CareSource

ADMINISTRATIVE POLICY STATEMENT
Georgia Medicaid

Policy Name & Number	Date Effective
Outpatient Physical Therapy, Occupational Therapy, and Speech-Language Pathology-GA MCD-AD-0986	09/01/2025-07/31//2026
Policy Type	
ADMINISTRATIVE	

Administrative Policy Statement prepared by CareSource and its affiliates are derived from literature based on and supported by clinical guidelines, nationally recognized utilization and technology assessment guidelines, other medical management industry standards, and published MCO clinical policy guidelines. Medically necessary services include, but are not limited to, those health care services or supplies that are proper and necessary for the diagnosis or treatment of disease, illness, or injury and without which the patient can be expected to suffer prolonged, increased or new morbidity, impairment of function, dysfunction of a body organ or part, or significant pain and discomfort. These services meet the standards of good medical practice in the local area, are the lowest cost alternative, and are not provided mainly for the convenience of the member or provider. Medically necessary services also include those services defined in any Evidence of Coverage documents, Medical Policy Statements, Provider Manuals, Member Handbooks, and/or other policies and procedures.

Administrative Policy Statements prepared by CareSource and its affiliates do not ensure an authorization or payment of services. Please refer to the plan contract (often referred to as the Evidence of Coverage) for the service(s) referenced in the Administrative Policy Statement. If there is a conflict between the Administrative Policy Statement and the plan contract (i.e., Evidence of Coverage), then the plan contract (i.e., Evidence of Coverage) will be the controlling document used to make the determination.

According to the rules of Mental Health Parity Addiction Equity Act (MHPAEA), coverage for the diagnosis and treatment of a behavioral health disorder will not be subject to any limitations that are less favorable than the limitations that apply to medical conditions as covered under this policy.

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A. Subject

Outpatient Physical Therapy, Occupational Therapy, and Speech-Language Pathology

B. Background

Occupational, physical, speech-language pathology, and feeding therapy services help improve the lives of patients through comprehensive evaluations, recommendations for adaptive equipment and training in use, and guidance and education for family members and caregivers.

Occupational therapy (OT) focuses on adapting the environment of the member to fit the member's needs. This includes helping members regain skills after an injury, supporting older adults who have experienced a physical or mental change, and teaching children with disabilities how to increase participation in school and social activities.

Physical therapy (PT) focuses on increasing the member's physical ability to participate in the environment. This includes helping people regain physical strength, reduce pain, and increase function and independence after an injury or mental change. PT teaches members how to manage a physical condition, prevent further injury, and achieve long-term health benefits.

Speech-language pathology services (ST) include the diagnosis and treatment of speech and language disorders. These services are provided by speech-language pathologists within the scope of a designated practice. Speech-language pathologists diagnose and treat swallowing disorders (dysphagia) and communication disabilities. Speech, language, and swallowing disorders can be a result of a variety causes, such as hearing loss, autism, developmental delays, Parkinson's disease, a cleft palate, stroke, or brain injury.

Feeding therapy and treatment of swallowing dysfunction and/or oral function (FT) for feeding involves the treatment of impairments or functional limitations of mastication, the preparatory phase, oral phase, pharyngeal stage, and esophageal phase of swallowing. Feeding therapists also make appropriate recommendations regarding diet and compensatory techniques and instruct in direct/indirect therapies to facilitate oral motor control for feeding.

A wide variety of settings may be used to provide physical therapy, occupational therapy, and speech-language pathology services, including hospitals, private practices, outpatient clinics, nursing homes and rehabilitation facilities, and the home. Location of services is determined by many factors, including the physical and medical condition of the individual receiving treatment, the need for specialized equipment or personnel, and the location of the individual in relation to needed services. Safety is a major concern, and the location in which services are provided should be adequately resourced and staffed to address potential medical needs that may arise during a treatment session.

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C. Definitions

- **Medically Necessary/Medical Necessity** – Care based upon generally accepted medical practices in light of conditions at the time of treatment which are:
  - Appropriate and consistent with the diagnosis and the omission of which could adversely affect or fail to improve the eligible enrollee's condition.
  - Compatible with the standards of acceptable medical practice in the US.
  - Provided in a safe and appropriate setting given the nature of the diagnosis and the severity of the symptoms.
  - Not provided solely for the convenience of the eligible enrollee or the convenience of the health care provider or hospital.
  - Not primarily custodial care.
- **Home Exercise Program (HEP)** – A 6-week program requiring an exercise prescription and/or plan and a follow-up documented in the medical record after completion, or documentation of the inability to complete a HEP due to a stated physical reason (eg, increased pain, inability to physically perform exercises). Patient inconvenience or noncompliance without explanation does not constitute an inability to complete.

