Habilitative Services

Policy Number: BIP202.J
Effective Date: December 1, 2024

➲ Instructions for Use

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Section 365:40-5-20 - Basic Health Care Services

https://www.law.cornell.edu/regulations/oklahoma/OAC-365-40-5-20

(4) Outpatient services and inpatient hospital services including short-term rehabilitation services and physical therapy which the HMO expects can result in the significant improvement of an enrollee's condition within two months.
(12) Inpatient and outpatient care for treatment of the birth defect known as cleft lip or cleft palate or both including medically necessary oral surgery, orthodontics, and otologic, audiological, and speed/language treatment.

Section 365:40-5-21 - Supplemental Health Care Services

https://www.law.cornell.edu/regulations/oklahoma/OAC-365-40-5-21

Supplemental health care services of an HMO may include the following:
(5) Long-term physical therapy and rehabilitative services.

Oregon

Oregon Revised Statutes (ORS)

Section 743A.190 Children with Pervasive Developmental Disorder

https://www.oregonlaws.org/ors/743A.190

(1) A health benefit plan, as defined in ORS 743B.005 (Definitions) must cover for a child enrolled in the plan who is under 18 years of age and who has been diagnosed with a pervasive developmental disorder all medical services, including rehabilitation services, that are medically necessary and are otherwise covered under the plan.
(2) The coverage required under subsection (1) of this section, including rehabilitation services, may be made subject to other provisions of the health benefit plan that apply to covered services, including but not limited to:
  (a) Deductibles, copayments or coinsurance;
  (b) Prior authorization or utilization review requirements; or
  (c) Treatment limitations regarding the number of visits or the duration of treatment.
(3) As used in this section:

(a) "Medically necessary" means in accordance with the definition of medical necessity that is specified in the policy, certificate or contract for the health benefit plan and that applies uniformly to all covered services under the health benefit plan.
(b) "Pervasive developmental disorder" means a neurological condition that includes autism spectrum disorder, developmental delay, developmental disability or mental retardation.
(c) "Rehabilitation services" means physical therapy, occupational therapy or speech therapy services to restore or improve function.

(4) The provisions of ORS 743A.001 (Automatic repeal of certain statutes on individual and group health insurance) do not apply to this section.
(5) The definition of "pervasive developmental disorder" is not intended to apply to coverage required under ORS 743A.168 (Behavioral health treatment) or section 2, chapter 771, Oregon Laws 2013. [2007 c.872 §2; 2013 c.771 §7]

Note: The amendments to 743A.190 (Children with pervasive developmental disorder) by section 20, chapter 771, Oregon Laws 2013, become operative January 2, 2022. See section 24, chapter 771, Oregon Laws 2013. The text that is operative on and after January 2, 2022, is set forth for the user's convenience.

743A.190 (Children with pervasive developmental disorder)

(1) A health benefit plan, as defined in ORS 743B.005 (Definitions) must cover for a child enrolled in the plan who is under 18 years of age and who has been diagnosed with a pervasive developmental disorder all medical services, including rehabilitation services, that are medically necessary and are otherwise covered under the plan.
(2) The coverage required under subsection (1) of this section, including rehabilitation services, may be made subject to other provisions of the health benefit plan that apply to covered services, including but not limited to:
(a) Deductibles, copayments or coinsurance;
(b) Prior authorization or utilization review requirements; or
(c) Treatment limitations regarding the number of visits or the duration of treatment.
(3) As used in this section:
(a) "Medically necessary" means in accordance with the definition of medical necessity that is specified in the policy, certificate or contract for the health benefit plan and that applies uniformly to all covered services under the health benefit plan.
(b) "Pervasive developmental disorder" means a neurological condition that includes autism spectrum disorder, developmental delay, developmental disability or mental retardation.
(c) "Rehabilitation services" means physical therapy, occupational therapy or speech therapy services to restore or improve function.
(4) The provisions of ORS 743A.001 (Automatic repeal of certain statutes on individual and group health insurance) do not apply to this section.
(5) The definition of "pervasive developmental disorder" is not intended to apply to coverage required under ORS 743A.168 (Behavioral health treatment).

