PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY / PROCEDURE

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<tr><td colspan="4">Approval Signature: Robert Moore, MD, MPH, MBA</td><td colspan="3">Approval Date: 08/12/2026</td></tr>
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I. RELATED POLICIES:

A. MCUP3041 – Treatment Authorization Request (TAR) Review Process
B. MCCP2024 – Whole Child Model for California Children's Services (CCS)
C. MCUP3125 – Gender Dysphoria/ Surgical Treatment
D. MPUG3011 – Criteria for Home Health Services
E. MCUP3113 – Telehealth Services

II. IMPACTED DEPTS:

A. Health Services
B. Claims
C. Member Services

III. DEFINITIONS:

A. California Children's Services (CCS): A state program for children up to 21 years of age, who have been determined eligible for the CCS program due to the presence of certain diseases or health problems.
B. Medical Necessity: Medical necessity means reasonable and necessary services to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness or injury.
C. Occupational Therapy (OT) provides task-oriented therapeutic activities and exercises designed to significantly improve, develop or restore physical functions lost or impaired as a result of a disease or injury; or to help an individual relearn daily living skills or compensatory techniques to improve the level of independence in the activities of daily living.
D. Physical Therapy (PT) is a service with an established theoretical and scientific base and widespread clinical applications in the restoration and promotion of optimal physical function. Physical therapists diagnose and manage movement dysfunction and enhance physical and functional abilities.
E. Physical and Occupational therapy services are designed to:
    1. Assess the existence or extent of a medical condition;
    2. Assess the impact of a medical condition, injury or surgery upon function and role performance;
    3. Restore deterioration in physical function and physical performance of activities of daily living from previous function, due to medical condition, injury, or surgery.
    4. Treat physical limitations or physical dysfunctions in physical activities or activities of daily living, due to a medical condition, surgery or procedure.
    5. Restore deterioration in cognitive skills that impact the ability to perform activities of daily living from previous function, due to medical condition, injury or surgery and treat sensory dysfunctions

due to a medical condition, injury or surgery that impact oral/pharyngeal intake or lead to bodily damage.

F. Speech Therapy (ST): The treatment of speech, swallowing and communication disorders. The approach used depends on the disorder. It may include physical exercises to strengthen the muscles used in speech and swallowing (oral-motor work), speech drills to improve clarity, or sound production practice to improve articulation.

IV. ATTACHMENTS:

A. N/A

V. PURPOSE:

To define the treatment authorization process for physical, occupational and speech therapies in the outpatient setting.

VI. POLICY / PROCEDURE:

A. Criteria for Remote PT, OT, and ST:
PT, OT, and ST services may be provided virtually, if the service provided does not require in-person or manual examination, manipulation or therapeutic techniques (see CMS and DHCS policies and Partnership policy MCUP3113 Telehealth Services).

B. General Guidelines for Authorization of PT, OT and ST.
   1. No Referral Authorization Form (RAF) is required for PT, OT, or ST services, but services must be ordered through a written prescription of a licensed physician (Doctor of Medicine, Osteopathy, Podiatric medicine, or Optometry (only for low vision rehabilitation) or non-physician practitioner (Physician Assistant, Clinical Nurse Specialist, Nurse Practitioner or Dentist).
   2. For all Members, no TAR or RAF is required for the initial evaluation.

C. Services That Do NOT Require a TAR
   1. Partnership does *not* require Treatment Authorization Requests (TARs) from contracted providers for PT, OT, or ST for:
      a. Members age 21 and over: No TAR required for up to 12 visits for a specific diagnosis (limit one visit per day) in a rolling 12-month period of time.
         1) A TAR will be required for services in excess of 12 visits for a specific diagnosis.

D. Services That Require a TAR
   1. After an initial evaluation, Partnership does require a TAR for PT, OT, or ST services for the following circumstances:
      a. Members under age 21
      b. Non-contracted Providers
      c. Home Health Services (A TAR is required for all ages for all PT, OT, or ST services provided through a home health agency. Refer to policy MPUG3011 Criteria for Home Health Services.)
   2. Submission Guidelines When a TAR is Required
      a. Partnership Members can be referred by a physician (Doctor of Medicine, Osteopathy, Podiatric medicine, or Optometry (only for low vision rehabilitation) or non-physician practitioner (Physician Assistant, Clinical Nurse Specialist, Nurse Practitioner or Dentist) for one consultation visit, through written prescription, for services to be rendered by a qualified Medi-Cal provider acting within the scope of their practice. As noted above, no TAR or RAF is required for the initial consultation/ evaluation.
      b. Following the initial evaluation, the service provider must submit a TAR for the requested services. The TAR should document, at a minimum, the following information:
         1) Medical diagnosis necessitating the service with a summary of medical condition
         2) Related medical conditions

