Clinical Policy: Physical, Occupational, Speech, and Feeding Therapy

Reference Number: GA.CP.MP.49
Last Review Date: 07/2021

Coding Implications
Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description
To provide guidelines for authorization of outpatient or home care physical, occupational and speech and/or feeding therapy evaluation and treatment services. Initial evaluation requirements are based on the individual member benefit contract.

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

Policy/Criteria

I. It is the policy of Peach State Health Plan (PSHP) that outpatient physical, occupational and speech and/or feeding therapy are considered **medically necessary** for the following indications:

A. The therapy is prescribed by the primary care practitioner (PCP) or other prescribing practitioner at the request of the PCP and provided by a qualified licensed therapist, or qualified therapy assistant who is supervised by a registered licensed therapist .Services provided by therapy assistants, students, and aides are NOT covered under the Children's Intervention Services (CIS) program. The member's plan of care or letter of medical necessity (POC/LMN) must be signed and dated by the member's PCP every 6 months.

B. The therapy requires the judgment, knowledge, and skills of a qualified licensed therapist or therapy assistant. Except in the case of therapy provided to a NON CIS member, therapy assistants, students, and aides are not allowed to provide services under the CIS Program. Only the CIS enrolled licensed therapists can provide services to CIS members.

C. The therapy must meet accepted standards of practice and must be specific and effective in treatment of the member's diagnosed impairment or condition.

D. The therapy cannot be reasonably learned and implemented by nonprofessional or lay caregivers;

E. The therapy does not duplicate services provided by other types of therapy, or by the same therapy provided in another setting.

1. Duplicated services are defined as therapy services that:
   a. provide the same general areas of treatment, treatment goals, or ranges of specific treatment or processing codes, notwithstanding a difference in the setting, intensity or modalities of skilled services, and
   b. address the same types and degrees of disability as other concurrently provided services (via Individualized Education Plan (IEP) or other community or hospital-based providers).

NOTE: If a child is tested and found to have severe or profound deficits (i.e.,standard scores of 69 or below), there may still be instances where additional therapy outside the school setting would be appropriate either based on frequency, setting or additional skill needs of the child. Determination of duplication will be made

on an individual basis after review of treatment notes and/or peer-to-peer discussion with the requesting therapist.

F. The therapy conforms to a POC specific to the member's diagnosed impairment or condition.
G. The therapy produces measurable progress toward the goals specified in the POC.
H. There is an expectation that the services will produce significant practical improvement in the member's level of functioning within a reasonable, and generally predictable, time period.
I. The therapy is not part of a maintenance program that continues the member's present level of function or prevents regression of function or that could be provided by an unskilled person.
J. Therapies are intended to restore functions to accomplish activities of daily living. Sports training or therapies to improve sport performance is not considered skilled medically necessary care.
K. Therapy to assist in the development of school specific skills (i.e.; reading, math skills, etc.), that would be part of a "normal curriculum" for a student, or therapy duplicative of those supports covered under state or federal guidelines in the school setting (i.e., free and state/federally funded tutoring) are not medically necessary and not covered per this policy, if no other goals or deficits are identified.
L. For children who are home schooled submission of a copy of the Georgia Department of Education (GADOE) document called "State of Georgia Home Study Program Declaration of Intent Form" or the copy of the confirmation email sent from the GADOE once the intent form is submitted for a home school child is required on an annual basis. http://www.gadoe.org/curriculum-instruction-and-assessment/pages/home-schools.aspx.
    1. Denial of requested therapy can occur if proof of home schooling document is not provided and the child is reported to be home schooled.
M. Therapy through CIS for children with ongoing chronic conditions, can be considered if offered by a CIS certified provider. CIS providers will be held to the CIS rules and regulations per the Georgia Medicaid CIS program manual and this policy.
N. As of 4/1/2017, The Georgia Department of Community Health is allowing previously ineligible providers known as Clinical Fellowship Year (CFY), the Clinical Fellows for Speech and Language Pathology to render speech and language therapy, as well as those modalities covered under the CIS manual. Peach State Health Plan will allow CFYs to provide speech and language therapy as well as feeding therapies to its members when all of the following are met:
    1. Prior Authorization requests need to be entered under the supervising speech and language pathologist (SLP), and claims for all services need to match the credentialed SLP on the prior authorization request.
    2. All supervision logs, paperwork etc., must be submitted with EACH subsequent request for ST visits for the member.
    3. All evaluations, POC, letter of medical necessity, daily treatment notes, progress summaries, addendums, etc. must be signed and dated by the rendering therapist and/or Clinical Fellowship Year (CFY), student, (except for CIS members, therapy students, therapy assistants or therapy aides are not allowed to provide services under the CIS Program).

