# Habilitation and Rehabilitation Therapy (Occupational, Physical, and Speech) (for Florida Only)

**Policy Number**: CS164FL.M
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Instructions for Use

**Table of Contents** **Page**

Application ..... 1
Coverage Rationale ..... 1
Definitions ..... 5
Applicable Codes ..... 5
References ..... 9
Policy History/Revision Information ..... 9
Instructions for Use ..... 9

**Related Policy**

- Habilitation and Rehabilitation Therapy (Occupational, Physical, and Speech) – Site of Service (for Florida Only)

## Application

This Medical Policy only applies to the state of Florida.

## Coverage Rationale

### Introduction

This policy addresses the required documentation for evaluation of outpatient speech, occupational, and physical therapy services and the criteria utilized to prior authorize therapy visits. These requirements will apply whether a member is new to therapy or currently receiving therapy. If prior authorization is not on file before therapy is provided, the therapy claim will be denied. For site of care, refer to the Medical Policy titled Habilitation and Rehabilitation Therapy (Occupational, Physical, and Speech) – Site of Service (for Florida Only).

**Note**: This Medical Policy does not apply to cognitive therapy; for outpatient cognitive therapy, refer to the Medical Policy titled Cognitive Rehabilitation.

**Habilitation, rehabilitation, and maintenance are proven and Medically Necessary in certain circumstances.** For Medical Necessity clinical coverage criteria, refer to the InterQual® LOC: Outpatient Rehabilitation & Chiropractic.

Click here to view the InterQual® criteria.

### General Requirements

UnitedHealthcare is required to adhere to the Florida Agency for Health Care Administration's (AHCA) definition of Medical Necessity (refer to the Definitions section).

Services must also be provided by:

- Licensed speech-language pathologists and provisionally licensed speech-language pathologists
- Licensed physical or occupational therapist
- Home health agencies that employ or contract with licensed physical and occupational therapists, licensed speech-language pathologists, and provisionally licensed speech-language pathologists

- Speech-language pathology assistants must be under the direct supervision of a licensee who has met all the requirements of Section 468.1185, F.S. unless acting pursuant to Board of Speech Language Pathology and Audiology approved protocols as established in Rule 64B20-4.0045 or 64B20-4.0046, F.A.C.d
- A licensed speech-language pathologist shall supervise and be responsible for all client services provided by an assistant
- Evaluations cannot be performed by therapy assistants
- If UnitedHealthcare intends to deny coverage on the basis that a diagnostic test, therapeutic procedure, or medical device or technology is experimental or investigational, UnitedHealthcare shall submit a request for coverage determination to the AHCA in accordance with rule 59G-1.035, F.A.C.

For information regarding speech, physical, and occupational therapy, refer to the Florida Medicaid Occupational Therapy Services Coverage Policy, Florida Medicaid Physical Therapy Services Coverage Policy, and Florida Medicaid Speech-Language Pathology Services Coverage Policy.

## *Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Considerations*

As required by federal law, UnitedHealthcare provides services to eligible members under the age of 21 years, if such services are Medically Necessary to correct or ameliorate a defect, a condition, or a physical or mental illness. Included are diagnostic services, treatment, equipment, supplies, and other measures described in section 1905(a) of the SSA, codified in Title 42 of the United States Code 1396d(a). As such, services for members under the age of 21 years exceeding the coverage described within this policy may be approved, if Medically Necessary.

## Documentation Requirements

### *Requests for Initial Evaluation*

- Prior authorization for initial evaluations must be submitted by the Primary Care Provider (PCP) for speech, occupational, and physical therapy for all service delivery settings.
- The PCP must submit all of the following:
  - For members under the age of 21 years:
    - Signed and dated physician order, less than 30 days old, specifying the discipline(s) to be evaluated
    - Current well child visit or an exam note describing the need for the requested evaluation(s)
    - For speech therapy initial evaluation requests for members under 6 years of age, documentation of a hearing screening performed per the Florida EPSTD Periodicity Schedule
      - In the case of behavioral issues or the inability to participate in the hearing screen, an objective description of the behavioral issues and/or inability to participate in the hearing screen along with a statement as to why a hearing deficit is not suspected should be included
      - In the case of suspected hearing deficit, a referral to an audiologist or physician who is experienced with the pediatric population and who offers auditory services would be appropriate; documentation of such a referral should be included in in the clinical documentation submitted
  - For members age 21 years and older:
    - Signed and dated physician order, less than 30 days old, specifying the discipline(s) to be evaluated
    - Exam note describing the need for the requested evaluation(s)