3) Functional limitations
4) Dates and length of treatment
5) Therapeutic goals of treatment and current functional status of the patient with respect to these goals
6) Dates of planned progress review
7) Specific services to be rendered (e.g. evaluation, treatment, modalities)

c. Partnership authorizes ancillary services on a case-by-case basis, provided that medical necessity has been demonstrated in the submitted documentation.

d. The Nurse Coordinators/ Utilization Management (UM) staff review each TAR and consult with the referring physician or ancillary provider as needed to determine the medical necessity of the requested services. If the Nurse Coordinator is unable to approve the requested service based upon information available, the case is submitted to one of Partnership's reviewing physicians for consideration. Determination that a requested service is not medically necessary may only be rendered by a physician.

1) Occupational and physical therapy may be considered medically necessary when:
   a) There is a reasonable expectation, determined by a physical or occupational therapist and the attending physician, that in a predictable period of time the therapy will achieve measurable improvement in the patient's mobility or activities of daily living.
   b) Measurable reversal of deterioration from previous levels of cognitive or communication functions.
   c) The services are used to assess the existence or extent of impairment due to a medical condition.
   d) A "reasonable expectation" referenced above shall be based upon evidence-based medicine. A reasonable expectation shall take into consideration the patient's mental alertness to participate and benefit from the therapy process.
   e) Any episode of physical or occupational therapy is not medically necessary and will not be approved when a patient has met established treatment goals or has stabilized and is not expected to continue to make significant gains.
2) Speech Therapy services for Members age 21 or over may be considered medically necessary based upon the receipt of appropriate medical documentation demonstrating that the Member and services meet the following criteria:
   a) Speech Pathologists are reimbursed for services only if the services are performed in response to the written referral of licensed practitioners, acting within the scope of their practice.
   b) Appropriate adult candidates for speech therapy must be able to participate in and/or benefit from the therapy process, have adequate attention span, cooperation and endurance to participate, and demonstrate behavior conductive to engaging in the process.
   c) Speech therapy as conversational therapy/ voice training should be considered prior to any pitch changing surgery for transgender or gender nonconforming beneficiaries as discussed in policy MCUP3125 Gender Dysphoria/Surgical Treatment.
   d) Speech therapy services are reviewed in accordance with clinical guidelines when considered medically necessary only when there is reasonable expectation that they will achieve significant, measurable improvement in the Member's communication, cognition or swallowing in a reasonable and predictable period of time as determined by the treating therapist and referring provider.
   e) A "reasonable expectation" referenced above shall be based upon evidence-based medicine. A reasonable expectation shall take into consideration the patient's mental alertness to participate in and benefit from the therapy process.

f) A course of speech therapy shall be determined to be no longer medically necessary when a patient has met established treatment goals or has stabilized and is not expected to continue to make significant gains.

3) The following are examples of conditions where therapy may be considered medically necessary based upon the receipt of appropriate medical documentation:
   a) Musculoskeletal Pathology or Dysfunction, including limitations in joint range of motion and/or mobility, deterioration from previous function of muscle strength and/or decreased endurance, soft tissue dysfunction, alterations in postural control and alignment.
   b) Neuromuscular Pathology or Dysfunction, including deterioration from previous function of gross and/or fine motor coordination, alterations in tone- increased or decreased, deterioration from previous function of motor planning skills, deterioration from previous function of balance, loss of selective motor control, decrease in bilateral integration.
   c) Neurocognitive Pathology or Dysfunction, including sensory dysfunctions regarding food textures and oral tactile defensiveness when impacting overall health; deterioration from previous function in cognitive, self-care or adaptive skills.
   d) Pathology or Dysfunction of the Vascular System, including primary or secondary lymphedema, edema and venous stasis.
   e) Pathology or Injury to Skin, including burns and/or sores following injury or surgery, open wounds.
   f) Assessments of Impairment Related to Medical Condition, including appropriate assessments as part of a multidisciplinary or interdisciplinary team of motor skills disorders and physical functions; appropriate individual assessments of post therapy functions and periodic review of appropriate maintenance activities for the patient and family
   g) Design of Maintenance Activities, including physical exercise, drills, techniques that a patient performs outside of therapy or after any therapy has concluded.
4) The following services are generally not considered “medically” necessary or are not covered:
   a) Recreational therapy
   b) Activities that provide diversion or general motivation
   c) Exercise programs for healthy individuals, including development and delivery of exercise programs; assisted walking
   d) Programs for communication/cognitive deficits from developmental disorders - where deficits do not impact overall health
   e) Maintenance physical or occupational therapy to preserve the patient's present level of function and prevent regression of that function. Maintenance begins when the therapeutic goals of the treatment plan have been achieved and when no further functional progress is apparent or expected to occur. Maintenance does not require the skills of a qualified provider of physical or occupational therapy services. The patient is responsible for practicing learned drills, techniques and exercises to preserve his or her present level of function and prevent regression of that function. Maintenance includes ongoing supervision of independent exercise programs, supervision/ observation of activities of daily living, and supervision of independent transfer activities.
      i. For Members residing in a skilled nursing facility, the facility must provide maintenance therapy that is included in the room and board fee and not separately reimbursable.