O. Not all therapy modalities are covered benefits. Coverage of specific modalities is dependent upon their proven efficacy, safety, and appropriateness.
P. Prior approval for services shall be for general areas of treatment based on clinical guidelines. Restrictions on location of service or number of services per day shall not be the sole determinant to deny PT/OT/ST service requests.
Q. For Medicaid members age 21 and above coverage for PT/OT/ST is only available for acute illnesses and injuries. An injury, illness, or impairment is considered to be acute if the onset of the condition is 90 days or less from the therapy evaluation and it is less than 90 days duration. Illnesses, or injuries, or impairment lasting more than 90 days are considered chronic and PT/OT/ST services for chronic conditions are not covered benefits.

II. Children under the age of 21 year old with Developmental delays

A. Some states have state funded early intervention programs where children identified with special needs between the ages of birth to 3 years may have an Individual Family Service Plan (IFSP) where therapy and family support is provided free or at a minimal charge.
B. There is also a federal mandate that children between the ages of 3 years and 21 years with educationally based needs be provided with and Individual Education Plan (IEP).
   1. The school system is the primary payer and therapy requests should be referred to the school system first if they are not supported medically.
   2. An exception to this is Georgia where legislation mandates that a family cannot be required to utilize the school system for services.
   3. In these cases, the health plan is required to review and authorize appropriate services.
C. An IEP/IFSP will be requested for review. An attestation that no IEP exist or that no duplications are occurring with IEP will need to be submitted if there is no IEP or IFSP. **See Attachment A.**
   1. Denial of requested therapy can occur if one or more of the following:
      a. IEP is available but not provided, or if the letter of attestation was not provided;
      b. If the provider requesting services is not the same provider listed on the IFSP.
      c. Denial for duplication of services can occur if documented.
D. When a child is serviced under and IFSP through the Babies Can't Wait (BCW) program, the provider may or may not be listed as the service provider. If the requesting provider is listed on the service plan, the frequency of visits and date range must match the service plan. Any other provider seeing the member who is covered under an IFSP must be listed under "Other Services" in the IFSP and the frequency and duration on the care plan may be approved if the request meets medical necessity.
E. Sensory integrative techniques, CPT 97533 to enhance sensory processing and promote adaptive responses to environmental demands, direct (one on-one) patient contact, each 15 minutes for the treatment of sensory processing disorder is not medically necessary and not covered per this policy because sensory processing disorder is not a diagnosis on its own and the amount of research regarding the effectiveness of sensory integration therapy is limited and inconclusive.
F. Standardized formal evaluation by a licensed therapist every 6 months is required.
G. Standard scores should show the presence of delays in functional skill acquisition or loss of skills to accident or illness. An example would be standard scores below 85 for speech

therapy testing. Test scores that are below normal or below average and age-appropriate goals may qualify as medically necessary services as part of the clinical review.

H. Judgments when standardized test scores and/or age equivalency are not available can be made on an individual basis i.e., speech dysfluencies or autism. If standardized testing is available for the member's conditions/diagnosis, results will be reviewed and a judgment made regarding the medical necessity for therapy.

I. Therapy can be approved based on severity as below, but also based on other factors outside standardized scores (SS) such as: adherence to HEP, additional medical diagnoses, progressive disease processes, significant changes in social, family structure, compliance in therapy attendance, and other factors that would influence the efficacy of continued skilled intervention.
   1. Mild developmental delays – Up to 1 x per week (standardized scores between 80-84).
   2. Moderate delays – Up to 2 x per week (standardized scores between 70-79).
   3. Severe delays or therapy for acute onset conditions- Up to 3 x per week (standardized scores below 70).

J. Up to 6 months of therapy can be authorized if requested and medically necessary.

K. Denial for no progress can be made if, despite therapy services, member under the age of 21 years of age achieves a relative clinical and functional plateau that has not ameliorated with therapy and/or if progress toward defined goals has not occurred. When the services being provided no longer require provision by a skilled therapist, but can be provided by a caregiver after education or through adherence to a HEP designed by the therapist.

L. Reinstitution of therapy may be approved if regression or additional delays occur.

M. The PCP or other prescribing practitioner at the request of the PCP signed order for therapy and a signed treatment plan or letter of medical necessity must accompany the request for therapy. Referrals are required from a physician or PCP or other prescribing practitioner at the request of the PCP at the start of any therapy for a CIS member as well as NON CIS member requests for therapy. Referrals must be dated prior to the initial member evaluation.

