

Clinical Policy: Physical, Occupational, and Speech Therapy Services

Reference Number: CP.MP.49

Date of Last Revision: 06/21

[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 evaluation and treatment services. Initial evaluation requirements are based on the individual benefit contract.

Note: This policy should only be used if there is no relevant clinical decision support criteria.

Policy/Criteria

I. Initial Authorization

It is the policy of health plans affiliated with Centene Corporation[®] that *outpatient speech therapy, occupational therapy, and/or physical therapy services* are considered **medically necessary** when all the following criteria are met:

- A. Signs and symptoms of physical deterioration or impairment in ≥ 1 of the following areas, or for prevention of disability in ≥ 1 of the following areas:
 1. Sensory/motor ability
 2. Functional status as evidenced by inability to perform basic activities of daily living (ADLs) and/or mobility
 3. Cognitive/psychological ability
 4. Cardiopulmonary status
 5. Speech/language/swallowing ability/cognitive-communication disorders that result in disability
- B. Treatment is ordered by an examining physician or other qualified healthcare professional (e.g., nurse practitioner, physician's assistant, etc.) and a formal evaluation is conducted by a licensed/registered speech, occupational, or physical therapist. The evaluation must include the following:
 1. History of illness or disability
 2. Relevant review of systems
 3. Pertinent physical assessment
 4. Current and previous level of functioning
 5. Tests or measurements of physical function
 6. Potential for improvement in the patient's physical function
 7. Recommendations for treatment and patient and/or caregiver education
- C. Treatment requires the judgment, knowledge, and skills of a licensed/registered therapist or therapy assistant and cannot be reasonably learned and implemented by non-professional or lay caregivers. Repetitive therapy drills which do not require a licensed/certified professional's feedback are not covered services.
- D. Treatment meets accepted standards of discipline-specific clinical practice, and is targeted and effective in the treatment of the diagnosed impairment or condition.
- E. Treatment does not duplicate services provided by other types of therapy, or services provided in multiple settings.

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- F. Treatment conforms to a plan of care (POC) specific to the diagnosed impairment or condition. The written POC signed by the therapist must include all of the following:
1. Diagnosis with date of onset or exacerbation;
 2. Short- and long- term functional treatment goals that are specific to the diagnosed condition or impairment, and measurable relative to the anticipated treatment progress. Planned treatment techniques and interventions are detailed, including amount, frequency, and duration required to achieve measurable goals;
 3. Education of the member/enrollee and primary caregiver, if applicable. This should include a plan for exercises/interventions to be completed at home between sessions with the therapist;
 4. A brief history of treatment provided to the member/enrollee by the current or most recent provider, if applicable;
 5. A description of the current level of functioning or impairment, and identification of any health conditions which could impede the ability to benefit from treatment;
 6. Most recent standardized evaluation scores, with documentation of age equivalency, percent of functional delay, or standard deviation (SD) score, when appropriate, for the diagnosis/disability.
 - a. Standardized scores ≥ 1.5 SD below the mean (except where state requirements are more stringent) may qualify as medically necessary as defined by age equivalent/chronological age; however, such a score may not be used as the sole criteria for determining eligibility for initial or continuing treatment services.
 7. Providers should also include any meaningful clinical observations, summary of a member's/enrollee's response to the evaluation process, and a brief prognosis statement.
- G. Treatment is expected to either:
1. Produce clinically significant and measurable improvement in the level of functioning within a reasonable, and medically predictable period of time; OR
 2. Prevent significant functional regression as part of a medically necessary program and:
 - a. If under age 21 and a clinical and functional plateau is achieved, the provider adjusts the POC, and provides monthly (or as appropriate) reassessments to update and modify the home care program. If functional level is in jeopardy or declining, the POC can be adjusted accordingly by the therapy provider.
 - b. EPSDT (early and periodic screening, diagnosis and treatment): those receiving EPSDT services may continue to receive medically necessary therapies where loss or regression of present level of function is likely within a reasonable and medically predictable period of time.
- H. Where appropriate, nationally recognized clinical decision support criteria will be used as a guideline in the medical necessity decision making process.