Texas

Texas Insurance Code (TIC), Title 8, Subtitle E, Chapter 1367, Subchapter E. Developmental Delays

Section 1367.201, Definition

https://statutes.capitol.texas.gov/DocViewer.aspx?DocKey=IN%2fIN.1367&Phrases=1367.201&HighlightType=1&ExactPhrase=False&QueryText=1367.201

In this subchapter, rehabilitative and habilitative therapies include:
(1) Occupational therapy evaluations and services;
(2) Physical therapy evaluations and services;
(3) Speech therapy evaluations and services; and
(4) Dietary or nutritional evaluations.

Section 1367.202, Applicability of Subchapter

https://statutes.capitol.texas.gov/DocViewer.aspx?DocKey=IN%2fIN.1367&Phrases=1367.202&HighlightType=1&ExactPhrase=False&QueryText=1367.202

This subchapter applies only to a health benefit plan that:
(1) Provides benefits for medical or surgical expenses incurred as a result of a health condition, accident, or sickness, including an individual, group, blanket, or franchise insurance policy or insurance agreement, a group hospital service contract, or an individual or group evidence of coverage that is offered by:
(A) An insurance company;

(B) A group hospital service corporation operating under Chapter 842;
(C) A fraternal benefit society operating under Chapter 885;
(D) A stipulated premium company operating under Chapter 884;
(E) A health maintenance organization operating under Chapter 843; or
(F) A multiple employer welfare arrangement subject to regulation under Chapter 846;
(2) Is offered by an approved nonprofit health corporation that holds a certificate of authority under Chapter 844; or
(3) Provides health and accident coverage through a risk pool created under Chapter 172, Local Government Code, notwithstanding Section 172.014, Local Government Code, or any other law.

Section 1367.203, Exception

https://statutes.capitol.texas.gov/DocViewer.aspx?DocKey=IN%2fIN.1367&Phrases=1367.203&HighlightType=1&ExactPhrase=False&QueryText=1367.203

This subchapter does not apply to:
(1) A plan that provides coverage:
(A) Only for a specified disease or for another limited benefit;
(B) Only for accidental death or dismemberment;
(C) For wages or payments in lieu of wages for a period during which an employee is absent from work because of sickness or injury;
(D) As a supplement to a liability insurance policy;
(E) For credit insurance;
(F) Only for dental or vision care; or
(G) Only for indemnity for hospital confinement;
(2) A small employer health benefit plan written under Chapter 1501;
(3) A Medicare supplemental policy as defined by Section 1882(g)(1), Social Security Act (42 U.S.C. Section 1395ss);
(4) A workers' compensation insurance policy;
(5) Medical payment insurance coverage provided under a motor vehicle insurance policy; or
(6) A long-term care insurance policy, including a nursing home fixed indemnity policy, unless the commissioner determines that the policy provides benefit coverage so comprehensive that the policy is a health benefit plan as described by Section 1367.202.

Section 1367.204, Offer of Coverage Required

https://statutes.capitol.texas.gov/DocViewer.aspx?DocKey=IN%2fIN.1367&Phrases=1367.204&HighlightType=1&ExactPhrase=False&QueryText=1367.204

(a) A health benefit plan issuer must offer coverage that complies with this subchapter.
(b) The individual or group policy or contract holder may reject coverage required to be offered under this section.

Section 1367.205, Coverage of Certain Therapies

https://statutes.capitol.texas.gov/DocViewer.aspx?DocKey=IN%2fIN.1367&Phrases=1367.205&HighlightType=1&ExactPhrase=False&QueryText=1367.205

(a) A health benefit plan that provides coverage for rehabilitative and habilitative therapies under this subchapter may not prohibit or restrict payment for covered services provided to a child and determined to be necessary to and provided in accordance with an individualized family service plan issued by the Interagency Council on Early Childhood Intervention under Chapter 73, Human Resources Code.
(b) Rehabilitative and habilitative therapies described by Subsection (a) must be covered in the amount, duration, scope, and service setting established in the child's individualized family service plan.
(c) A child is entitled to benefits under this subchapter if the child, as a result of the child's relationship to an insured or enrollee in a health benefit plan, would be entitled to coverage under an accident and health insurance policy under Section 1201.061, 1201.062, 1201.063, or 1201.064.