### *Requests for Re-Evaluation*

Re-evaluations must be completed at least once every five (5) months and the request for re-evaluations in all service delivery settings must be submitted by the PCP. The PCP must submit all of the following:

- Current well child exam or visit note documenting a face-to-face encounter with the PCP at least every six (6) months; and
- Signed and dated physician order, less than 30 days old, specifying the discipline(s) to be re-evaluated

### *Requests for Initial Therapy Visits*

The therapy evaluation report must accompany any authorization requests for initial therapy visits. The servicing provider may submit the authorization request if an authorization for an initial evaluation was obtained. If no authorization is on file, the request for therapy visits must be submitted by the referring PCP. The therapy evaluation report must be discipline specific and include all of the following:

- Date of initial evaluation
- Member's name, age, and birthdate
- A brief statement of the member's medical history, including onset date of the illness, injury, or exacerbation that requires the therapy services and any prior therapy treatment
- Relevant review of systems

- The member's language knowledge/exposure; this must include home language(s) and (if applicable) school, daycare, or community language(s) of instruction/exposure
- A description of the member's functional impairment including its impact on their health, safety, and/or independence
- A comparison prior level of function to current level of function, as applicable
- A clear diagnosis and reasonable prognosis, including the member's potential for meaningful and significant progress
- Baseline objective measurements, including a description of the member's current deficits and their severity level which include:
    - Current standardized assessment scores, age equivalents, percentage of functional delay, criterion-referenced scores, and/or other objective information as appropriate for the member's condition or impairment
    - Standardized tests administered must correspond to the delays identified and relate to the long- and short-term goals

**Notes**:
- Standardized test results will **not** be used as the sole determinant as to the Medical Necessity of the request services. If the member has a medical condition that prevents them from completing standardized assessment(s), the therapist may provide in-depth objective clinical information using task analysis to describe the member's deficit area(s) in lieu of standardized assessments. The therapist should include checklists, caregiver reports or interviews, and clinical observation
- Eligibility for speech therapy services:
    - Articulation and language screeners will not be accepted in lieu of standardized assessment(s); vocabulary tests should not be used to establish eligibility for a receptive and expressive language delay.
    - Members with exposure to more than 1 language should also receive culturally and linguistically adapted norm-referenced standardized testing in all languages the child is exposed to in order to compare potential deficits.

The initial authorization for therapy must also include a plan of care (POC). The POC must be signed and dated by the referring provider (PCP) (MD, DO, PA, or NP) or appropriate specialist. Providers must develop a member's POC based on the results of the evaluation. The POC must include at a minimum of all the following:
- Date of initial evaluation
- Member's name, age, and birthdate
- Medical condition, including diagnostic codes
- Medications, treatments, and equipment, as applicable
- Functional limitations
- Specific therapy to be provided
- Short and long-term therapeutic goals and objectives:
    - Treatment goals should be specific to the member's diagnosed condition or impairment; treatment goals must be functional, measurable, attainable, and time based
    - Treatment goals must relate to member-specific functional skills; treatment goals written with targets set for achievements specific to standardized testing benchmarks will not be accepted
- Treatment frequency, length, and duration
- Therapeutic methods and monitoring criteria
- Diet as indicated, if applicable
- Means of demonstrating and teaching the member, family, and other relevant caregivers
- Coordination with other prescribed services
- Treatment plan must be signed and dated by the treating therapist

**Notes**:
- Vocabulary tests should not be used to establish eligibility for a receptive and expressive language delay.
- Members with exposure to more than 1 language should also receive culturally and linguistically adapted norm-referenced standardized testing in all languages the child is exposed to.
- Treatment goals written with targets set for achievements specific to standardized testing benchmarks will not be accepted.