II. Continued Authorization

- A. Treatment progress must be clearly documented in an updated POC/current progress summary signed by the therapist, as submitted by the requesting provider at the end of each authorization period and/or when additional visits are being requested. Documentation must include the following:

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1. Updated standardized evaluation scores, with documentation of age equivalency, percent of functional delay, or SD score, if applicable.
2. Objective measures of functional progress relative to each treatment goal and a comparison to the previous progress report.
3. Summary of response to therapy, with documentation of any issues which have limited progress.
4. Documentation of participation in treatment, or caregiver's if member/enrollee is unable to participate in treatment.
5. Documentation of participation in or adherence with a home exercise program (HEP), if applicable.
6. Brief prognosis statement with clearly established discharge criteria.
7. An explanation of any significant changes to the POC and the clinical rationale for revising the POC.
8. Prescribed treatment modalities, their anticipated frequency and duration.
9. Physician or other qualified healthcare professional (e.g., nurse practitioner, physician's assistant, etc.) signature must be on the POC or on a prescription noting the service type.
10. If applicable, IFSP/IEP or attestation is submitted and verifies no duplication of services for children with developmental delays.

III. Discontinuation of Therapy

- A. Reasons for discontinuing treatment may include, but are not limited to, the following:
 1. Treatment goals have been achieved as evidenced by one or more of the following:
 - a. No longer demonstrates functional impairment or has achieved goals set forth in the plan of care;
 - b. Has returned to baseline function;
 - c. Will continue therapy with a HEP;
 - d. Has adapted to impairment with assistive equipment or devices;
 - e. Is able to perform ADLs with minimal to no assistance from caregiver.
 2. A functional plateau in progress has been reached, or additional therapy will no longer be beneficial.
 - a. A denial of treatment due to "failure to benefit or progress" may be made in those cases when a condition or developmental deficit being treated has failed to be ameliorated or effectively treated despite the application of therapeutic interventions in accordance with the POC, or if maximum medical benefit has been achieved.
 3. Unable to participate in the POC due to medical, psychological, or social complications.
 4. Non-compliance with a HEP and/or lack of participation in scheduled therapy appointments.
- B. Treatment(s) may be re-instituted in accordance with this policy should a documented regression occur.

IV. Reevaluation

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- A. A formal reevaluation by a licensed/registered therapist is considered medically necessary up to once every six months when there is documentation of one of the following (but is not a requirement for assessing the need for continued treatment):
 - 1. New clinical findings or a significant change in condition that was not anticipated in the POC;
 - 2. Failure to respond to therapeutic interventions outlined in the POC.

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

- VI. Treatment in the home may be medically necessary if:
 - A. Criteria in section I or II is met;
 - B. The treatment can be safely and adequately performed in the home environment;
 - C. The diagnosed impairment or condition makes transportation to an outpatient rehab facility impractical or medically inappropriate.

Background

Physical and occupational therapy are defined as therapeutic interventions and services that are designed to improve, develop, correct or ameliorate, rehabilitate or prevent the worsening of physical functions and functions that affect 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 correct or 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 or other qualified healthcare professional (e.g., nurse practitioner, physician’s assistant, etc.) and which (pursuant to the EPSDT Program) diagnose or correct or significantly ameliorate defects, physical and mental illnesses, and health conditions. “Correct” or “ameliorate” means to optimize a health condition, to compensate for a health problem, to prevent serious medical deterioration, or to prevent the development of additional health problems.