Section 1367.206, Prohibited Actions

https://statutes.capitol.texas.gov/DocViewer.aspx?DocKey=IN%2fIN.1367&Phrases=1367.206&HighlightType=1&ExactPhrase=False&QueryText=1367.206

Under the coverage required to be offered under this subchapter, a health benefit plan issuer may not:
(1) Apply the cost of rehabilitative and habilitative therapies described by Section 1367.205(a) to an annual or lifetime maximum plan benefit or similar provision under the plan; or
(2) Use the cost of rehabilitative or habilitative therapies described by Section 1367.205(a) as the sole justification for:
(A) Increasing plan premiums; or
(B) Terminating the insured's or enrollee's participation in the plan.

Section 1367.207, Rules

https://statutes.capitol.texas.gov/DocViewer.aspx?DocKey=IN%2fIN.1367&Phrases=1367.207&HighlightType=1&ExactPhrase=False&QueryText=1367.207

The commissioner may adopt rules necessary to implement this subchapter.

TIC, Title 8, Subtitle C, Chapter 1271, Subchapter D. Certain Benefits Required

Section 1271.156, Benefits for Rehabilitation Services and Therapies

https://statutes.capitol.texas.gov/DocViewer.aspx?DocKey=IN%2fIN.1271&Phrases=1271.156&HighlightType=1&ExactPhrase=False&QueryText=1271.156

(a) If benefits are provided for rehabilitation services and therapies under an evidence of coverage, the provision of a rehabilitation service or therapy that, in the opinion of a physician, is medically necessary may not be denied, limited, or terminated if the service or therapy meets or exceeds treatment goals for the enrollee.

(b) For an enrollee with a physical disability, treatment goals may include maintenance of functioning or prevention of or slowing of further deterioration.

Washington

Revised Code of Washington (RCW), Section 18.74.010, Definitions

https://app.leg.wa.gov/rcw/default.aspx?cite=18.74.010

(8) Physical therapist" means a person who meets all the requirements of this chapter and is licensed in this state to practice physical therapy

(9) (a) "Physical therapist assistant" means a person who meets all the requirements of this chapter and is licensed as a physical therapist assistant and who performs physical therapy procedures and related tasks that have been selected and delegated only by the supervising physical therapist. However, a physical therapist may not delegate sharp debridement to a physical therapist assistant.

(b) "Physical therapy aide" means an unlicensed person who receives ongoing on-the-job training and assists a physical therapist or physical therapist assistant in providing physical therapy patient care and who does not meet the definition of a physical therapist or physical therapist assistant or other assistive personnel. A physical therapy aide may directly assist in the implementation of therapeutic interventions, but may not alter or modify the plan of therapeutic interventions and may not perform any procedure or task which only a physical therapist may perform under this chapter.

(c) "Other assistive personnel" means other trained or educated health care personnel, not defined in (a) or (b) of this subsection, who perform specific designated tasks related to physical therapy and within their license, scope of practice or formal education, under the supervision of a physical therapist, including but not limited to licensed massage therapists, athletic trainers, and exercise physiologists. At the direction of the supervising physical therapist, and if properly credentialed and not prohibited by any other law, other assistive personnel may be identified by the title specific to their training or education.

(10)“Physical therapy" means the care and services provided by or under the direction and supervision of a physical therapist licensed by the state. Except as provided in RCW 18.74.190 the use of Roentgen rays and radium for diagnostic and therapeutic purposes, the use of electricity for surgical purposes, including cauterization, and the use of spinal manipulation, or manipulative mobilization of the spine and its immediate articulations, are not included under the term "physical therapy" as used in this chapter.

