.

- A. Coverage for physical therapy, occupational therapy, or speech therapy services includes evaluation and treatment of functions that have been impaired by acute illness or exacerbation of a chronic illness or condition only.
- B. Rehabilitative services may be provided when there is an expectation that the member's functioning will improve measurably within 30 days.

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- C. The provider must ensure that rehabilitative services are provided under a written treatment plan based on the physician's diagnosis and orders and services are documented in the member's clinical record.
- D. Documentation of services must conform to the requirements outlined within this policy.

X. Documentation Requirements

A. Initial Treatment Authorization Visits

Initial authorization for therapy treatment must include a treatment plan.

1. The treatment plan must be signed and dated by the member's PCP (MD, DO, PA or NP) or appropriate specialist. In lieu of having the treatment plan signed, the provider may submit a physician referral or order signed and dated the day of the evaluation or after, specifying the frequency and duration of the requested service.
2. The treatment plan must also be signed and dated by the evaluating therapist. Physical Therapist Assistants, Certified Occupational Therapy Assistants and Speech-Language Pathology Assistants may not sign progress notes or re-evaluations regardless if the PT, OT or SLP co-signs.
3. The treatment plan must document:
 - a. Date of evaluation
 - b. Member's age
 - c. A brief statement of the member's medical history, including onset date of the illness, injury, or exacerbation that requires the therapy services and any prior therapy treatment.
 - d. Relevant review of systems
 - e. Pertinent physical assessment including a description of the member's current deficits and their severity level documented using **objective data**.
*Note: Documentation **may** include current standardized assessment scores, age equivalents, and percentage of functional delay, criterion-referenced scores **or** other objective information as appropriate for the member's condition or impairment.*
 - f. A clear diagnosis and reasonable prognosis including the member's potential for meaningful and significant progress.
 - g. A description of the member's functional impairment with a comparison of prior level of function to current level of function, when applicable.
 - h. A statement of the prescribed treatment modalities and their recommended frequency and duration.
 - i. Proposed patient and caregiver education
 - j. Treatment goals must be written in the S.M.A.R.T. format (Specific, Measurable, Attainable, Relevant and Time-based), and relate to the member's specific functional outcomes.
 - k. Treatment goals written with targets set for achievements specific to standardized testing benchmarks will not be accepted. Treatment goals must relate to the member's specific functional skills.
 - l. Treatment plan may not be more than 60 days old.

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- m. If the treatment plan is part of a medically necessary program to maintain or prevent a significant functional regression, it must document skilled services to be provided and have treatment goals that address maintenance. Therapy maintenance programs are a benefit for members under 21 years of age or HCBS program (waiver) members.
- n. Additional requirements for speech therapy treatment requests include:
 - i. Language evaluations – should include oral-mechanism examination and objective assessment of hearing, speech production, voice, and fluency skills.
 - ii. Speech production - should include objective assessment of language skills, hearing, voice, and fluency skills.
 - iii. Oral motor, swallowing and feeding - if swallowing, feeding problems or signs of aspiration are noted as a concern, then a complete objective, clinical-bedside swallow evaluation is expected, as per ASHA standards for both pediatric and adult dysphagia. The member's language, speech, hearing, voice and fluency skills must also be addressed in the assessment via a screen or objective testing.

B. Continued Authorization Visits

Progress toward treatment goals must be clearly documented in an updated treatment plan or current progress summary. This documentation must be submitted by the servicing provider at the end of each authorization period or when additional visits are being requested.

1. The treatment plan must be signed and dated by the member's PCP (MD, DO, PA or NP) or appropriate specialist.
2. In lieu of having the treatment plan signed, the provider may submit a physician referral or order signed and dated the day of the evaluation or after, specifying the frequency and duration of the requested service regardless of history.

