Habilitation and Rehabilitation Therapy (Occupational, Physical, and Speech)

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➲ Instructions for Use

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- Habilitation and Rehabilitation Therapy (Occupational, Physical, and Speech)

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- Skilled Nursing Facility, Rehabilitation, Long-Term Acute Care Hospital, and Private Duty Nursing
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Application

UnitedHealthcare Commercial

This Medical Policy applies to UnitedHealthcare Commercial benefit plans.

UnitedHealthcare Individual Exchange

This Medical Policy applies to Individual Exchange benefit plans.

Coverage Rationale

➲ See Benefit Considerations

Note: This policy applies to benefit plans that have medical necessity requirements for habilitation, rehabilitation, and maintenance therapies.

This Medical Policy does not apply to cognitive therapy. For outpatient cognitive therapy, refer to the Medical Policy titled Cognitive Rehabilitation and Coma Stimulation.

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.

The documentation requirements outlined below are used in addition to InterQual® to assess whether the individual meets the clinical criteria for coverage but does not guarantee coverage of the service requested.

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Initial Therapy Evaluation/Initial Therapy Visit Requests

The therapy evaluation report must include **all** the following:

- A statement of the individual's medical history; and
- A comparison of prior level of function to current level of function, as applicable; and
- A description of the individual's functional impairment, including its impact on their health, safety, and/or independence; and
- A clear diagnosis, including the appropriate *International Statistical Classification of Diseases, Tenth Revision* (ICD-10) code; and
- Reasonable prognosis, including the individual's potential for meaningful and noteworthy progress; and
- Baseline objective measurements (current versions of standardized assessments), including a description of the individual'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 individual's condition or impairment
    - Standardized assessments administered must correspond to the delays identified and relate to the long- and short-term goals
    - Standardized assessment results will not be used as the sole determinant as to the medical necessity of the requested initial therapy visit
    - If the individual has a medical condition that prevents them from completing standardized assessment(s), alternatives could include:
        - The therapist provides in-depth, objective clinical information, using task analysis to describe the individual's deficit area(s) in lieu of standardized assessments
        - The therapist should include checklists, caregiver reports or interviews, and clinical observation

Plan of Care

The initial authorization for therapy must also include a plan of care (POC). Providers must develop an individual's POC based on the results of the evaluation. The POC must include **all** the following:

- Functional or physical impairment; and
- Short- and long-term therapeutic goals and objectives:
    - Treatment goals should be specific to the individual's diagnosed condition or functional or physical impairment
    - Treatment goals must be functional, measurable, attainable, and time based
    - Treatment goals must relate to individual-specific functional skills

  and
- Treatment frequency and duration and anticipated length of treatment session(s)

Re-Evaluations

Re-evaluations must be completed at least once every 12 months or more frequently, based on state regulatory requirements, to support the need for ongoing services. Re-evaluations performed more often than once should only be completed when the individual experiences a significant change in functional level in their condition or functional status. The documentation must be reflective of this change. Re-evaluations must include current standardized assessment scores, percentage of functional delay, criterion-referenced scores, or other objective information as appropriate for the individual's condition or impairment. The therapy re-evaluation report must include **all** the following:

- Date of last therapy evaluation; and
- Number of therapy visits authorized and number of therapy visits attended; and
- Adherence to home program; and
- Description of the individual's current deficits and their severity level, documented using objective data; and
- Objective demonstration of the individual's progress toward each treatment goal:
    - Using consistent and comparable methods to report progress on short-term and long-term treatment goals established
    - For all unmet goals, baseline and current function so that the individual's progress toward goals can be measured

  and
- An updated statement of the prescribed treatment modalities and their recommended frequency/duration; and
- A brief prognosis, with clearly established discharge criteria; and
- An updated individualized POC must include updated measurable, functional, and time-based goals:
    - The updated POC/progress summary must not be older than 90 days; and
    - If the majority of the long- and short-term goals were not achieved, the POC must include a description of the barriers or an explanation of why the goal(s) needed to be modified or discontinued

  and

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- A revised POC stating 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 toward the individual's goals alone is not sufficient to establish a need for continued medically necessary therapy

Treatment Session Notes

All treatment session notes must include:

- Date of treatment
- Specific treatment(s) provided that match the CPT code(s) billed
- Accurate documentation of the length of treatment session
- The individual's response to treatment
- Skilled ongoing reassessment of the individual's progress toward the goals
- All progress toward the goals in objective, measurable terms, using consistent and comparable methods
- Any problems with or changes to the POC
- Individual or caregiver involvement in and feedback about home program activities
- Signature and date from the treating provider