(11)“Practice of physical therapy" is based on movement science and means:

(a) Examining, evaluating, and testing individuals with mechanical, physiological, and developmental impairments, functional limitations in movement, and disability or other health and movement-related conditions in order to determine a diagnosis, prognosis, plan of therapeutic intervention, and to assess and document the ongoing effects of intervention;

(b) Alleviating impairments and functional limitations in movement by designing, implementing, and modifying therapeutic interventions that include therapeutic exercise; functional training related to balance, posture, and movement to facilitate self-care and reintegration into home, community, or work; manual therapy including soft tissue and joint mobilization and manipulation; therapeutic massage; assistive, adaptive, protective, and devices related to postural control and mobility except as restricted by (c) of this subsection; airway clearance techniques; physical agents or modalities; mechanical and electrotherapeutic modalities; and patient-related instruction;

(c) Training for, and the evaluation of, the function of a patient wearing an orthosis or prosthesis as defined in RCW 18.200.010. Physical therapists may provide those direct-formed and prefabricated upper limb, knee, and ankle-foot orthoses, but not fracture orthoses except those for hand, wrist, ankle, and foot fractures, and assistive technology devices specified in RCW 18.200.010 as exemptions from the defined scope of licensed orthotic and prosthetic services. It is the intent of the legislature that the unregulated devices specified in RCW 18.200.010 are

in the public domain to the extent that they may be provided in common with individuals or other health providers, whether unregulated or regulated under Title 18 RCW, without regard to any scope of practice;
(d) Performing wound care services that is limited to sharp debridement, debridement with other agents, dry dressings, wet dressings, topical agents including enzymes, hydrotherapy, electrical stimulation, ultrasound, and other similar treatments. Physical therapists may not delegate sharp debridement. A physical therapist may perform wound care services only by referral from or after consultation with an authorized health care practitioner;
(e) Performing intramuscular needling;
(f) Reducing the risk of injury, impairment, functional limitation, and disability related to movement, including the promotion and maintenance of fitness, health, and quality of life in all age populations; and
(g) Engaging in administration, consultation, education, and research.

RCW, Section 18.74.012, Consultation with Health Care Practitioner Not Required For Certain Treatments

https://app.leg.wa.gov/rcw/default.aspx?cite=18.74.012

A consultation and periodic review by an authorized health care practitioner is not required for treatment of neuromuscular or musculoskeletal conditions.

RCW, Section 48.43.045, Health Plan Requirements - Annual Reports - Exemptions

https://app.leg.wa.gov/rcw/default.aspx?cite=48.43.045

(1) Every health plan delivered, issued for delivery, or renewed by a health carrier, 1996, shall:
  (a) Permit every category of health care provider to provide health services or care included in the basic essential health benefits benchmark plan established by the commissioner consistent with RCW 48.43.715,to the extent that:
    (i) The provision of such health services or care is within the health care provider's permitted scope of practice;
    (ii) The providers agree to abide by standards related to:
      (A) Provision, utilization review, and cost containment of health services;
      (B) Management and administrative procedures; and
      (C) Provision of cost-effective and clinically efficacious health services; and
    (iii) The plan covers such services or care in the essential health benefits benchmark plan. The reference to the essential health benefits does not create a mandate to cover a service that is otherwise not a covered benefit.

RCW, Section 48.44.450, Neurodevelopmental Therapies - Employer-Sponsored Group Contracts

https://app.leg.wa.gov/rcw/default.aspx?cite=48.44.450

(1) Each employer-sponsored group contract for comprehensive health care service which is entered into, or renewed, on or after twelve months after July 23, 1989, shall include coverage for neurodevelopmental therapies for covered individual's age six and under.
(2) Benefits provided under this section shall cover the services of those authorized to deliver occupational therapy, speech therapy, and physical therapy. Benefits shall be payable only where the services have been delivered pursuant to the referral and periodic review of a holder of a license issued pursuant to chapter 18.71 or 18.57 RCW or where covered services have been rendered by such licensee. Nothing in this section shall prohibit a health care service contractor from requiring that covered services be delivered by a provider who participates by contract with the health care service contractor unless no participating provider is available to deliver covered services. Nothing in this section shall prohibit a health care service contractor from negotiating rates with qualified providers.
(3) Benefits provided under this section shall be for medically necessary services as determined by the health care service contractor. Benefits shall be payable for services for the maintenance of a covered individual in cases where significant deterioration in the patient's condition would result without the service. Benefits shall be payable to restore and improve function.
(4) It is the intent of this section that employers purchasing comprehensive group coverage including the benefits required by this section, together with the health care service contractor, retain authority to design and employ utilization and cost controls. Therefore, benefits delivered under this section may be subject to contractual provisions regarding deductible amounts and/or copayments established by the employer purchasing coverage and the health care service contractor. Benefits provided under this section may be subject to standard waiting periods for preexisting conditions, and may be subject to the submission of written treatment plans.
(5) In recognition of the intent expressed in subsection (4) of this section, benefits provided under this section may be subject to contractual provisions establishing annual and/or lifetime benefit limits. Such limits may define the total dollar benefits available or may limit the number of services delivered as agreed by the employer purchasing coverage and the health care service contractor.