Documentation must include the following:

1. Number of therapy visits authorized and number of therapy visits attended.
2. A clear diagnosis and reasonable prognosis including the member's potential for meaningful and significant progress.
3. A description of the member's current deficits and their severity level documented using objective data. This may include current standardized assessment scores, age equivalents, percentage of functional delay, criterion-referenced scores, or other objective information as appropriate for the member's condition or impairment.
4. Objective demonstration of the member's progress towards each prior treatment goal.
 - a. Treatment goals are developed by the treating therapist to be met within the timeframe specified on the treatment plan.
 - b. If any goals are unmet, it is the treating therapist's responsibility to objectively describe specific barriers to progress that were encountered and make appropriate modifications to the treatment plan in order to meet the member's needs.

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- c. For all unmet treatment goals, report the status of the goal at the beginning of the previous treatment period, and the current status at the time of reporting as they compare to the target.
- d. If the treatment plan was written with maintenance goals, a status statement would be expected for each maintenance goal directed at a skilled service.
5. An updated statement of the prescribed treatment modalities and their recommended frequency and duration.
6. A clear, member specific prognosis with established discharge criteria.
7. A description of the member's functional impairment with a comparison of prior level of function to current level of function, when applicable.
8. Treatment goals must be written in the S.M.A.R.T. format (Specific, Measurable, Attainable, Relevant and Time-based), and relate to the member's specific functional outcomes.
9. Updated treatment plan or progress summary may be no older than 60 days ~~old~~.
10. Treatment plan must be signed and dated by the treating therapist.

Note: As the member's medical need for therapy decreases, it is expected that the therapy frequency will be decreased as well.

XI. Change of Provider

If a therapy provider discontinues services during an existing prior authorization period and the member requests service through a new provider, the following must be submitted:

- A. Change of provider letter signed by the member or member's caregiver
 1. Documents the date the member ended therapy (effective date of change) with the previous provider
 2. Names of the previous and new treating providers, and an explanation of why providers were changed
- B. A member may request the discharge summary from the previous provider be submitted with the request for therapy.

XII. Treatment Notes

Documentation of all therapy evaluations, re-evaluations and daily notes must be kept on file by the treating provider and be available upon request. This documentation must be legible and include:

- A. Member's name
- B. Date of service
- C. Time in and out of each therapy session
- D. Objectives addressed (must coincide with treatment plan) and progress noted, if applicable
- E. Description of specific skilled therapy services provided and the activities rendered during each therapy session, along with a form of measurement
- F. Member's response to treatment
- G. Assessments of the member's progress or lack of progress

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Background

For the purpose of medical necessity review of therapy documentation, it is expected that each request will include all required elements as set forth in this policy, document the safety of the treatment to be delivered, and meet best practice standards of the therapy national associations (AOTA, APTA and ASHA) and State of Texas licensure laws.

Per chapter 322. Practice, of the June 2016 Texas Board of Physical Therapy Examiners Rules; chapter 372 Provision of, of the December, 2016 Texas Board of Occupational Therapy Examiners Rules; and §741.64 Requirements for an Assistant in Speech-Language Pathology License, of The State Board of Examiners for Speech-Language Pathology and Audiology Rules & Regulations, therapy assistants may not perform evaluations or assessments nor design, create or revise treatment plans.

Definitions:

- Coding Implications - multiple codes exist for these services. If needed, exact codes should be obtained from the provider requesting the service. Refer to your State contract for exact coverage implications.
- “Correct” or “Ameliorate” - means to optimize a Member’s health condition, to compensate for a health problem, to prevent serious medical deterioration, or to prevent the development of additional health problems.
- Physical and occupational therapy are defined as therapeutic interventions and services that are designed to improve, develop, ameliorate, rehabilitate, or prevent the worsening of physical functions and functions that affect activities of daily living (ADLs) that have been lost, impaired, or reduced as a result of an acute or chronic medical condition, congenital anomaly, or injury. Various types of interventions and techniques are used to focus on the treatment of dysfunctions involving neuromuscular, musculoskeletal, or integumentary systems to optimize functioning levels and improve quality of life.
- Speech therapy is defined as services that are necessary for the diagnosis and treatment of speech and language disorders that result in communication disabilities and for the diagnosis and treatment of swallowing disorders (dysphagia), regardless of the presence of a communication disability. Speech therapy is designed to ameliorate, restore, or rehabilitate speech/language communication and swallowing disorders that have been lost or damaged as a result of chronic medical conditions, congenital anomalies, or injuries.
- “Medically necessary services” refers to services or treatments which are ordered by an examining Physician and which (pursuant to the EPSDT Program) diagnose, correct, or significantly ameliorate deficits, physical and mental illnesses, and health conditions. “Correct” or “ameliorate” means to optimize a member’s health condition, to compensate for a health problem, to prevent a serious medical deterioration, or to prevent the development of additional health problems. In considering medical necessity for therapy services, the member’s current health status, therapy history and the efficacy of the therapy treatment plan will be taken into consideration.

