Clinical Policy: Physical, Occupational, and Speech Therapy Expanded Benefit

Reference Number: FL.CP.MP.21
Effective Date: 11/25 Revision Log

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

Description
This policy provides guidelines for the authorization of speech therapy, occupational therapy, and/or physical therapy evaluation and treatment services as an expanded benefit for Sunshine Health's Managed Medical Assistance (MMA), Long Term Care (LTC), HIV/AIDS and Serious Mental Illness (SMI) members.

Physical Therapy & Occupational Therapy: One (1) evaluation and one (1) re-evaluation per year, and up to seven (7) therapy treatment units per week with prior authorization

Speech Therapy: One (1) evaluation and re-evaluation per year; one (1) evaluation of oral an pharyngeal swallowing function per year; up to seven (7) therapy treatment units per week; one (1) augmentative and alternative communication (AAC) initial evaluation and one (1) AAC re-evaluation per year; up to four (4) thirty (30)-minute AAC fitting, adjustment, and training sessions per year with prior authorization

Policy/Criteria

I. It is the policy of Sunshine Health that *initial requests for outpatient speech therapy, occupational therapy, and/or physical therapy services* are considered **medically necessary** when all of the following criteria are met:
   A. Member must be ≥ 21 years of age;
   B. Services must be rendered in an office setting;
   C. Signs and symptoms of physical deterioration or impairment in one or more of the following areas, or for prevention of disability in one or more 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;
   D. 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.

E. 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.

F. Treatment meets accepted standards of discipline-specific clinical practice and is targeted and effective in the treatment of the diagnosed impairment or condition.

G. Treatment does not duplicate services provided by other types of therapy, or services provided in multiple settings.

H. 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;
   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.

I. Treatment is expected to do one of the following:
   1. Produce clinically significant and measurable improvement in the level of functioning within a reasonable, and medically predictable period of time;
   2. Prevent significant functional regression as part of a medically necessary program.

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

II. It is the policy of Sunshine Health that *continued authorization for outpatient speech therapy, occupational therapy, and/or physical therapy services* is considered **medically necessary** when all of the following criteria are met:

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. 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;

III. It is the policy of Sunshine Health that *discontinuation of outpatient speech therapy, occupational therapy, and/or physical therapy services* is considered **medically necessary** when one or more of the following criteria are met:

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;
   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.

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.[3,8]

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.[4]

Medically Necessary Services refer 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 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.[10]

Expanded benefits are services offered by health plans that exceed state Medicaid benefits. The services are offered at no additional cost to the state and supplement the standard Medicaid benefit package. Plans are not required to offer all expanded benefits; however, Sunshine Health offers many expanded benefits, including physical therapy, occupational therapy and speech therapy. Expanded benefits offered by Sunshine Health are listed in the member/enrollee handbook.[2,12]

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 2024, 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

HCPCS Codes	Description

Reviews, Revisions, and Approvals	Revision Date	Approval Date
Initial approval date		07/18
Annual review; no changes		05/19
Annual review; updated policy name and number; no criteria changes.		06/20

Reviews, Revisions, and Approvals	Revision Date	Approval Date
Annual review; no changes		07/21
Policy update; Added SMI to product line to coverage and Physical Therapy & Occupational Therapy: One (1) evaluation and one (1) re-evaluation per year, and up to seven (7) therapy treatment units per week with prior authorization Speech Therapy: One (1) evaluation and re-evaluation per year; one (1) evaluation of oral and pharyngeal swallowing function per year; up to seven (7) therapy treatment units per week; one (1) augmentative and alternative communication (AAC) initial evaluation and one (1) AAC re-evaluation per year; up to four (4) thirty (30)-minute AAC fitting, adjustment, and training sessions per year with prior authorization to "Purpose".		11/21
Annual review; no changes		12/22
Transitioned policy onto state specific template and sent to market for approval; policy number changed from FL.UM.62.00 to FL.CP.MP.21.	06/23	
Annual review; minor grammatical changes; no criteria changes.	11/23	
Annual review. Added HIV/AIDS to description. Removed criteria throughout policy that references members less than 21 years of age. Minor grammatical edits to criteria with no impact to meaning. Background updated. References reviewed and updated.	11/25	

References

1. CP.MP.49 Physical, Occupational, and Speech Therapy Services.
2. Agency for Health Care Administration. Statewide Medicaid Managed Care Expanded Benefits. https://ahca.myflorida.com/content/download/9113/file/Expanded-Benefits_Program_Highlight_Final_101618.pdf. Effective October 16, 2018. Accessed November 3, 2025.
3. 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. Updated May 19, 2014. Accessed November 3, 2025.
4. American Physical Therapy Association (APTA). Standards of practice for physical therapy . https://www.apta.org/siteassets/pdfs/policies/standards-of-practice-pt.pdf. Updated August 12, 2020. Accessed November 3, 2025.
5. American Speech Language Hearing Association. Speech-language pathology medical review guidelines. https://www.asha.org/practice/reimbursement/SLP-medical-review-guidelines/. Published 2015. Accessed November 3, 2025.
6. 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 to 690. doi:10.5014/ajot.62.6.684.
7. Change Healthcare InterQual® criteria.
8. MCG (formerly Milliman Care Guidelines®) guidelines.

9. Revised by the Commission on Practice, 2020:, Casto SC, Davis C, et al. Standards of Practice for Occupational Therapy. *Am J Occup Ther*. 2022;75(Supplement_3):7513410030. doi:10.5014/ajot.2021.75S3004
10. World Physiotherapy. Standards of physical therapy practice guideline. https://world.physio/sites/default/files/2020-07/G-2011-Standards-practice.pdf. Published 2011. Accessed November 3, 2025.
11. Agency for Health Care Administration (AHCA). State of Florida Medicaid. Expanded benefits RPA grid 2025. https://ahca.myflorida.com/content/download/25560/file/SMMC%203.0%20Expanded%20Benefits%20Grid_Health%20Plan_02012025v2.pdf. Effective February 1, 2025. Accessed November 4, 2025.

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/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.

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/enrollees, 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/enrollees and their representatives agree to be bound by such terms and conditions by providing services to members/enrollees and/or submitting claims for payment for such services.

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.