N. Only licensed therapists for OT, PT and ST, and Clinical Fellows for Speech Therapy (CFY) are allowed to treat CIS members as they are they only clinicians enrolled by the program and licensed in the State of Georgia (except for CFY who can perform treatment under the supervision of a licensed credentialed speech therapist.

O. Parent / caregiver participation is required as well as teaching of a home program for CIS members.

III. Feeding/Swallowing Therapy Guidelines

To define Feeding Therapy and the appropriate use of the treatment of swallowing dysfunction and/or oral function for feeding (CPT 92526).

The treatment of swallowing dysfunction and/or oral function for feeding (CPT 92526) is meant to be used for those children with a physiological and/or sensory feeding limitation that deals with the act of chewing, manipulating food within the mouth to create a bolus, propelling the bolus in preparation for swallowing and the act of swallowing safely.

A. Therapists wishing to obtain prior authorization for this modality, must show evidence of a feeding disorder that involves either one, or a combination of the following:
   1. Oral phase deficits (the act of sucking, chewing and moving food or liquid into the throat;

2. Pharyngeal phase deficits (starting the swallow and squeezing food down the throat closing the airway to keep food/ liquid out); OR
3. Esophageal phase deficits (opening and closing of the esophagus).

B. Therapists will need to forward a physician or PCP prescription with an appropriate feeding diagnosis, or documentation of conversation with the physician or PCP about a feeding/ swallowing disorder and the request to evaluate and treat as such, as well as a full feeding evaluation that contains all of the following information:
   1. Detailed past medical history especially feeding history (including cardiac, G.I., neurological)
   2. All diagnostic testing done regarding feeding
   3. Other services child is receiving
   4. Detailed oral motor evaluation
   5. Full food listing-preferred and non preferred (that family/caregivers have attempted and or child has lost)
   6. Positioning for feeding
   7. Physical limitations
   8. Full daily menu/list of foods child eats
   9. Parent/caregiver report of feeding abilities, limitations, behaviors
   10. Food trials (when appropriate and medically safe) including type of food, volume, presentation, observations, behaviors shown)
   11. Responses to food trials (behavioral and physiological)
   12. Adaptations and responses
   13. Volumes in at trials and during therapy
   14. Responses to feeds

C. Care plans must be signed by the referring physician or PCP, and have clear short and long term goals, dates goals are expected to be met, as well as treatment modalities, and POC date range.

D. Treatment notes will be required for any additional review. Treatment notes must show all required information including date and time of treatment, member's name, objective information and plan going forward), as well as active parent involvement in sessions, home programming, and teaching to the family/caregivers, including a listing of foods presented (if able), volume taken and responses.

E. Treatment sessions for feeding therapy must include the use of food/liquid or be in preparation for presentation of such. Notes must show the process of feeding and what the therapist is actually doing in the sessions. If working with any of the above areas that make up the oral feeding process, CPT code 92526 is appropriate.

F. Therapy utilization management reviewers may request any of the following in order to ascertain medical necessity, skilled intervention needs, and/or progress with skilled intervention:
   1. Notes from the child's referring physician or PCP regarding growth, body mass index (BMI) percentile for age, or other feeding and nutritional concerns and diagnostics.
   2. If therapist notes show possibility of aspiration, signs or symptoms of aspiration, soft signs of unsafe oral intake, or reports incidents of pneumonia, upper respiratory infection (URI) or frequent respiratory issues, we may request copies of a modified barium swallow (MBS) or other swallowing study to assure safety with this modality,

or that the therapist cease treatment and refer the member back to the physician for further diagnostic studies or orders to continue therapeutic oral feeds.

G. In the case that the Therapy utilization management reviewer is presented with therapist documentation of poor weight gain, FTT (Failure to thrive) or perilous feeding conditions necessitating further medical intervention, requests for short bursts of intensive therapy (3-5 times per week) may be appropriate and approved with a signed care plan from the member's physician or PCP.

IV. Medicare members can be authorized for ongoing therapy services if their continuation is judged to prevent deterioration of their condition, prevent the development of additional health problems, or maintain the overall health.