Note: Neurodevelopmental therapies are services rendered to children age six (6) and under, who have developmental delay due to diagnosable medical cause such as autism, prematurity, or cerebral palsy. Benefits provided will cover the services of those authorized to deliver occupational therapy, speech therapy and physical therapy. Benefits will be payable to restore and improve function and for the maintenance of a condition where significant deterioration in the child's condition would result without the service**.** Inpatient or residential neurodevelopmental programs in the absence of a medical condition requiring acute medical care are never covered.

For regulatory guidance, Refer to the Washington State Department of Social and Health Services' Division of Developmental Disabilities.

For specific visit limitations, refer to the member's Schedule of Benefits (SOB) or contact the Customer Service Department.

a. **Habilitative Services:** Short-term Habilitative Services are covered on an outpatient basis for members with a Congenital, genetic, or early acquired disorder when both of the following conditions are met:
   - The treatment is administered by a licensed speech-language pathologist, licensed audiologist, licensed occupational therapist, licensed physical therapists, or Physician.
   - The initial or continued treatment must be proven and not an Experimental and/or Investigational Procedure, Item and Treatment.

Covered Services for Habilitative Services do not apply to those services that are solely educational in nature or otherwise paid under state or federal law for purely educational services. Custodial Care, respite care, day care, therapeutic recreation, vocational training and residential treatment are not Habilitative Services. A service that does not help the member meet functional goals in a treatment plan within a prescribed time frame is not a Habilitative Service. When the member reaches his/her maximum level of improvement or does not demonstrate continued progress under a treatment plan, a service that was previously Habilitative is no longer Habilitative.

We may require that a treatment plan be provided, request medical records, clinical notes, or other necessary data to allow us to substantiate the initial or continued medical treatment is needed and that the member's condition is clinically improving as a result of the Habilitative Service. When the treating Provider anticipates that continued treatment is or will be required to permit the member to achieve demonstrable progress, we may request a treatment plan consisting of diagnosis, proposed treatment type, frequency the treatment plan will be updated.

State Market Plan Enhancements

Texas

Members may have additional supplemental benefit coverage for rehabilitative and Habilitative Services for dependent children under the age of three with developmental delays as deemed necessary to and in accordance with an individualized family service plan issued by the Interagency Council on Early Childhood Intervention under Chapter 73, Human Resources Code. Refer to the state-specific mandated coverage in the *Federal/State Mandated Regulations* section.

Covered Benefits

Important Note: Covered benefits are listed in *Federal/State Mandated Regulations*, *State Market Plan Enhancements*, and *Covered Benefits* sections. Always refer to the *Federal/State Mandated Regulations* and *State Market Plan Enhancements* sections for additional covered services/benefits not listed in this section.

Refer to the member's Evidence of Coverage (EOC)/Schedule of Benefits (SOB) to determine coverage eligibility.

Benefits for outpatient Habilitative Services include:
- Physical therapy.
- Occupational therapy.
- Post-cochlear implant aural therapy.
- Cognitive habilitative therapy.
- Manipulative treatment.
- Speech therapy.

Note: For plans that provide Essential Health Benefits, benefits are provided for Habilitative Services for members to help a member with a disabling condition to keep, learn, or improve skills and functioning for daily living.