Reviews, Revisions, and Approvals	Revision Date	Approval Date
Initial approval date		04/11
Clarified in I.A. that prevention of disability should also apply to one or more of criteria I.A.1 - I.A.5. Added “cognitive-communication	08/17	08/17

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disorders that result in disability” as an indication in I.A.5 per updated ST guidelines. Added to I.F.3. the requirement for a home exercise plan to be taught to member/enrollee and/or caregiver. Edited I.G. and I.H. to state that treatment should either produce improvement or prevent regression (per updated ST guidelines citing Medicare changes). Outpatient/Home Health Utilization Guidelines section I: specified that evaluation should meet all of the criteria in I.B.		
Removed section C. in “Initial request” and “Continued Authorization” that specified approved frequency of visits based on severity criteria.	12/17	
References reviewed and updated	06/18	06/18
Revised wording in section IF. Children with Developmental Delays Section II: Removed initial paragraph as informative; Clarified ability to request IEP in IIA and revised accordingly; Due to duplication, moved and combined as follows: IIA to IG, IIB to IIIB, IID to IVA2, IIE to IVB, IIF to IIIA8. Outpatient/Home Health Utilization Guidelines Section I: Due to duplication, moved and combined as follows: IA to IIA, (old IIB and IC to IIB; Removed IB as duplicative. Added “Initial Authorization” to Section I and removed statement from this section that up to 6 months of treatment may be authorized at a time.	12/18	
Removed criteria from continuation section that up to 6 months of treatment may be authorized at a time.	02/19	
Added note before criteria that this policy should only be used if there is no other relevant clinical decision support criteria. In continued authorization, clarified that documentation notes member/enrollee/caregiver’s participation in treatment, and split out from criteria regarding HEP. In section IV on home care, noted that the member/enrollee must meet criteria in sections I or II.	04/19	
References reviewed and updated. Specialist reviewed	05/19	06/19
Removed section on school based services from I.E.1. References reviewed and updated.	06/20	06/20
Added criteria to section IV. for a formal reevaluation, requiring that there must be documentation of new clinical findings or a significant change in condition, or a failure to respond to therapeutic interventions outlined in the POC. Replaced "member" with "member/enrollee."	11/20	11/20
In I.B, noted that treatment order can come from “other qualified health professional,” with examples, as well as a physician; added “other qualified healthcare professional” with examples to II.A.9, and the background. References reviewed, updated, and reformatted. Revised wording with no clinical significance. Changed “review date” in the header to “date of last revision” and “date” in the revision log header to “revision date.”	06/21	06/21

References

1. American Physical Therapy Association (APTA). Guidelines: physical therapy documentation of patient/client management). <https://www.apta.org/siteassets/pdfs/policies/guidelines-documentation-patient-client-management.pdf>. Accessed June 1, 2021.
2. American Physical Therapy Association (APTA). Standards of practice for physical therapy (2020). <https://www.apta.org/siteassets/pdfs/policies/standards-of-practice-pt.pdf>. Accessed June 1, 2021.
3. American Speech Language Hearing Association. Speech-language pathology medical review guidelines. (2015). <https://www.asha.org/practice/reimbursement/SLP-medical-review-guidelines/>. Accessed June 1, 2021.
4. Clark GF, Youngstrom MJ; American Occupational Therapy Association Commission on Practice. Guidelines for documentation of occupational therapy. *Am J Occup Ther*. 2008;62(6):684-690. doi:10.5014/ajot.62.6.684.
5. McKesson Corporation InterQual[®] criteria.
6. MCG (formerly Milliman Care Guidelines[®]) guidelines.
7. American Occupational Therapy Association. Standards of practice for occupational therapy. *American Journal of Occupational Therapy*. 2015; 69 (6913410057): 1-6. <https://doi.org/10.5014/ajot.2015.696S06>. Accessed June 1, 2021.
8. World Physiotherapy. Standards of physical therapy practice guideline. (Revised 2011). <https://world.physio/sites/default/files/2020-06/G-2011-Standards-practice.pdf>. Accessed June 1, 2021.

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

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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.

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/enrollees. This clinical policy is not intended to recommend treatment for members/enrollees. Members/enrollees 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.

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Note: For Medicaid members/enrollees, 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/enrollees, 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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