V. Initial Authorization

A. Initial evaluations (one visit only performed within 30 days of issuance of prescription) do not require authorization.
B. Out of network or non-participating providers require a prior authorization for evaluations.
C. Re-evaluations and care plan updates are required and only allowed every 180 days for CIS members.
D. Initial authorization following evaluation
   1. The full evaluation must contain ALL of the following:
      a. The member's name
      b. The member's date of birth
      c. The date of the evaluation
      d. The name of the evaluating therapist
      e. The name of the referring physician or PCP
      f. Diagnosis with date of onset or exacerbation
      g. The member's past medical history, and psychosocial history and current status
      h. Other professional services the member is receiving and any past services for therapy
      i. Objective information and standardized testing when indicated and required
      j. Assessment and recommendations
   2. The plan of care (POC) must document ALL of the following:
      a. Description of current level of functioning including standardized testing results or objective findings.
      b. Diagnosis
      c. Treatment modalities
      d. Expected frequency and duration
      e. Short and long term goals with a specified time frame
      f. Start date and end date of the POC
      g. The PCP or other prescribing practitioner at the request of the PCP signature (within 30 days of initiation of the POC) and date of signature.
   3. For ST requests the hearing screening results done at the PCP or specialist office need to be included.
   4. For OT requests that involve visual motor deficits and testing, the vision screening results done at the PCP office or specialist office need to be included.

E. Where appropriate, nationally recognized clinical decision support criteria will be used as a guideline in the medical necessity decision making process.

VI. 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:
   1. The member's updated standardized evaluation scores, with documentation of age equivalency, percent of functional delay, or standardized scores, if applicable.
   2. Objective measures of the member's functional progress relative to each treatment goal and a comparison to the previous report.
   3. Summary of member's response to therapy, with documentation of any issues which have limited progress.
   4. Documentation of member's participation in treatment, or caregiver's if member is unable to participate in treatment.
   5. Documentation of member/caregiver 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 member's POC and the clinical rationale for revising the POC.
   8. Prescribed treatment modalities, their anticipated frequency and duration.
   9. PCP signature must be on the POC or LMN.
   10. Updated letter of attestation (LOA), or any new/updated IFSP/IEP.
   11. Clinical treatment/progress notes for the last authorization for review.
   12. For continued OT services that involve visual motor deficits and testing, the vision screening results done at the PCP or specialist office need to be provided once a year.
      a. In the case where progress to goals is not occurring per therapist or reviewer expectation, additional or updated vision testing may be requested.

VII. Length of Authorization/Approval for Therapy (see attachment B Criteria for Authorization Time Length)

A. Approval for ongoing therapy services shall be up to 6 months per Georgia House Bill (HB) 507. Determination of either 3 month or 6 month authorization shall be based on criteria (see attachment B) that look at:
   1. Age of the child
   2. Diagnosis
   3. Level of deficit / disability
   4. Goals of the skilled therapy to be provided
   5. Therapy plan/interventions
   6. The provider requesting therapy approval

VIII. Discontinuation of Therapy

A. Reasons for discontinuing treatment may include, but are not limited to, the following:
   1. Member has achieved treatment goals 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. Member is able to perform ADLs with minimal to no assistance from caregiver.
   2. Member has reached a functional plateau in progress, or will no longer benefit from additional therapy.
      a. A denial of treatment due to a member's "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 member's POC, or if maximum medical benefit has been achieved.
   3. Member is 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.
   5. When clinical documentation shows no evidence of skilled therapy being delivered.

B. Treatment(s) may be re-instituted in accordance with this policy should a documented regression occur.

IX. 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 clinical practice guidelines.

X. Treatment of the member in the home may be medically necessary if:

A. Member meets criteria in section VI. Initial Authorization or VII. Continued Authorization;
   B. The treatment can be safely and adequately performed in the member's home environment;
   C. The diagnosed impairment or condition makes transportation to an outpatient rehab facility impractical or medically inappropriate.
   D. Babies Can't Wait (BCW) Georgia's early intervention program participants should be seen in the home or daycare for teaching.

Background

Definitions: (This information is informational only and not indicative of coverage):

Medically Necessary Services: (includes concepts of Medically Necessary and Medical Necessity):

Based upon generally accepted medical practices in light of Conditions at the time of treatment, Medically Necessary Services are those that are:

i. Required to correct or ameliorate a defect, physical or mental illness, or a Condition.

ii. Appropriate and consistent with the diagnosis and the omission of which could adversely affect the eligible Member's medical Condition.
iii. Compatible with the standards of acceptable medical practice.
iv. Provided in a safe, appropriate, and cost-effective setting given the nature of the diagnosis and the severity of the symptoms.
v. Not provided solely for the convenience of the Member or the convenience of the Health Provider.
vi. Not primarily custodial care unless custodial care is a Covered Service or benefit under the Member's evidence of coverage.
vii. Provided when there is no other effective and more conservative or substantially less costly treatment, service and setting available.