Group Therapy

The documentation must include **all** the following:

- Prescribing provider's order for group therapy; and
- Individualized treatment plan that includes frequency and duration of the prescribed group therapy and individualized treatment goals; and
- Name and signature of licensed therapist providing supervision over the group therapy session; and
- Specific treatment techniques used during the group therapy session and how the techniques will restore function; and
- Accurate documentation of the length of treatment session; and
- Group therapy setting or location; and
- Number of clients in the group

Feeding and Swallowing Disorders

For feeding and swallowing evaluations, **all** the following must be submitted:

- Interview/case history; and
- Medical/clinical records, including the potential impact of medications, if any; and
- Physical examination; and
- Previous screening and assessments; and
- Collaboration with providers and other caregivers
    - During assessment, therapists determine whether the individual is an appropriate candidate for treatment and/or management; this determination is based on findings that include medical stability, cognitive status, nutritional status, and psychosocial, environmental, and behavioral factors

  and
- Assessment must result in one or more of the following outcomes:
    - Description of the characteristics of swallowing function, including any breakdowns in swallow physiology
    - Diagnosis of a swallowing disorder
    - Determination of the safest and most efficient route (oral vs nonoral) of nutrition and hydration intake
    - Identification of the effectiveness of intervention and support
    - Recommendations for intervention and support for oral, pharyngeal, and/or laryngeal disorders
    - Prognosis for improvement and identification of other relevant factors, if appropriate

Discharge Criteria

Discharge criteria include but are not limited to all the following (as applicable):

- Treatment goals and objectives have been met
- Functional abilities have become comparable to those of individuals of the same chronological age
- The desired level of function that has been agreed to by the individual and provider has been achieved
- The skill of a therapist or other licensed health care professional (within the scope of their licensure) is not required
- The individual exhibits behavior that interferes with improvement or participation in treatment, and efforts to address these factors have not been successful
- In some situations, the individual, family, or designated guardian may choose not to participate in treatment, may relocate, or may seek another provider if the therapeutic relationship is not satisfactory; therefore, discharge is also

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appropriate in the following situations, provided that the individual, family, and/or guardian have been advised of the likely outcomes of discontinuation:
  - There is a request to be discharged or request for continuation of services with another provider
  - The individual is transferred or discharged to another location at which ongoing service from the current provider is not reasonably available; efforts should be made to ensure continuation of services in the new locale
  - The individual is unable to tolerate treatment because of a serious medical, psychological, or other condition

Speech and Language Considerations

- Bilingual and multilingual speakers are frequently misclassified as developmentally delayed. Equivalent proficiency in both languages should not be expected. Individuals with limited English proficiency must receive culturally and linguistically adapted norm-referenced standardized testing in all languages that the child is exposed to in order to compare potential deficits. For speech and language therapy services for an individual with limited English proficiency, all the following criteria must be met:
  - All speech deficits must be present in the language in which the individual has the highest proficiency; and
  - Language deficits must be present in the language in which the individual has the highest proficiency; and
  - Delivery of services must be in the language in which the individual has the highest receptive language proficiency
- For individuals with dyslexia, test results substantiating a diagnosis of receptive or expressive language delay must be included, with goals addressing the corresponding language deficits

Definitions

The following definitions may not apply to all plans. Refer to the member specific benefit plan document for applicable definitions.

Work Hardening: Treatment programs designed to return a person to work or to prepare a person for specific work (Certificate of Coverage, 2018).

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 the member specific benefit plan document 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

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CPT Code	Description
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.
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.

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CPT Code	Description
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.
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

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CPT Code	Description
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

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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

Description of Services

Rehabilitative services are intended to improve, adapt, or restore functions that have been impaired or permanently lost as a result of illness, injury, loss of a body part, or congenital abnormality. Such services involve goals that an individual can reach in a reasonable period of time with the assistance of a therapist or a therapy assistant under the supervision of a therapist. Services may include occupational, physical, or speech therapy.

Habilitation services are health care services that help a person keep, learn, or improve skills and functioning for daily living. Examples include therapy for a child who is not walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology, and other services for individuals with disabilities in a variety of inpatient and/or outpatient settings.