e. If therapy is required beyond the visits initially approved, a new TAR must be submitted.
f. The approval of continuation of therapy will be based on documentation of measurable improvement in the patient's condition in a reasonable and predictable period of time, based on the written care plan and the clinical judgment of the treating physical or occupational therapist with the patient's referring physician. Regular evaluation of the patient is required to determine that continuation of therapy is medically appropriate. The medical need for continuation must be documented on the TAR submitted to Partnership.
    1) Continued therapy will not be approved once a Member has met established treatment goals, or has stabilized and is not expected to continue to make significant gains, based on the written care plan and the clinical judgment of the treating PT or OT in conjunction with the patient's referring physician.

3. Speech Therapy Related to Hearing Loss for Members Under 21 Years of Age:
    a. Partnership Members who have a California Children's Services (CCS)-eligible condition are enrolled in the Whole Child Model (WCM) program. The WCM program integrates CCS program-covered services with Members' regular Medi-Cal benefits to provide seamless care for children and youth.
        1) Partnership covers the medical condition of hearing loss for hearing tests, evaluations by audiologists, and medical evaluations by head and neck surgeons and physicians in other clinical specialties.
        2) Under the WCM program, Partnership also covers speech and language therapy for hearing impaired children who have hearing aids or need to use sign language, but do not have physical impairment of the articulators. For these conditions, the Member should be referred to CCS in the county of residence to determine program eligibility. Once CCS program eligibility is established, all medically necessary covered services, including case management and authorization of services, for CCS-eligible conditions will be provided by Partnership under the WCM program. See policy MCCP2024 Whole Child Model for California Children's Services (CCS).
    b. Speech Pathologists are reimbursed for services only if the services are performed in response to the written referral of licensed practitioners, acting within the scope of their practice.
    c. A Member may receive services through the Local Educational Agency (LEA) but is not required to do so prior to receiving therapy benefits under Partnership. If a Member is receiving medically necessary services through the LEA, Partnership will coordinate with the LEA to provide additional services to the extent determined to be medically necessary. For example, if it is determined that the Member medically requires speech therapy three times per week, and he/she receives speech services by the LEA one time per week, Partnership will approve the additional two visits per week if criteria are met.

VII. REFERENCES:

A. Social Security Act Section 1905(r)
B. Medi-Cal Provider Manual/ Guidelines: Physical Therapy (*phys*); Occupational Therapy *(occu)*; Speech Therapy *(speech)*; Medicine: Telehealth (*medne tele*), Home Health Agencies *(home hlth)*
C. California Children's Services (CCS) Medical Eligibility
D. Consolidated Appropriations Act, 2026 (*extends Medicare telehealth flexibilities through 2027*)

VIII. DISTRIBUTION:

A. Partnership Department Directors
B. Partnership Provider Manual

IX. POSITION RESPONSIBLE FOR IMPLEMENTING PROCEDURE: Chief Health Services Officer

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Original Date: 06/20/2012		**Next Review Date: 08/12/2027** **Last Review Date: 08/12/2026**	
Applies to:	☒ **Medi-Cal**	☐ **Employees**	

X. REVISION DATES: 01/20/16; 11/16/16; 11/15/17; *02/13/19; 03/11/20; 06/10/20; 01/13/21; 02/09/22; 02/08/23; 03/13/24; 08/14/24; 09/10/25, 08/12/26

*Through 2017, Approval Date reflective of the Quality/Utilization Advisory Committee meeting date. Effective January 2018, Approval Date reflects that of the Physician Advisory Committee's meeting date.

PREVIOUSLY APPLIED TO: N/A

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In accordance with the California Health and Safety Code, Section 1363.5, this policy was developed with involvement from actively practicing health care providers and meets these provisions:

- Consistent with sound clinical principles and processes
- Evaluated and updated at least annually
- If used as the basis of a decision to modify, delay or deny services in a specific case, the criteria will be disclosed to the provider and/or enrollee upon request

The materials provided are guidelines used by Partnership to authorize, modify or deny services for persons with similar illnesses or conditions. Specific care and treatment may vary depending on individual need and the benefits covered under Partnership.

Partnership's authorization requirements comply with the requirements for parity in mental health and substance use disorder benefits in 42 CFR 438.910.