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.

Feeding disorders are estimated to occur in as many as 25-45% of children with normal development, 33% with developmental disabilities, and up to 80% of children with profound mental retardation. More than 50% are said to present with mixed causes that may include behavioral, physiological and developmental factors.

By definition from Centers for Medicare and Medicaid Services (CMS), the CPT code 92526 is the " Treatment of swallowing dysfunction and/or oral function for feeding" and "*involves the treatment for impairments/functional limitations of mastication, the preparatory phase, oral phase, pharyngeal stage, and esophageal phase of swallowing. Make appropriate recommendations regarding diet and compensatory techniques and instruct in direct/indirect therapies to facilitate oral motor control for feeding".*

Reviews, Revisions, and Approvals	Date	Approval Date
Original approval date	03/09	03/09
Annual Review – Changes made under Criteria #6- CIS providers will be held to the CIS rules and regulations per the Georgia Medicaid CIS program manual. Under Initial Authorization #2 a- Attachment 1 will serve as a guideline for Maximum Allowable Visits Prior to Consultant or Medical	03/12	03/12

Director Review. #3 a- "for those diagnoses listed on Attachment 1 may be authorized for no more than 3 visits per week and a total of 12 visits per month. These services may not be authorized for more than 1 month at a time. Requests for authorization for longer than 1 month blocks or more than 3 visits per week" was removed. Section C #3 added may qualify. Section C #5 added standardized test scores. Section C #10-removed or and added and.		
Policy/Criteria- Changes to #1 a - The members plan of care must be updated and signed by a physician every 6 months. Changes to #1 e -or by the same therapy provided in another setting. Changes to #1 i - or that could be provided by an unskilled person. Added #1 j- Therapies are intended to restore functions to accomplish activities of daily living. Sports training or therapies to improve sport performance is not considered skilled medically necessary care. Procedures with Work Process- A. Initial Authorization 2a. added "as described in attachment 1 will require review but" and DELETED "for ongoing therapy visits." 2d and 2e: Changed all CCMS to the electronic medical documentation system. Procedures with Work Process- B. Continued Authorization. 1a Added 4th bullet point All clinical treatment notes for visits provided. Procedures with Work Process- C. Developmentally delayed children #3. ADDED the letter "a" so paragraph reads: Standardized formal evaluation by a licensed therapist every 6 months is required. Changed #3 and #4 to its appropriate numbering of #4 and #5. #5. ADDED "If standardized testing is available for the member's conditions/diagnosis, results will be reviewed and a judgment made regarding the medical necessity for therapy." #6 ADDED: (scores between 80-85) to Mild developmental,(scores between 70-79) to Moderate delays and (scores below 70) to Severe delays. Procedures with Work Process D. Discontinuation of Therapy #3. Update Policy Reference Number to: GA.UMQI.41.07 Adverse Determination (Denial) Notices). #5. Deleted the first and CCMS while adding "the electronic medical documentation system at the end. References Updated: American Speech Language hearing Association, 2005 Standards for the Certificate of Clinical Competence in Speech-Language Pathology, at http://www.asha.org/about/membershipcertification/new_standards.htm Standards of Practice, the American Occupational Therapy Association. http://www.aota.org/general/docs/otsp05.pdf Standards for Appropriateness of Physical Therapy Care Prepared by the WSPTA Delivery of Care Committee Board Approved 9/26/98; Revised and Board Approved 10/00 at http://www.ptwa.org/StandardsPTCare.htm	03/13	03/13
A. Under Initial Authorization added: • For speech therapy requests the hearing screening results done at the primary care provider (PCP) or specialist office need to be included.	10/13	10/13

