PROVIDER POLICIES & PROCEDURES

HABILITATIVE THERAPY SERVICES (PHYSICAL, OCCUPATIONAL, AND SPEECH THERAPY) FOR INDIVIDUALS DIAGNOSED WITH INTELLECTUAL DISABILITY/DEVELOPMENTAL DELAY/AUTISTIC DISORDER/OTHER DEVELOPMENTAL DISORDER

The primary purpose of this document is to assist providers enrolled in the Connecticut Medical Assistance Program (CMAP Providers) with the information needed to support a medical necessity determination for habilitative therapy services (physical, occupational, and speech therapy) for individuals whose primary diagnosis is intellectual disability, developmental delay, autism or other developmental disorder. By clarifying the information needed for prior authorization of services, HUSKY Health hopes to facilitate timely review of requests so that individuals obtain the medically necessary care they need as quickly as possible.

Benefits and Prior Authorization Requirements
Please refer to the HUSKY Health Program Benefit Grids for coverage information and prior authorization requirements for therapy services performed in a home, independent therapy, and rehabilitation clinic settings to individuals whose primary diagnosis is intellectual disability, developmental delay, autism or other developmental disorder.

CLINICAL GUIDELINE
Coverage guidelines for habilitative therapy services for individuals diagnosed with intellectual disability, developmental delay, autistic disorder, or other developmental disorder are made in accordance with the Department of Social Services (DSS) definition of Medical Necessity. Coverage determinations are based on an assessment of the individual and his or her unique clinical needs. If the criteria conflict with the definition of Medical Necessity, the definition of Medical Necessity shall prevail.

Habilitative Physical, Occupational, or Speech Therapy Services: Initial Authorization Requests
Habilitative physical, occupational, and speech therapy services for individuals whose primary diagnosis is intellectual disability, developmental delay, autistic disorder, or other developmental disorder may be considered medically necessary when:

A. The services are not duplicative of school-based services currently provided or if some are duplicative, there is documentation to support the need for additional outpatient services;
B. The therapy is intended to keep, learn, or improve skills and function for daily living which have not (but normally would have) developed or which are at risk of being lost secondary to the individual's diagnosis;
C. The services require the judgement, knowledge, and skills of a CT licensed provider of PT, OT, or ST services (i.e. physical therapist, physical therapy assistant, occupational therapist, occupational therapy assistant, speech language pathologist);
D. The treatment plan includes:

1. Diagnosis;
2. Current level of functional impairment or developmental delay supported by age-appropriate standardized assessments (*Note: a summary of how the results compare to expected values for the individual's age must be included*);
3. A description of the individual's habilitation potential;
4. Skilled interventions to be performed;
5. Anticipated frequency and duration of services;
6. Long- and short-term treatment goals with projected time frame for achievement (*Note: treatment goals and objectives must be specific and measurable*);
7. Quantitative outcome measures that will be used to assess function objectively;
8. A plan for individual and/or caregiver education/home program;

E. If intensive services are requested (frequency of services is three (3) times per week or greater):
   1. A short-term goal has been identified and deemed quickly achievable; OR
   2. After a medical event or surgery, intense therapy is needed to regain temporarily lost function (the individual can then return to their regular therapy schedule); OR
   3. New adaptive equipment has been ordered, and the individual requires a short course of intense therapy for training with the new device; OR
   4. A new problem or goal has been identified based on a change in functional status or developmental expectation and a more intensive "burst" of therapy is needed; AND
   5. The individual can tolerate an intensity of services at three (3) times per week or greater.

Note: If approved, authorization will be given for up to twelve (12) weeks.