## *Requests for Continuation of Therapy Visits*

The servicing provider may submit the authorization request for continuation of therapy visits if an authorization for a re-evaluation was obtained. If no authorization is on file, the request for continuation of therapy visits must be submitted by the referring PCP. The therapy re-evaluation report must include all of the following:
- Date of last therapy evaluation
- Member's name, age, and date of birth

- Number of therapy visits authorized, and number of therapy visits attended
- Compliance to home program
- Description of the member's current deficits and their severity level documented using objective data
- Objective demonstration of the member's progress towards each treatment goal

  **Notes**:
  - For all unmet goals, baseline and current function must be submitted so that the member's progress towards goals can be measured.
  - As the treating therapist has set the goals for a specified time period, it would be expected that those goals would be met within the specified time frame. If the member has not achieved a majority of the long- and short-term goals established, the plan of care should include a description of the barriers to progress or an explanation why the goal(s) needed to be modified or discontinued.
- An updated statement of the prescribed treatment modalities and their recommended frequency/duration
- A brief prognosis with clearly established discharge criteria; and
- An updated Individualized plan of care (POC) should include updated measurable, functional, and time-based goals

  **Notes**:
  - The updated POC/progress summary must not be older than 90 days.
  - If the majority of the long and short-term goals were not achieved, the plan of care should include a description of the barriers or an explanation why the goal(s) needed to be modified or discontinued.

**Notes**:
- A comprehensive reevaluation must be completed at least once every five (5) months and include current standardized assessment scores, age equivalents, percentage of functional delay, criterion referenced scores, or other objective information as appropriate for the member's condition or impairment.
- A revised plan of care that the treating therapist has not made a meaningful update to support the need for continued services will not be accepted. In addition, the notation of the percentage accuracy towards the member's goals alone is not sufficient to establish a need for continued, Medically Necessary therapy.

## Speech Therapy

### *Visit Guidelines*

The provider is expected to include the results of standardized assessments in their evaluation report. If the member has a medical condition that prevents them from completing a standardized assessment, this should be explained, and the therapist may provide in-depth objective clinical information using task analysis to describe the member's deficit area(s) in lieu of standardized assessments.

In addition, criteria are met, and visits are approved according to the following scores:
- **Mild** [-1 to -1.5 standard deviation from the mean (or a score of 85 to 78)]: Approval of up to 1 visit weekly, up to 26 weeks, on a case-by-case basis
- **Moderate** [-1.5 to -2 standard deviation from the mean (or a score of 77 to 71)]: Approval of up to 2 visits weekly, up to 26 weeks, on a case-by-case basis
- **Severe and profound** [> 2 standard deviation from the mean (or a score of 70 or below)]: Approval of up to 3 visits weekly, up to 13 weeks, on a case-by-case basis

If the therapy provider anticipates that the member has a continued need for therapy visits after the duration of the authorization, they may follow the reevaluation process to request additional visits.

### *Standardized Assessments*

Standardized assessments include, but are not limited to, the following:
- Goldman Fristoe Test of Articulation – 3 (GFTA3)
- Preschool Language Scale – 5 (PLS5)
- Clinical Evaluation of Language Fundamentals – 5 (CELF5)
- Clinical Evaluation of Language Fundamentals Preschool 2
- Oral and Written Language Scales (OWLS-II)
- Test of Language Development Primary 4th Edition (TOLD P4)
- Basic Concepts Scale-Revised (BBCS-R)

### *Discharge Criteria*

Discharge criteria includes but is not limited to all of the following (as applicable):

- Treatment goals and objectives have been met
- Speech, language, communication, or feeding and swallowing disorder are within normal limits or is consistent with the individual's baseline
- Communication abilities have become comparable to those of others of the same chronological age, gender, ethnicity, or cultural and linguistic background
- The desired level of enhanced communication skills has been reached
- The speech, language, communication, and/or feeding and swallowing skills no longer affect the individual's health status
- The individual is unwilling to participate in treatment, requests discharge, or exhibits behavior that interferes with improvement or participation in treatment (e.g., noncompliance, nonattendance)
- The level of services do not require a speech-language pathologist or other licensed healthcare professional (within the scope of his/her licensure)
- The individual is unable to tolerate treatment because of a serious medical, psychological, or other condition
- The individual will get services from a different provider