D. Policy

I. CareSource requires all outpatient occupational, physical, speech pathology, and feeding therapy services to meet medical necessity criteria.

II. Evaluations
   A. Evaluations for outpatient speech therapy are limited to 2 a year, per member.
   B. Evaluations for outpatient physical therapy and occupational therapy are limited to 1 initial evaluation a year, per member, per discipline, per diagnosis and 1 re-evaluation every 180 days, per member, per discipline, per diagnosis.

III. CareSource considers outpatient occupational, physical, speech pathology, and feeding therapy services provided in a non-facility outpatient setting (eg, community provider, private practice, HEP) a covered service when documentation by the patient's healthcare provider and the evaluating therapist supports medical necessity using MCG criteria (when available) or the *Speech Therapy and Language Disorder Rehabilitation GA-MCD-MM-0714* policy relative to the appropriate diagnosis and service.

IV. CareSource considers outpatient occupational, physical, speech pathology, and feeding therapy services medically necessary in a hospital outpatient hospital department or hospital outpatient clinic when **ONE** of the following criteria are met:
   A. One of the following conditions is present:
      1. The prescribed physical therapy, occupational therapy, or speech-language pathology regimen requires specialized equipment or services which would only routinely be available in the hospital outpatient department or hospital outpatient clinic setting.

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2. The inherent complexity of, or risk posed by, the prescribed physical therapy, occupational therapy or speech-language pathology regimen is such that it can only be performed safely and effectively by or under the general supervision of skilled medical personnel in a hospital setting.
3. The individual's medical status requires enhanced monitoring beyond what would routinely be needed for physical therapy, occupational therapy, or speech-language pathology services.
4. The equipment for the size of the individual (eg, a very young or small child) is not available in a freestanding facility.
5. There is significant risk of sudden life-threatening changes in the individual's clinical condition and immediate access to specific services provided in a medical center/hospital setting is considered advisable (eg, access to emergency resuscitation equipment and personnel, inpatient admission, intensive care facilities). Clinical conditions that may warrant such access include, but are not limited to, the following:
   a. acute mental status changes
   b. history of falls with significant bleeding
   c. history or significant risk of a major cardiac or thromboembolic event
   d. significant burn care management

B. There are no other geographically accessible appropriate alternative sites for the individual to receive the prescribed physical therapy, occupational therapy or speech-language pathology services.

V. Non-Covered Services

A. Physical therapy, occupational therapy, and speech-language pathology services in the hospital outpatient department or hospital outpatient clinic level of care are considered not medically necessary, for all other indications, including when the criteria above have not been met.

B. Training in nonessential self-help, recreational tasks, or athletic performance is not covered. Therapeutic care is care provided to relieve the functional loss associated with an injury or condition and is necessary to return the patient to the functioning level required to perform their activities of daily living, instrumental activities of daily living and work activities. Therapy to return to a sport is non-covered.

C. Hippotherapy, or equine movement therapy (CPT code S8940), describes a form of physical, occupational, or speech and language therapy using horses. It is a form of therapeutic horseback riding or equestrian therapy that is considered investigational and not medically necessary in all cases.

E. Conditions of Coverage

N/A

F. Related Policies/Rules

Medical Necessity Determinations
Speech Therapy and Language Disorder Rehabilitation

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G. Review/Revision History

DATES		ACTION
Date Issued	02/03/2021	New Policy
Date Revised	02/16/2022	Added Evaluations Section II
	03/15/2023	Removed Covid red box. No content changes; updated references. Approved at committee.
	03/27/2024	Updated references. Approved at Committee.
	04/23/2025	Updated references. Approved at Committee.
Date Effective	09/01/2025	
Date Archived	07/31/2026	This Policy is no longer active and has been archived. Please note that there could be other Policies that may have some of the same rules incorporated and CareSource reserves the right to follow CMS/State/NCCI guidelines without a formal documented Policy.

H. References

1. *Children's Intervention Services (CIS) Provider Manual*. Georgia Dept of Community Health; 2025. Accessed March 25, 2025. www.georgia.gov
2. Content Guide to Ambulatory Care. MCG Health; 2024. 28th ed. Accessed March 24, 2024. www.careweb.careguidelines.com
3. Definitions, GA CODE ANN. § 33-20A-31 (2023).
4. *Introduction to Medicaid*. American Speech-Language-Hearing Association. Accessed March 25, 2025. www.asha.org
5. *Policies and Procedures for Hospital Services*. Georgia Dept of Community Health; 2025. Accessed March 25, 2025. www.georgia.gov

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The ADMINISTRATIVE Policy Statement detailed above has received due consideration as defined in the ADMINISTRATIVE Policy Statement Policy and is approved.