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Coding Implications

This clinical policy references Current Procedural Terminology (CPT®). CPT® is a registered trademark of the American Medical Association. All CPT codes and descriptions are copyrighted 2021, American Medical Association. All rights reserved. CPT codes and CPT descriptions are from the current manuals and those included herein are not intended to be all-inclusive and are included for informational purposes only. Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

CPT® Codes	Description
N/A	

HCPCS Codes	Description
N/A	

ICD-10-CM Diagnosis Codes that Support Coverage Criteria

ICD-10-CM Code	Description
N/A	

Reviews, Revisions, and Approvals	Date	Approval Date
Updated Authorization Protocol and Authorization Work Process. Added Waiver approval notification work process. Updated References, Definitions and Signatories.	05/14	05/14
Moved medically necessary from criteria to description. Added the non-covered benefit criteria. Added the criteria subsets for InterQual under criteria. Revised the authorization requirement for plan of care. Updated signatories. Updated references.	08/14	08/14
Added the SC MRSA TruCare Queues under Section 3 of the policy/criteria. Added the STAR+PLUS NF add-on rehabilitative services criteria under Section 4 of the policy/criteria. Updated signatures. Removed work process and embedded in attachment section. Added policy to reference list.	02/15	02/15
Updated References. Updated signatories. Removed work process imbedded in attachment section. Added requirement for documentation of medical necessity on TH Steps or specialist note for all member's under age 21.	1/16	01/16

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Reviews, Revisions, and Approvals	Date	Approval Date
<p>Extended age requirement for developmental screen from 30 days to 90 days. Added that developmental screen may be waived for members with a major diagnosis that would require treatment in most instances. Changed origin point for re-evaluation from ordering provider to servicing provider. Added specific requirements for language evaluations, speech production evaluations and oral/motor/swallowing /feeding evaluations. Added specific criteria for speech therapy with bilingual members. Added specific criteria for defining progress. Added requirements for change of provider, for transfer of provider within the same practice and for treatment notes. Added clarifying information on ECI requests, standard deviation and standard score levels, and adjustment of scores for premature children. Added information about frequency and duration for acute injury and illness. Added ABA as not a covered benefit.</p> <p>Removed Star Plus waiver language regarding S codes and work process. Removed qualification information for ECI. Removed language regarding request for IEP. Removed language about school based services. Removed language about medical home by AAP. Removed speech intelligibility information.</p>		
<p>Removed MRSA and CHIP RSA from Products. Added STAR Kids to Products.</p>	09/16	09/16
<p>Updated references and signatories.</p>	01/17	01/17
<p>Minor edit. Added to page five the following note: “The Initial Therapy Evaluation Request Supplemental Information Form may be used as an alternative to sending each individual required form.”</p>	05/17	05/17
<p>Updated references and signatories. Annual Review. Revision of place of service decisions, added a clarification of provider types for ordering of therapy and updated new documentation requirements. Deleted revision history prior to 2014.</p>	07/18	07/18
<p>Updated policy TX.UM.10.49 to new template (TX.CP.MP.549 nomenclature implementation 09/14/19). Updated language around treatment goals, “Treatment goals must be written in the S.M.A.R.T. format (Specific, Measurable, Attainable, Relevant and Time-based), and relate to member specific functional outcomes”. Updated language assessment information for speech therapy requests and stated under documentation requirements for continued authorization visits. Updated section IX. A. ‘Developmental Delay Criteria Using Standardized Testing’. Removed work process information related to InterQual specific subsets. Removed statement, “All therapy requests pre or post-surgery or discharge from an inpatient hospitalization will be reviewed per TX.UM.02.10 Discharge Planning and are not included in this policy”. Grammatical edits.</p>	07/19	07/19