Habilitative Physical, Occupational, and Speech Therapy Services: Reauthorization Requests
Requests to continue habilitative physical, occupational, and speech therapy services for individuals whose primary diagnosis is intellectual disability, developmental delay, autistic disorder, or other developmental disorder may be considered medically necessary when:

A. Submitted documentation objectively verifies that, at a minimum, functional status is kept or developed;
B. An updated treatment plan documents the following:
   1. Anticipated frequency and duration and rationale for continuation of services;
   2. Demonstrated measurable, functional progress towards goals including an assessment of potential achievement and likelihood of goal attainment/achievement;
   3. A plan for transition to a home program/discharge with an assessment of the individual's current level of readiness for transition/discharge;
   4. Demonstrated functional progress on quantitative outcome measures previously used to assess function;
C. If intensive services are requested (frequency of services is three [3] times per week or greater):
   1. A short-term goal has been identified and deemed quickly achievable; OR
   2. After a medical event or surgery, intense therapy is needed to regain temporarily lost function (the individual can then return to their regular therapy schedule); OR
   3. New adaptive equipment has been ordered, and the individual requires a short course of intense therapy for training with the new device; OR
   4. A new problem or goal has been identified based on a change in functional status or developmental expectation and a more intensive "burst" of therapy is needed; AND
   5. The individual can tolerate an intensity of services at three (3) times per week or greater.

Note: If approved, authorization will be given for up to twelve (12) weeks.

NOTE: EPSDT Special Provision
Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) is a federal Medicaid requirement that requires the Connecticut Medical Assistance Program (CMAP) to cover services, products, or procedures for Medicaid enrollees under 21 years of age where the service or good is medically necessary health care to correct or ameliorate a defect, physical or mental illness, or a condition identified through a screening examination. The applicable definition of medical necessity is set forth in Conn. Gen. Stat. Section 17b-259b (2011) [ref. CMAP Provider Bulletin PB 2011-36].

LIMITATIONS

Physical, occupational, and speech therapies, and audiology services are not covered for individuals 21 years of age and older when provided in an independent setting. Individuals must receive these services in a clinic setting. This limitation applies only to therapy providers and therapy groups. Physicians and physician groups are not subject to this limitation.

PROCEDURE

The following information is needed to review requests for therapy services:

1. A completed authorization request via web portal. Note: the authorization request must list the name of the physician, advanced practice registered nurse (APRN), physician assistant (PA) that is referring/ordering the therapy services as the referring provider;
2. A therapy evaluation that includes standardized assessment scores and treatment plan;
3. For individuals under 21 years of age, an attestation* from the treating therapist stating:
    a. That the individual is not receiving school-based therapy services;
    b. That the individual is receiving school-based services and the requested services are not duplicative of school-based services; or
    c. That the requested services are duplicative of school-based services but are medically necessary. The attestation must indicate the reason services are medically necessary; and
4. An updated treatment plan as outlined in the *Clinical Guideline* section of this policy and a minimum of four (4) daily treatment notes (***reauthorization requests only***)

***Note: a copy of the individual education program (IEP) is not required.**

EFFECTIVE DATE

This Policy is effective for prior authorization requests for therapy services for individuals covered under the HUSKY Health Program on or after January 1, 2026.

CODES AND CODE GROUPINGS

Outpatient Hospitals:

Modality	Revenue Center Codes (RCC)
Physical Therapy	0421, 0423, 0424
Occupational Therapy	0431, 0433, 0434
Speech Therapy	0441, 0443, 0444

Rehabilitation Clinics:

Code Group	Benefit	CPT Codes/Modifiers
RCSTI	ST Initial	92507, 92508, 92521, 92522, 92523, 92524, 92526, 97129, 97130 (option to use modifier GN for all codes)
RCSTR	ST Re-authorization	
RCPTI	PT Initial	20560, 20561, 29125, 29126, 29131, 29260, 29280, 29540, 29580, 29581, 29584, 97010, 97012, 97014, 97016, 97018, 97022, 97026, 97032-97035, 97110, 97112, 97113, 97116, 97124, 97129, 97130, 97140, 97150, 97158, 97161, 97162, 97163, 97164, 97530, 97533, 97535, 97542, 97597-97602, 97760, 97761, 97763 (all with modifier GP, or with modifiers GP and 59, or with modifier CQ, or with modifier CO, or with modifiers CO and 59, or with modifiers CO and 95, or with modifiers CO, 59, and 95)
RCPTR	PT Re-authorization	
RCOTI	OT Initial	20560, 20561, 29125, 29126, 29131, 29260, 29280, 29540, 29580, 29581, 29584, 97010, 97012, 97014, 97016, 97018, 97022, 97026, 97032-97035, 97110, 97112, 97113, 97116, 97124, 97140, 97150, 97158, 97165, 97166, 97167, 97168, 97530, 97533, 97535, 97542, 97597, 97598, 97602, 97760, 97761, 97763 (all with modifier GO, or with modifier CO, or with modifiers GO and CO, or with modifiers GO, CO, and 59)
RCOTR	OT Re-authorization	

For services performed in a rehabilitation clinic not included in the table above request authorization using the applicable CPT or HCPCS code.

Independent Therapists:

Code Group	Benefit	CPT Codes
INSTI	ST Initial	92507, 92508, 92521, 92522, 92523, 92524, 92526, 92630, 92633, 97129, 97130
INSTR	ST Re-authorization	
INPTI	PT Initial	20560, 20561, 97010-97150, 97161-97168, 97530, 97535, 97542, 97760, 97761, 97763
INPTR	PT Re-authorization	
INOTI	OT Initial	20560, 20561, 97010-97150, 97161-97168, 97530, 97535, 97542, 97760, 97761, 97763
INOTR	OT Re-authorization	

Physician Therapy Providers:

Code Group	Benefit	CPT Codes
MDPTI	Physician Therapy Initial	97010-97530, 97533-97546

Please note that authorization is based on medical necessity at the time the authorization is issued and is not a guarantee of payment. Payment is based on the individual having active coverage, benefits and policies in effect at the time of service.

To determine if a service or procedure requires prior authorization, CMAP Providers may refer to the *Benefit and Authorization Grids* summaries on www.ct.gov/husky by clicking on "For Providers" followed by "Benefit Grids". For a definitive list of benefits and service limitations, CMAP Providers may access the CMAP provider fee schedules and regulations at www.ctdssmap.com.

MDPTR	Physician Therapy Re-authorization	

DEFINITIONS

1. **HUSKY A**: Connecticut children and their parents or a relative caregiver; and pregnant women may qualify for HUSKY A (also known as Medicaid). Income limits apply.
2. **HUSKY B**: Uninsured children under the age of 19 in higher income households may be eligible for HUSKY B (also known as the Children's Health Insurance Program) depending on their family income level. Family cost-sharing may apply.
3. **HUSKY C**: Connecticut residents who are age 65 or older or residents who are ages 18-64 and who are blind, or have another disability, may qualify for Medicaid coverage under HUSKY C (this includes Medicaid for Employees with Disabilities (MED-Connect), if working). Income and asset limits apply.
4. **HUSKY D**: Connecticut residents who are ages 19-64 without dependent children and who: (1) do not qualify for HUSKY A; (2) do not receive Medicare; and (3) are not pregnant, may qualify for HUSKY D (also known as Medicaid for the Lowest-Income populations).
5. **HUSKY Health Program**: The HUSKY A, HUSKY B, HUSKY C, HUSKY D and HUSKY Limited Benefit programs, collectively.
6. **HUSKY Limited Benefit Program or HUSKY, LBP**: Connecticut's implementation of limited health insurance coverage under Medicaid for individuals with tuberculosis or for family planning purposes and such coverage is substantially less than the full Medicaid coverage.
7. **Medically Necessary or Medical Necessity**: (as defined in Connecticut General Statutes § 17b-259b) Those health services required to prevent, identify, diagnose, treat, rehabilitate or ameliorate an individual's medical condition, including mental illness, or its effects, in order to attain or maintain the individual's achievable health and independent functioning provided such services are: (1) Consistent with generally-accepted standards of medical practice that are defined as standards that are based on (A) credible scientific evidence published in peer-reviewed medical literature that is generally recognized by the relevant medical community, (B) recommendations of a physician-specialty society, (C) the views of physicians practicing in relevant clinical areas, and (D) any other relevant factors; (2) clinically appropriate in terms of type, frequency, timing, site, extent and duration and considered effective for the individual's illness, injury or disease; (3) not primarily for the convenience of the individual, the individual's health care provider or other health care providers; (4) not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the individual's illness, injury or disease; and (5) based on an assessment of the individual and his or her medical condition.
8. **Occupational therapy:** Services prescribed by a physician for the evaluation, planning, and implementation of a program of purposeful activities to develop or maintain adaptive skills necessary to achieve the maximal physical and mental functioning of the individual in his daily pursuits. The practice of "occupational therapy" includes, but is not limited to, evaluation and treatment of individuals whose abilities to cope with the tasks of living are threatened or impaired by physical illness or injury, emotional disorder, congenital or development disability, using (1) such treatment techniques as task-oriented activities to prevent or correct physical or emotional deficits or to minimize the disabling effect of these deficits in the life of the individual, (2) such evaluation techniques as assessment of sensory motor abilities, assessment of the development of self-care activities and capacity for independence, assessment of the physical capacity for prevocational and work tasks, assessment of play and leisure performance, and appraisal of living areas for the