Maintenance therapy includes services that seek to prevent disease, promote health, and prolong and enhance quality of life or maintain or prevent deterioration of a chronic condition. When further clinical improvement cannot reasonably be expected from continuous, ongoing care and the treatment becomes supportive rather than corrective in nature, the treatment is then considered maintenance therapy. Services may include occupational, physical, or speech therapy.

Benefit Considerations

The following benefit considerations may not apply to all plans. Refer to the member specific benefit plan document for applicable benefit considerations.

The following exclusions apply to habilitative, rehabilitation, and maintenance therapy:

- Services that are considered non-skilled
- Services that are solely educational or vocational in nature or otherwise paid under state or federal law for purely educational services
- Services that are considered by UnitedHealthcare to be unproven, investigational, or experimental
- Custodial care, respite care, day care, vocational training, and residential treatment
- Therapeutic recreation (examples include but are not limited to arts/crafts, dance, drama, music, swimming, and sports)

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- Physiological modalities and procedures that result in similar or redundant therapeutic effects when performed on the same body region during the same visit or office encounter (an example includes but is not limited to the same day combined use of hot packs, ultrasound, and iontophoresis in the treatment of strain)
- Work Hardening (refer to the Definitions section)
- Confinement, treatment, services, or supplies that are required: a) only by a court of law, or b) only for insurance, travel, employment, and school or camp purposes
- Speech therapy if the provider is school based (check benefit language and state mandates)
- Sign language interpreter services (does not require the services of a licensed or certified healthcare professional)

Clinical Evidence

Erikson et al. (2021) studied 80 second-grade children (aged 7-9 years). Overall, 40 bilingual, Spanish-English children were paired with monolingual, English-speaking peers based on age, gender, and percentage scores on the Goldman-Fristoe Test of Articulation 2. This study was to assess if bilingual, Spanish-English–speaking children had an increased rate of English phonological errors over their monolingual peers. Additional inclusionary criteria were used to rule out language impairment for bilingual children, as bilingual children with typical development may score lower than their monolingual peers on standardized tests. Descriptive testing was administered to the participants over six sessions. The authors stated that the study contributes to the understanding of the English phonological skills of bilingual, Spanish-English–speaking, school-aged individuals and the determination of whether some phonological targets may be more vulnerable for bilingual, school-aged children. The authors concluded that phonological differences between bilingual individuals and their monolingual peers are observed during the school-age years, even when bilingual children can speak English with a high level of proficiency, and that these challenges have the potential to impact learning success. Limitations of the study include this study being a post hoc analysis; additionally, the analyses did not address the clinical utility of the test in improving participants' learning success.

Fabiano-Smith et al. (2018) conducted a study in bilingual children whose phonological skills were evaluated using measures designed for monolingual, English-speaking children and who were at risk of being misdiagnosed with speech sound disorders. Overall, 44 children (average age, 5 years) were included: 15 typically developing, monolingual English speakers; seven monolingual English speakers with phonological disorders; 14 typically developing, bilingual Spanish-English speakers; and eight bilingual children with phonological disorders. Single-word speech sounds were examined on the PCC-R (Percentage of Consonants Correct–Revised) and the accuracy of early-, middle-, and late-developing sounds in English and were compared with those of bilingual speakers with or without speech sound disorders. The results showed that for monolingual English speakers, the PCC-R was accurate in identifying speech sound disorder at this age, and this was also the case for bilingual children. The accuracy of early-, middle-, and late-developing sounds showed similar results in monolingual and bilingual children. The authors concluded that bilingual-speaking children in the current study, at the age of approximately 5 years, perform much like their monolingual, English-speaking peers on measures of phonological abilities. Additionally, misdiagnosis continues to be problematic when standardized tests of articulation that are normed on monolingual English-speaking children are used by speech-language pathologists for bilingual children.