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Reviews, Revisions, and Approvals	Date	Approval Date
Updated section regarding frequency and duration of therapy services, updated language regarding HCBS waiver benefits, and updated language regarding acute and chronic benefits for both adults and pediatrics. Updated references.	01/20	01/20
In section III. Criteria For Discontinuation of Therapy Services, L. removed “If a request has been denied for lack of medical necessity, it will be denied for the entirety of the requested dates of service.” Updated References.	6/20	6/20
Replaced “client” with “member” throughout the document. Removed Section VIII. STAR +PLUS Nursing Facility (NF) Add-On Services. Removed A. and B. from Documentation Requirements, and C. became “A. Initial Treatment Authorization Visits”.	06/21	05/20
Annual Review. Updated products to include MMP. For clarification, created Section II “Not Medically Necessary” without change to criteria as criteria was pulled from Section I. Removed Section XI A. and B. Replaced “client” with “member” throughout policy. Grammatical corrections. Updated references.	05/21	05/21
Removed language regarding ABA was non-covered benefit due to benefit change per Texas Health and Human Services (HHS).	02/22	
Annual Review. References Updated. Gramatical corrections. Clarified in Section III B and C that 6 months or up to 180 days	05/22	05/22
Annual Review. References Updated. Grammatical corrections with no impact to clinical criteria.	05/23	05/23

References

1. Texas Insurance Code Section 1271.156 (a) and (b)
2. Texas Medicaid Provider Procedures Manual, Children’s Services Handbook 2.7 Comprehensive Outpatient Rehabilitation Facilities (CORFs); Outpatient Rehabilitation Facilities (ORFs), April 2023
3. Texas Medicaid Provider Procedures Manual, Physical Therapy, Occupational Therapy, & Speech Therapy Services Handbook, Section 5.2, Authorization Requirements for PT, OT, and ST Services April 2023
4. Texas Medicaid Provider Procedures Manual, Physical Therapy, Occupational Therapy, & Speech Therapy Services Handbook, Section 5.3, Developmental Delay Criteria, April 2023
5. Health and Human Services Contract B-2.1 Version 2.1 - Page 304
6. The American Physical Therapy Association (APTA), Guidelines: Physical Therapy Documentation of Patient/Member Management (2014). <https://www.apta.org/apta-and-you/leadership-and-governance/policies/guidelines-documentation-patient-client-management>
7. American Occupation Therapy Association. Standards of practice for occupational therapy. The American Journal of Occupational Therapy. Nov/Dec 2010, 64:6.

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<https://www.aota.org//media/Corporate/Files/AboutAOTA/OfficialDocs/Standards/Standards-Practice-OT-2010.PDF>

8. The American Physical Therapy Association (APTA), Criteria for Standards of Practice for Physical Therapy (2014).
http://www.apta.org/uploadedFiles/APTAorg/About_Us/Policies/Practice/CriteriaStandardsPractice.pdf#search=%22standards of practice%22
9. American Speech Language hearing Association, Medical Review Guidelines for Speech-Language Pathology Services (2011).
<http://www.asha.org/practice/reimbursement/SLP-medical-review-guidelines/>
10. Clark GF. Guidelines for documentation of occupational therapy (2008). Am J Occupational Therapy. 2008 Nov-Dec; 62(6):684-690.
11. Standards of Practice, the American Occupational Therapy Association.
<http://www.aota.org/general/docs/otsp05.pdf>

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. “Health Plan” means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan’s affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.



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This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

This clinical policy is the property of the Health Plan. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members and their representatives agree to be bound by such terms and conditions by providing services to members and/or submitting claims for payment for such services.

Note: For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

Note: For Medicare members, to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs, LCDs, and Medicare Coverage Articles should be reviewed prior to applying the criteria set forth in this clinical policy. Refer to the CMS website at <http://www.cms.gov> for additional information.

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