### Limitations and Exclusions

- Duplication of services
- The service does not meet the Medical Necessity criteria
- The member does not meet the eligibility requirements
- Developing and updating the POC
- Mileage and travel expenses
- Securing, installing, or maintaining therapy equipment
- Services not listed on the fee schedule
- Telephone communications with members, their representatives, caregivers, and other providers, except for services rendered in accordance with the UnitedHealthcare telemedicine policy
- Time spent supervising assistants and students
- Treatment visits provided on the same day as an evaluation service
- Multiple AAC fitting, adjustment, and training visits on the same day (speech therapy only)

## Definitions

**Medically Necessary or Medical Necessity**: The medical or allied care, goods, or services furnished or ordered must meet the following conditions:

- Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain
- Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient's needs
- Be consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational
- Be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available statewide
- Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider

The fact that a provider has prescribed, recommended, or approved medical or allied care, goods, or services does not, in itself, make such care, goods, or services Medically Necessary or a Medical Necessity or a covered service. Medically Necessary or Medical Necessity for inpatient hospital services requires that those services furnished in a hospital on an inpatient basis could not, consistent with the provisions of appropriate medical care, be effectively furnished more economically on an outpatient basis or in an inpatient facility of a different type (AHCA, May 2024).

## Applicable Codes

The following list(s) of procedure and/or diagnosis codes is provided for reference purposes only and may not be all inclusive. Listing of a code in this policy does not imply that the service described by the code is a covered or non-covered health service. Benefit coverage for health services is determined by federal, state, or contractual requirements and

applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other Policies and Guidelines may apply.

| CPT Code | Description |
|---|---|
| 92507 | Treatment of speech, language, voice, communication, and/or auditory processing disorder; individual |
| 92508 | Treatment of speech, language, voice, communication, and/or auditory processing disorder; group, 2 or more individuals |
| 92521 | Evaluation of speech fluency (e.g., stuttering, cluttering) |
| 92522 | Evaluation of speech sound production (e.g., articulation, phonological process, apraxia, dysarthria); |
| 92523 | Evaluation of speech sound production (e.g., articulation, phonological process, apraxia, dysarthria); with evaluation of language comprehension and expression (e.g., receptive and expressive language) |
| 92524 | Behavioral and qualitative analysis of voice and resonance |
| 92526 | Treatment of swallowing dysfunction and/or oral function for feeding |
| 92609 | Therapeutic services for the use of speech-generating device, including programming and modification |
| 92610 | Evaluation of oral and pharyngeal swallowing function |
| 96105 | Assessment of aphasia (includes assessment of expressive and receptive speech and language function, language comprehension, speech production ability, reading, spelling, writing, e.g., by Boston Diagnostic Aphasia Examination) with interpretation and report, per hour |
| 97012 | Application of a modality to 1 or more areas; traction, mechanical |
| 97014 | Application of a modality to 1 or more areas; electrical stimulation (unattended) |
| 97016 | Application of a modality to 1 or more areas; vasopneumatic devices |
| 97018 | Application of a modality to 1 or more areas; paraffin bath |
| 97022 | Application of a modality to 1 or more areas; whirlpool |
| 97024 | Application of a modality to 1 or more areas; diathermy (e.g., microwave) |
| 97026 | Application of a modality to 1 or more areas; infrared |
| 97028 | Application of a modality to 1 or more areas; ultraviolet |
| 97032 | Application of a modality to 1 or more areas; electrical stimulation (manual), each 15 minutes |
| 97033 | Application of a modality to 1 or more areas; iontophoresis, each 15 minutes |
| 97034 | Application of a modality to 1 or more areas; contrast baths, each 15 minutes |
| 97035 | Application of a modality to 1 or more areas; ultrasound, each 15 minutes |
| 97036 | Application of a modality to 1 or more areas; Hubbard tank, each 15 minutes |
| 97039 | Unlisted modality (specify type and time if constant attendance) |
| 97110 | Therapeutic procedure, 1 or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility |
| 97112 | Therapeutic procedure, 1 or more areas, each 15 minutes; neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing activities |
| 97113 | Therapeutic procedure, 1 or more areas, each 15 minutes; aquatic therapy with therapeutic exercises |
| 97116 | Therapeutic procedure, 1 or more areas, each 15 minutes; gait training (includes stair climbing) |
| 97139 | Unlisted therapeutic procedure (specify) |
| 97140 | Manual therapy techniques (e.g., mobilization/ manipulation, manual lymphatic drainage, manual traction), 1 or more regions, each 15 minutes |
| 97150 | Therapeutic procedure(s), group (2 or more individuals) |