In a 2010 study, Fabiano-Smith et al. conducted a study to determine how between-language interaction contributes to phonological acquisition in typically developing, bilingual, Spanish-English–speaking children aged 3 to 4 years. Overall, 24 children were included in the study: eight bilingual, Spanish-English–speaking children; eight monolingual, Spanish-speaking children; and eight monolingual, English-speaking children. The individuals were from the United States and Mexico. The children were categorized into three groups based on language history: eight bilingual, Spanish-English–speaking children (mean age, 3.6 years; range, 3.0-4.0 years); eight monolingual Spanish speakers (mean age, 3.4 years; range, 3.2-4.0 years); and eight monolingual English speakers (mean age, 3.3 years; range, 3.0-3.11 years). Additionally, a parent and/or teacher report was used to determine phonological ability and ensure that all children were without speech, language, cognitive, or neurological deficits. Both single-word and connected speech samples were collected from each child for analysis. The authors concluded that the bilingual children were able to maintain separation between their two phonological systems; therefore, supporting between-language interaction at this level is rare. Additionally, overall consonant accuracy in Spanish was significantly higher in monolingual individuals than in bilingual individuals; however, the rate was within the normal range for age-matched monolingual children. Lastly, the bilingual children did not have a faster rate of acquisition than their monolingual peers. They had phonological skills that fell within the range of that for their monolingual peers. The small number of individuals is a major limitation of this study, as an attempt to create a homogeneous sample out of a heterogeneous population limited the number of individuals.

In a 2008 study, Gildersleeve-Neumann et al. compared the speech acquisition in typically developing 3- to 4-year-old children with monolingual English with that in the same age group with bilingual Spanish-English backgrounds. This study was to evaluate the impact of Spanish language exposure on English skills and to assess if this resulted in increased English errors in bilingual children. The study consisted of 33 children between the ages of 3 years and 1 month and 3

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years and 10 months who were enrolled in a Head Start program in central Texas. Individuals were from English, Mexican English-Spanish, and Mexican Spanish home language environments, with the majority residing in bilingual homes. The children were divided into English-only, predominantly English, and balanced bilingual English-Spanish exposure groups. English was the main language spoken and encouraged in the Head Start program; however, some staff were bilingual, but Spanish was rarely spoken. Language development was established based on their performance on English and Spanish versions of the Receptive and Expressive One-Word Picture Vocabulary Tests; the Comprehension subtest of the Stanford-Binet Intelligence Scale, Fourth Edition; and dynamic assessment procedures. Spoken responses to a picture-naming task were collected at the beginning and at the end of the Head Start school year (8 months later). The results showed that regardless of language background or level of English exposure, these 3- and 4-year-old children produced most sounds of English in their single-word productions, as would be expected for overall chronological speech development, and had similar phonetic inventories in each language environment. As expected, the children with the greatest exposure to English made fewer errors, on average, which decreased over time in all groups. Differences were seen in pronunciation, as letters are pronounced differently in Spanish than English, as well as the ability to enunciate sounds in this age group. With regard to word complexity, final consonants and cluster reduction showed differences related to the amount of English exposure, which is related to differences in the two languages as well as the physical mechanisms required for speech, including respiration, phonation, articulation, and resonance, to generate and shape speech sounds. Early resolved error patterns were mastered equally well across the three groups regardless of language exposure, suggesting the ability to more easily transfer from one language to the other. Vowel sounds were comparably accurate among the groups. Spanish speech patterns remained the highest in the balanced bilingual English-Spanish group, and vocalization errors were more frequent in this group as well. Final consonant devoicing was higher in the bilingual children at both time points and showed the highest error rate in the balanced bilingual English-Spanish group, possibly due to children taking longer to physically produce some sounds. The authors concluded that this study is in agreement with previous research that indicates that (1) the phonological rules of one language may transfer to the second language during acquisition and that (2) language-specific error patterns may be typical for bilingual development in transferring into English usage and are not an indicator of clinical speech disorder or delay.

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Policy History/Revision Information

Date	Summary of Changes
07/01/2026	**Supporting Information** • Updated *Clinical Evidence* and *References* sections to reflect the most current information • Archived previous policy version MP.026.26

Instructions for Use

This Medical Policy provides assistance in interpreting UnitedHealthcare standard benefit plans. When deciding coverage, the member specific benefit plan document must be referenced as the terms of the member specific benefit plan may differ from the standard plan. In the event of a conflict, the member specific benefit plan document governs. Before using this policy, check the member specific benefit plan document and any applicable federal or state mandates. 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.

This Medical Policy may also be applied to Medicare Advantage plans in certain instances. In the absence of a Medicare National Coverage Determination (NCD), Local Coverage Determination (LCD), or other Medicare coverage guidance, CMS allows a Medicare Advantage Organization (MAO) to create its own coverage determinations, using objective evidence-based rationale relying on authoritative evidence (Medicare IOM Pub. No. 100-16, Ch. 4, §90.5).

UnitedHealthcare may also use tools developed by third parties, such as InterQual® Guidelines, to assist us in administering health benefits. 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.

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