• For occupational therapy requests that involve visual motor deficits and testing, the vision screening results done at the PCP office or specialist office need to be included. B. Under Continued Authorization added: For continued speech therapy services, the updated hearing screening results done at the PCP or specialist office need to be provided once a year		
Annual Review. Under Policy/Criteria: 1. i. add " Medicare members are exempt from this requirement. Services can be continued to prevent regression, even if the member's progress in therapy has ceased." Under Policy/Criteria: 2. add (down a space as if adding a new bullet) "Medicare members can be authorized for ongoing therapy services if there continuation is judged to prevent deterioration of their condition, prevent the development of additional health problems, or maintain the overall health". Under Policy/Criteria: 7. Add the word "Medicaid" to the first sentence:. "For Medicaid members age 21 and above…" . Add another line (skipping a space as if to add another bullet) that says: "For Ambetter members, therapy benefits are limited to 20 visits per year of PT, OT and ST.	03/14	03/14
Duplicated services definition was added	05/14	05/14
Added information on therapy coverage guidelines for school specific skills, sensory integration. Added requirement documentation for home schooled children. Updated references	09/14	09/14
Added length of Authorization/Approval for Therapy to include up to 6 months. Attachment B: Criteria for Authorization Time Length (3 months or 6 months per review). Approved by UM Committee.	05/15	05/15
Policy/Criteria #1.k. added "if no other goals or deficits are identified." #5 Babies Can't Wait participants should be seen in the home or daycare for teaching. Added (ARNP/PNP/PA) under other licensed practitioner. Under A. Initial Authorization added "Non-par or out of network providers will require a prior authorization for evaluations". Policy/Criteria. 9. For Ambetter members, no prior authorization required for outpatient therapy. Benefits include 20 visits per year of physical therapy (PT) and occupational therapy (OT) combined, and 20 visits per year of speech therapy. Under A. Initial Authorization 2.c. Start date and end date of the Plan of Care; Physician signature (PCP within 30 days of initiation of the Plan). C.2. IEP/IFSP added "or if the provider requesting services is not the same provider listed on the IFSP." C.4. "Standard scores that show the presence of delays in functional skill acquisition or loss of skills to accident or illness. An example would be standard scores below 85 for speech therapy testing Test scores and age-appropriate goals may qualify as medically necessary services as part of the clinical review." C.6 "Severe delays or therapy for acute onset conditions – Up to 3 x per week (standardized scores below 70). C.8. "When the services being provided no longer require provision by a skilled therapist, but can be provided by a caregiver after education or through adherence to a Home Exercise Program designed by the therapist."	05/16	05/16

Annual Review. Updated references. Policy/Criteria: 1.a. Added (services provided by a therapy assistant are NOT covered under the CIS program). Policy/Criteria 9. Changed number of combined therapy visits to 40. "For Ambetter members, no prior authorization required for outpatient therapy. Benefits include 40 visits per year of combined PT, OT, ST, and chiropractic." E. Discontinuation of Therapy. 3. And 4. Replaced Notice of Proposed Action for "Notice of Adverse Benefit Determination" in accordance with the content, process and timelines stipulated in the "Benefit Determination (Denial) Notices, GA.QI.41." F. Added section: As of 4/1/17, The Georgia Department of Community Health is allowing previously Ineligible providers known as Clinical Fellowship Year (CFY), Clinical Fellows for Speech and Language Pathology to render speech and language therapy, as well as those modalities covered under the Children's Intervention Services (CIS) manual. Peach State Health Plan will allow CFYs to provide speech and language therapy as well as feeding therapies to its members only when all of the following are met: 1. Prior Authorization requests will need to be entered under the Supervising speech and language pathologist (SLP), and claims for all services will need to match the credentialed SLP on the Prior authorization request; 2. All supervision logs, paperwork etc., must be submitted with EACH subsequent request for visits on the member. 3. All evaluations, plan of care, letter of medical necessity, daily treatment notes, progress summaries, discharge summaries, addendums, etc. must be signed and dated by the rendering therapist and/or Clinical Fellowship Year (CFY), student, etcetera.	5/17	5/17
Annual Review. Updated references. Updated Definition of Medically Necessary per Georgia State Contract between the Georgia Department of Community Health and Peach State Health Plan, Inc. for Provision of Services to Georgia Families RFP No.: DCH0000100 Contract No. 2016006. 5. Policy/Criteria 8. Clarified definition of acute illness: An injury, illness, or impairment is considered to be acute if the onset of the condition is 90 days or less from the therapy evaluation and it is less than 90 days duration. Illnesses, or injuries, or impairment lasting more than 90 days are considered chronic and PT/OT/ST services for chronic conditions are not covered benefits. 9. Added: Prior authorization is required for both the evaluation and then the additional therapy visits for Ambetter/Marketplace out of network or non-participating providers. A. Initial Authorization 1. Added: Re-evaluations and care plan updates are required and only allowed every 180 days for CIS patients. 2 A & B: Removed "Members with specific conditions as described in attachment 1 will require review but may receive initial authorization, if	5/18	5/18