| CPT Code | Description |
|---|---|
| 97161 | Physical therapy evaluation: low complexity, requiring these components: A history with no personal factors and/or comorbidities that impact the plan of care; An examination of body system(s) using standardized tests and measures addressing 1-2 elements from any of the following: body structures and functions, activity limitations, and/or participation restrictions; A clinical presentation with stable and/or uncomplicated characteristics; and Clinical decision making of low complexity using standardized patient assessment instrument and/or measurable assessment of functional outcome. Typically, 20 minutes are spent face-to-face with the patient and/or family. |
| 97162 | Physical therapy evaluation: moderate complexity, requiring these components: A history of present problem with 1-2 personal factors and/or comorbidities that impact the plan of care; An examination of body systems using standardized tests and measures in addressing a total of 3 or more elements from any of the following: body structures and functions, activity limitations, and/or participation restrictions; An evolving clinical presentation with changing characteristics; and Clinical decision making of moderate complexity using standardized patient assessment instrument and/or measurable assessment of functional outcome. Typically, 30 minutes are spent face-to-face with the patient and/or family. |
| 97163 | Physical therapy evaluation: high complexity, requiring these components: A history of present problem with 3 or more personal factors and/or comorbidities that impact the plan of care; An examination of body systems using standardized tests and measures addressing a total of 4 or more elements from any of the following: body structures and functions, activity limitations, and/or participation restrictions; A clinical presentation with unstable and unpredictable characteristics; and Clinical decision making of high complexity using standardized patient assessment instrument and/or measurable assessment of functional outcome. Typically, 45 minutes are spent face-to-face with the patient and/or family. |
| 97164 | Re-evaluation of physical therapy established plan of care, requiring these components: An examination including a review of history and use of standardized tests and measures is required; and Revised plan of care using a standardized patient assessment instrument and/or measurable assessment of functional outcome Typically, 20 minutes are spent face-to-face with the patient and/or family. |
| 97165 | Occupational therapy evaluation, low complexity, requiring these components: An occupational profile and medical and therapy history, which includes a brief history including review of medical and/or therapy records relating to the presenting problem; An assessment(s) that identifies 1-3 performance deficits (i.e., relating to physical, cognitive, or psychosocial skills) that result in activity limitations and/or participation restrictions; and Clinical decision making of low complexity, which includes an analysis of the occupational profile, analysis of data from problem-focused assessment(s), and consideration of a limited number of treatment options. Patient presents with no comorbidities that affect occupational performance. Modification of tasks or assistance (e.g., physical or verbal) with assessment(s) is not necessary to enable completion of evaluation component. Typically, 30 minutes are spent face-to-face with the patient and/or family. |
| 97166 | Occupational therapy evaluation, moderate complexity, requiring these components: An occupational profile and medical and therapy history, which includes an expanded review of medical and/or therapy records and additional review of physical, cognitive, or psychosocial history related to current functional performance; An assessment(s) that identifies 3-5 performance deficits (i.e., relating to physical, cognitive, or psychosocial skills) that result in activity limitations and/or participation restrictions; and Clinical decision making of moderate analytic complexity, which includes an analysis of the occupational profile, analysis of data from detailed assessment(s), and consideration of several treatment options. Patient may present with comorbidities that affect occupational performance. Minimal to moderate modification of tasks or assistance (e.g., physical or verbal) with assessment(s) is necessary to enable patient to complete evaluation component. Typically, 45 minutes are spent face-to-face with the patient and/or family. |

