

Outpatient Speech, Occupational and Physical Therapy Services (for Florida Only)

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[Instructions for Use](#)

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Related Policy

- [Outpatient Speech, Occupational and Physical Therapy – Site of Service \(for Florida Only\)](#)

Application

This Utilization Review Guideline only applies to the state of Florida.

Coverage Rationale

Introduction

This guideline 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 Utilization Review Guideline titled [Outpatient Speech, Occupational and Physical Therapy – Site of Service \(for Florida Only\)](#).

For medical necessity clinical coverage criteria for therapy services, 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 (see [Definitions](#)).

Services must also be provided by:

- Licensed speech-language pathologists and provisionally licensed speech-language pathologists; and
- 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.

State Required Benefits

Speech Therapy

Speech therapy is a covered benefit when followed in accordance with the applicable fee schedule(s):

- One augmentative and alternative communication (AAC) initial evaluation per year, per member

For members under the age of 21 years:

- One initial speech-language pathology evaluation per year, per recipient
- One speech-language re-evaluation every five months, per recipient
- Up to 14 therapy treatment units per week (Sunday-Saturday), per recipient (maximum of four units per day)
 - Group therapy must be at least 30 minutes in duration, and may include no more than six participants (the group may include non-Medicaid recipients)
- One follow-up AAC evaluation upon delivery of the device, per recipient
- Up to eight 30-minute AAC fitting, adjustment, and training sessions per year, per recipient
- Up to two AAC reevaluations per year, per recipient with an AAC device

For members age 21 years and older:

- One initial speech therapy evaluation per year, per member
- One speech therapy re-evaluation per year, per member of as specified in this policy
- One evaluation of oral and pharyngeal swallowing per year, per member
- Up to 7 therapy treatment (includes speech, occupational, and physical therapy) units per week, per member (max of 4 units per day)
- One follow-up AAC evaluation upon delivery of the device, per member
- Up to four AAC reevaluations per year, per member with an AAC device

Physical and Occupational Therapy

Physical and occupational therapy is a covered benefit when followed in accordance with the applicable fee schedule(s).

Wheelchair evaluations:

- One wheelchair evaluation every five years, per member
- One follow-up wheelchair evaluation including adjustments and fittings when the wheelchair is delivered
- One follow-up wheelchair evaluation including adjustments and fittings six months after the wheelchair has been delivered

For members under the age of 21 years:

- One initial therapy evaluation per year, per member
- One therapy re-evaluation every five months, per member
- Up to 14 therapy treatment units per week, per member (max of 4 units per day)
- Up to two casting and strapping applications per day, per member

For members age 21 years and older:

- One initial therapy evaluation per year, per member
- One therapy re-evaluation per year, per member or as defined by this policy
- Up to 7 therapy treatment units per week, per member (max of 4 units per day)

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 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; and
- 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 the following:

- 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, August 2017)

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
Physical/Occupational Therapy	
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)
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.

CPT Code	Description
Physical/Occupational Therapy	
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.
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.

CPT Code	Description
Physical/Occupational Therapy	
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
97533	Sensory integrative techniques to enhance sensory processing and promote adaptive responses to environmental demands, direct (one-on-one) patient contact, 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
97537	Community/work reintegration training (e.g., shopping, transportation, money management, avocational activities and/or work environment/modification analysis, work task analysis, use of assistive technology device/adaptive equipment), direct one-on-one contact, each 15 minutes
97542	Wheelchair management (e.g., assessment, fitting, training), each 15 minutes
97545	Work hardening/conditioning; initial 2 hours
97546	Work hardening/conditioning; each additional hour (List separately in addition to code for primary procedure)
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
Speech Therapy	
70371	Complex dynamic pharyngeal and speech evaluation by cine or video recording
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
92597	Evaluation for use and/or fitting of voice prosthetic device to supplement oral speech
92609	Therapeutic services for the use of speech-generating device, including programming and modification
92610	Evaluation of oral and pharyngeal swallowing function

CPT Code	Description
Speech Therapy	
92626	Evaluation of auditory function for surgically implanted device(s) candidacy or postoperative status of a surgically implanted device(s); first hour
92627	Evaluation of auditory function for surgically implanted device(s) candidacy or postoperative status of a surgically implanted device(s); each additional 15 minutes (List separately in addition to code for primary procedure)
92630	Auditory rehabilitation; prelingual hearing loss
92633	Auditory rehabilitation; postlingual hearing loss
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

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HCPCS Code	Description
Physical/Occupational Therapy	
G0129	Occupational therapy services requiring the skills of a qualified occupational therapist, furnished as a component of a partial hospitalization treatment program, per session (45 minutes or more)
G0151	Services performed by a qualified physical therapist in the home health or hospice setting, each 15 minutes
G0152	Services performed by a qualified occupational therapist in the home health or hospice setting, each 15 minutes
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
G0282	Electrical stimulation, (unattended), to one or more areas, for wound care other than described in G0281
G0283	Electrical stimulation (unattended), to one or more areas for indication(s) other than wound care, as part of a therapy plan of care
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
Speech Therapy	
S9152	Speech therapy, re-evaluation
V5362	Speech screening
V5363	Language screening

Revenue Code	Description
Physical Therapy	
420	Physical Therapy
421	Visit charge
422	Hourly charge
423	Group rate
424	Evaluation or reevaluation
429	Other physical therapy
977	Physical Therapy

Revenue Code	Description
Occupational Therapy	
430	Occupational Therapy
431	Visit charge
432	Hourly charge
433	Group rate
434	Evaluation or reevaluation
439	Other occupational therapy
978	Occupational therapy
Speech Therapy	
440	Speech pathology
441	Visit charge
442	Hourly charge
443	Group rate
444	Evaluation or reevaluation
449	Other speech-language pathology
979	Speech pathology

References

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- Agency for Health Care Administration, Florida Medicaid, Physical Therapy Services Coverage Policy. October 2016 at http://ahca.myflorida.com/medicaid/review/Specific/59G_4-320_Physical_Therapy_Services.pdf. Accessed June 2, 2021.
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- American Speech-Language-Hearing Association. Admission/discharge Criteria in Speech-Language Pathology. <http://www.asha.org/policy/GL2004-00046/>. Accessed June 2, 2021.
- American Speech-Language Hearing Association. Speech Language Pathology Medical Review Guidelines. <https://www.asha.org/practice/reimbursement/SLP-medical-review-guidelines/>. Accessed June 2, 2021.

Guideline History/Revision Information

Date	Summary of Changes
06/01/2022	<p>Coverage Rationale</p> <ul style="list-style-type: none"> Removed reference to specific InterQual® release date; refer to the most current InterQual® criteria <p>Supporting Information</p> <ul style="list-style-type: none"> Archived previous policy version CS162FL.H

Instructions for Use

This Utilization Review Guideline summarizes AHCA requirements related to outpatient speech, occupational and physical therapy services and provides assistance in interpreting UnitedHealthcare Florida Community Plan criteria related to these services. When deciding coverage, the federal, state or contractual requirements for benefit plan coverage must be referenced

as the terms of benefit plan coverage may be subject to change without notification from applicable state or federal entities. In the event of a conflict, the federal, state or contractual requirements for benefit plan coverage govern. Before using this guideline, 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 Utilization Review Guideline 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 Utilization Review Guidelines 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.