handicapped, (3) specific occupational therapy techniques such as activities of daily living skills, the fabrication and application of splinting devices, sensory motor activities, the use of specifically designed manual and creative activities, guidance in the selection and use of adaptive equipment, specific exercises to enhance functional performance, and treatment techniques for physical capabilities for work activities. Services are performed by an occupational therapist to evaluate the individual's level of functioning and develop a plan of treatment. The implementation of the plan may be carried out by an occupational therapy assistant functioning under the general supervision of the occupational therapist.

9. **Physical therapy:** (1) diagnostic services to determine an individual's level of functioning, employing such performance tests as measurements of strength, balance, endurance, and range of motion; (2) treatment services which utilize therapeutic exercises and modalities of heat, cold, water, and electricity, for the purpose of preventing, restoring, or alleviating a lost or impaired physical function. Services are performed by a licensed physical therapist who develops a written individual program of treatment. The term "physical therapy" does not include the use of cauterization or the use of Roentgen rays or radium for diagnostic or therapeutic purposes.
10. **Prior Authorization**: A process for approving covered services prior to the delivery of the service or initiation of the plan of care based on a determination by CHNCT as to whether the requested service is medically necessary.
11. **Speech therapy or Speech Pathology Services**: The application of principles, methods and procedures for the measurement, testing, diagnosis, prediction, counseling or instruction relating to the development and disorders of speech, voice or language for the purpose of diagnosing, preventing, treating, ameliorating or modifying such disorders and conditions. Services are provided by a speech pathologist.

ADDITIONAL RESOURCES AND REFERENCES:

- Academy of Pediatric Physical Therapy (APTA). Fact Sheet: Intensity of Service in an Outpatient Setting for Children with Chronic Conditions. Published 2012; Accessed November 11, 2025. https://pediatricapta.org/includes/fact-sheets/pdfs/FactSheet_IntensityofServiceforChidlrenwithChronicConditionsOutpatientSetting.pdf
- Houtrow A, Murphy N; COUNCIL ON CHILDREN WITH DISABILITIES. Prescribing Physical, Occupational, and Speech Therapy Services for Children with Disabilities. *Pediatrics*. 2019;143(4):e20190285. doi:10.1542/peds.2019-0285

PUBLICATION HISTORY

Status	Date	Action Taken
Original publication	December 2025	Approved at the CHNCT Medical Reviewer meeting on December 10, 2025. Approved by the CHNCT Clinical Quality Subcommittee on December 15, 2025. Approved by DSS on December 16, 2025.