deemed necessary based on the individual's specific needs. Attachment 1 will serve as a guideline for Maximum Allowable Visits Prior to Consultant or Medical Director Review. For conditions not listed on Attachment 1, following the completion of the initial evaluation, authorization of additional visits will require a Plan of Care." 2a. Added: The full evaluation is required. The evaluation must contain ALL of the following information: • The patient name • The patient date of birth • The date of the evaluation • The name of the evaluating therapist • The name of the referring physician • The diagnosis • The onset date • The patient's past medical history, and psychosocial history and current status • Other professional services the patient is receiving and any past services for therapy • Objective information and standardized testing when indicated and required • Assessment and recommendations **The evaluation and care plan can be combined, however the document must include all the required information for both a care plan and evaluation. 2b. Added: and date of signature on Physician signature (PCP within 30 days of initiation of the Plan of Care) and date of signature. B. Continued Authorization 1. Removed for continued speech therapy services, the updated hearing screening results done at the PCP or specialist office need to be provided once a year. C. Children with Developmental delays 3. Added. When a child is serviced under and IFSP through the BCW program, the provider may or may not be listed as the service provider. If the requesting provider is listed on the service plan, the frequency of visits and date range must match the service plan. If the provider is listed as other, or is not included on the service plan, the frequency and duration on the care plan may be approved if the request meets medical necessity. 12. Added– (except in the case of a CIS request). Removed Attachment 1 UTILIZATION REVIEW GUIDELINES FOR OCCUPATIONAL/PHYSICAL THERAPY as it is no longer used.		
Under C. 12. Children with Developmental delays – deleted "(except in the case of a CIS request)". Added Attachment C. Feeding therapy guidelines. Changed prescribed by the physician or other licensed practitioner (ARNP/PNP/PA) for primary care practitioner (PCP) or other prescribing practitioner at the request of the PCP throughout the document.	08/18	08/18

Under Policy and Procedure Approval Changed "The electronic approval retained in Compliance 360 to Sharepoint, Centene's Policy and Procedure management software". Updated References.		
Converted to new Centene Corporation clinical policy template. Reference Number changed from GA.MP.05 to GA.CP.MP.49 to match to the Centene Therapy policy reference number. Specialist reviewed. Updated Description section. Added "Initial evaluation requirements are based on the individual member benefit contract. ***Note:*** *This policy should only be used if there is no relevant clinical decision support criteria.* Removed process sections and explanations throughout the policy that do not apply to the Centene Clinical policy template. Replaced the word patient for member throughout the policy. Added criteria for Discontinuation of Therapy. Added definitions for speech therapy and occupational therapy in the background section. Updated references.	07/19	07/19
I. Deleted Medically necessary services definition since it appears in Background Definitions section. II. G. added "that are below normal or below average" to Test scores that are below normal or below average and age-appropriate goals may qualify as medically necessary services as part of the clinical review. II. M added Referrals must be dated prior to the initial member evaluation. II. Added O. Parent/caregiver participation is required as well as teaching of a home program for CIS members. Initial Authorization: Deleted process section "5. The following information must be documented by the reviewer in the notes section of the referral authorization: a. The diagnosis and type of modality/service being rendered b. The number of services authorized and timeframe during which visits" Added "E. Where appropriate, nationally recognized clinical decision support criteria will be used as a guideline in the medical necessity decision making process. Deleted Attachment C. Feeding Therapy Guidelines and moved Feeding/Swallowing Therapy Guidelines to Policy/Criteria section III. IX. Added 5. When clinical documentation shows no evidence of skilled therapy being delivered. Removed duplicative sentences. Minor reformatting throughout. Updated Background. Updated references. Specialist Review.	07/2020	07/2020
Removed "/or" from the title. Deleted section IV. Of Ambetter/Health Insurance Marketplace (HIM) members, since outpatient therapy services requests are review by National Imaging Associates (NIA) since 01/01/2021. On **Attachment A. Provider Attestation Regarding IEP/IFSP for Outpatient Therapy Services,** added "First Name, Middle Name, Last Name" under Member Name. Changed Member ID Number to Member Medicaid ID Number. Changed [CMO name] to Peach State Health Plan. Updated references. Specialist Review.	06/2021	06/2021

References

1. Centene Corporation Clinical Policy: CP.MP.49 Physical, Occupational, and Speech Therapy Services. Last Review date 6/19; 6/2020.