| CPT Code | Description |
|---|---|
| 97167 | Occupational therapy evaluation, high complexity, requiring these components: An occupational profile and medical and therapy history, which includes review of medical and/or therapy records and extensive additional review of physical, cognitive, or psychosocial history related to current functional performance; An assessment(s) that identifies 5 or more performance deficits (i.e., relating to physical, cognitive, or psychosocial skills) that result in activity limitations and/or participation restrictions; and Clinical decision making of high analytic complexity, which includes an analysis of the patient profile, analysis of data from comprehensive assessment(s), and consideration of multiple treatment options. Patient presents with comorbidities that affect occupational performance. Significant modification of tasks or assistance (e.g., physical or verbal) with assessment(s) is necessary to enable patient to complete evaluation component. Typically, 60 minutes are spent face-to-face with the patient and/or family. |
| 97168 | Re-evaluation of occupational therapy established plan of care, requiring these components: An assessment of changes in patient functional or medical status with revised plan of care; An update to the initial occupational profile to reflect changes in condition or environment that affect future interventions and/or goals; and A revised plan of care. A formal reevaluation is performed when there is a documented change in functional status or a significant change to the plan of care is required. Typically, 30 minutes are spent face-to-face with the patient and/or family. |
| 97530 | Therapeutic activities, direct (one-on-one) patient contact (use of dynamic activities to improve functional performance), each 15 minutes |
| 97535 | Self-care/home management training (e.g., activities of daily living (ADL) and compensatory training, meal preparation, safety procedures, and instructions in use of assistive technology devices/adaptive equipment) direct one-on-one contact, each 15 minutes |
| 97542 | Wheelchair management (e.g., assessment, fitting, training), each 15 minutes |
| 97750 | Physical performance test or measurement, (e.g., musculoskeletal, functional capacity) with written report, each 15 minutes |
| 97755 | Assistive technology assessment (e.g., to restore, augment or compensate for existing function, optimize functional tasks and/or maximize environmental accessibility), direct one-on-one contact, with written report, each 15 minutes |
| 97760 | Orthotic(s) management and training (including assessment and fitting when not otherwise reported), upper extremity(ies), lower extremity(ies) and/or trunk, initial orthotic(s) encounter, each 15 minutes |
| 97761 | Prosthetic(s) training, upper and/or lower extremity(ies), initial prosthetic(s) encounter, each 15 minutes |
| 97763 | Orthotic(s)/prosthetic(s) management and/or training, upper extremity(ies), lower extremity(ies), and/or trunk, subsequent orthotic(s)/prosthetic(s) encounter, each 15 minutes |
| 97799 | Unlisted physical medicine/rehabilitation service or procedure |



| HCPCS Code | Description |
|---|---|
| G0281 | Electrical stimulation, (unattended), to one or more areas, for chronic Stage III and Stage IV pressure ulcers, arterial ulcers, diabetic ulcers, and venous stasis ulcers not demonstrating measurable signs of healing after 30 days of conventional care, as part of a therapy plan of care |
| G0283 | Electrical stimulation (unattended), to one or more areas for indication(s) other than wound care, as part of a therapy plan of care |
| S8948 | Application of a modality (requiring constant provider attendance) to one or more areas; low-level laser; each 15 minutes |
| S8990 | Physical or manipulative therapy performed for maintenance rather than restoration |
| S9129 | Occupational therapy, in the home, per diem |
| S9131 | Physical therapy; in the home, per diem |
| S9152 | Speech therapy, re-evaluation |

# References


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American Speech-Language-Hearing Association. Admission/discharge Criteria in Speech-Language Pathology. http://www.asha.org/policy/GL2004-00046/. Accessed April 10, 2025.

American Speech-Language Hearing Association. Speech Language Pathology Medical Review Guidelines. https://www.asha.org/practice/reimbursement/SLP-medical-review-guidelines/. Accessed April 10, 2025.


# Policy History/Revision Information

| Date | Summary of Changes |
|---|---|
| 11/01/2025 | **Supporting Information**<br>• Updated *References* section to reflect the most current information<br>• Archived previous policy version CS164FL.L |

# Instructions for Use

This Medical Policy provides assistance in interpreting UnitedHealthcare standard benefit plans. When deciding coverage, the federal, state or contractual requirements for benefit plan coverage must be referenced as the terms of the federal, state or contractual requirements for benefit plan coverage may differ from the standard benefit plan. In the event of a conflict, the federal, state or contractual requirements for benefit plan coverage govern. Before using this policy, please check the federal, state or contractual requirements for benefit plan coverage. UnitedHealthcare reserves the right to modify its Policies and Guidelines as necessary. This Medical Policy is provided for informational purposes. It does not constitute medical advice.

UnitedHealthcare may also use tools developed by third parties, such as the InterQual® criteria, to assist us in administering health benefits. The UnitedHealthcare Medical Policies are intended to be used in connection with the independent professional medical judgment of a qualified health care provider and do not constitute the practice of medicine or medical advice.