2. Part II Policies and Procedures for Children's Intervention Services (CIS), Georgia Department of Community Health, Division of Medicaid. Revised 4/16; 4/17; 4/18; 7/18; 7/19; 7/2020 04/2021.
3. American Speech-Language-Hearing Association (ASHA) "Medicare CPT Coding Rules for Speech-Language Pathology Services"https://www.asha.org/practice/reimbursement/medicare/SLP_coding_rules/. Accessed 8/1/18.
4. Therapy CPT CODE – 92507,97124,92526,97532,92506 with time" http://www.medicarepaymentandreimbursement.com/2010/07/therapy-cpt-92506925079262697532925 06. Accessed 8/1/18.
5. ASHA "Feeding and Swallowing Disorders in Children" https://www.asha.org/public/speech/swallowing/Feeding-and-Swallowing-Disorders-in-Children/. Accessed 8/1/18.
6. American Speech Language Hearing Association, 2005 Standards for the Certificate of clinical Competence in Speech--Language Pathology, at http://www.asha.org/about/membership- certification/new_standards.htm
7. Standards of Practice, the American Occupational Therapy Association. http://www.aota.org/general/docs/otsp05.pdf Clark GF. Guidelines for documentation of occupational therapy (2003). Am J Occup Ther. 2003 Nov-Dec;57(6):646-9.
8. Standards of Appropriateness of Physical Therapy Care Prepared by the WSPTA Delivery of Care Committee Board Approved 9/26/98; Revised and Board Approved 10/00 at http://www.ptwa.org/StandardsPTCare.htm
9. Georgia Department of Education ttp://www.gadoe.org/curriculum-instruction-and-assessment/pages/home-schools.aspx. Accessed 9/15/14. Sensory Integration Therapies for Children With Developmental and Behavioral Disorders. SECTION ON COMPLEMENTARY AND INTEGRATIVE MEDICINE and COUNCIL ON CHILDREN WITH DISABILITIES. *Pediatrics* 2012;129;1186; originally published online May 28, 2012; DOI: 10.1542/peds.2012-0876. http://pediatrics.aappublications.org/content/129/6/1186.full.html,. Accessed 9/15/14, 8/1/18.
10. Prescribing Therapy Services for Children with Motor Disabilities. Linda J. Michaud and Committee on Children With Disabilities. *Pediatrics* 2004;113;1836. http://pediatrics.aappublications.org/content/113/6/1836.full.html. Accessed 9/17/14. Management of Children With Autism Spectrum Disorders. Scott M. Myers and Chris Plauché Johnson. *Pediatrics* 2007;120;1162; originally published online October 29, 2007; DOI: 10.1542/peds.2007-2362. http://pediatrics.aappublications.org/content/120/5/1162.full.pdf+html. Accessed 9/17/14.

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.

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.

Attachment A. Provider Attestation Regarding IEP/IFSP for Outpatient Therapy Services

_____

Member First Name, Middle Name, Last Name

_____

Member Medicaid ID Number

I have conducted a reasonable review of the facts regarding the therapy services recommended for the above referenced member, including a discussion with the parent regarding other services that are currently provided. Based upon my review and attestation from the parent, the member does not have an existing Individualized Educational Plan (IEP) or Individualized Family Service Plan (IFSP).

I understand that under my provider participation agreement, Peach State Health Plan and applicable regulators including the Centers for Medicare and Medicaid Services, and the Georgia Department of Community Health or their representatives may inspect and evaluate my records related to members and the provision of and payment for services to audit compliance with this review requirement, and other contractual requirements and federal and state laws and regulations.

NOTE: If member does have an existing IEP or IFSP, it should be submitted, along with the request for treatment.

_____
Provider Signature

_____
Print Name

_____
Title

_____
Provider Medicaid Identification Number

_____
Date

_____
Contact Phone Number

_____
Contact Fax Number

Attachment B. Criteria for Authorization Therapy Time Length (3 months or 6 months per review)

1. Age of Child:	0-6 months	YES
	Milestones period	POSSIBLY
	Transition (IFSP to school, etc.)	NO
2. Diagnosis:	Congenital	YES
	Major Medical Diagnosis	YES
	Progressive Disease	NO
	Short Term Diagnosis	NO
	Developmental Delay or Long Term	POSSIBLY
3. Testing:	Significant Delays/Deficits	YES
	Moderate Delays/Deficits	YES
	Mild Delays/Deficits	NO
4. Goals:	Skill Acquisition	YES
	Learning	YES
	Parent/Member Teaching/Home program	NO
	Education/School based	NO
	Self Care Skills	POSSIBLY
5. Therapy Plan:	Hands on/Skilled Intervention	YES
	Teaching	POSSIBLY
	Member INDEPENDENTLY performing with Guidance	NO
	Re-evaluation/POC Imminent	NO
6. Therapy Provider:	Multiple Date Extensions	NO
	Good Outcomes	YES
	Goals Met in Time Frames	YES
	On Fraud Waste Abuse (FWA) Reports	NO