Habilitative services must be:

- Ordered by a physician and performed by a licensed speech-language pathologist, licensed audiologist, licensed occupational therapist, licensed physical therapist, physician, licensed nutritionist, licensed social worker or licensed psychologist, a licensed behavioral analyst, or assistant behavioral analyst or autism technician licensed under the laws of the state, and
- Provided in a physician's office or on an outpatient basis at a hospital or alternate facility (such as health care facility that provides outpatient rehabilitative services).

We may require documentation to substantiate that initial or continued medical treatment is needed. Refer to the Medical Management Guideline titled Habilitation and Rehabilitation Therapy (Occupational, Physical, and Speech) for additional information.

For coverage of durable medical equipment and prosthetic devices, refer to the Benefit Interpretation Policy titled Durable Medical Equipment (DME), Prosthetics, Corrective Appliances/Orthotics (Non-Foot Orthotics) and Medical Supplies for additional information.

Additional Information

- Habilitative Services received while in an inpatient setting (e.g., inpatient hospital, inpatient rehabilitation facility or skilled nursing facility) are covered when the member is admitted or the services are authorized by either the member's network medical group or UnitedHealthcare. Refer to the member's Evidence of Coverage (EOC) Schedule of Benefits (SOB) for additional information.
- Eligible physical therapy and occupational therapy received in the home and provided by:
  - A home health agency is covered under the *Home Health Care* section of the plan.
  - An independent physical or occupational therapist is covered under the Habilitative Services benefit.
- Benefits for Habilitative Services provided by the plan do not affect or reduce any obligation to provide services under an individualized education program per the education code or individualized service plan as described in the Welfare and Institutions Code or Disabilities Education Act.

Not Covered

- Biofeedback services. Refer to the member's Evidence of Coverage (EOC)/Schedule of Benefits (SOB).
- Cardiac and pulmonary therapy.(These are rehabilitative services) Refer to the Benefit Interpretation Guideline titled Rehabilitation Services (Physical, Occupational, and Speech Therapy) for additional information.
- 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. Refer to the member's Evidence of Coverage (EOC)/Schedule of Benefits (SOB) and state mandates.
- Custodial care, respite care, day care, therapeutic recreational care, vocational training, and residential treatment.
- Gym and fitness club memberships and fees, health club fees, exercise equipment, or supplies.
- 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.
- Programs that do not require the supervision of physician and/or a licensed therapy provider.
- Services that:
  - Are beyond any visit limits, if any, as specified in the member specific benefit document. Refer to the member's Evidence of Coverage (EOC)/Schedule of Benefits (SOB).
  - Do not help the member to meet or maintain functional goals in a treatment plan within a prescribed time frame.
  - Are considered by UnitedHealthcare to be unproven, investigational, or experimental.
  - Are solely educational or vocational in nature or otherwise paid under state or federal law for purely educational services.
  - Are provided once the treatment plan goals have been met.
  - Are provided when the member does not meet criteria for coverage as indicated in the *Covered Benefits* section above or in the member's Evidence of Coverage (EOC)/Schedule of Benefits (SOB).
  - Are performed to improve a member's general well-being or physical condition in the absence of a disabling condition.
- Social services.

- Work Hardening.

Definitions

Congenital Anomaly/Defect (also commonly referred to as congenital anomalies, birth defects, congenital disorders, congenital malformations, or congenital abnormalities): Are conditions of prenatal origin that are present at birth, potentially impacting an infant's health, development, and/or survival.

Habilitative Services: 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 people with disabilities in a variety of inpatient and/or outpatient settings.

Work Hardening: Work Hardening is an interdisciplinary program consisting of physical therapy, occupational therapy and counseling professionals for injured workers or other adults whose injuries or disease processes interfere with their ability to work. It provides structured treatment designed to progressively improve physical function as a transition between acute care and return to work.

References

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"Habilitative/Habilitation Services - Glossary" (n.d.). HealthCare.gov, Department of Health & Human Services. https://www.healthcare.gov/glossary/habilitative-habilitation-services/. Accessed September 29, 2023.

Policy History/Revision Information

Date	State(s) Affected	Summary of Changes
12/01/2024	All	**Covered Benefits** • Replaced language for plans that provide Essential Health Benefits indicating "benefits are provided for Habilitative Services for members to help a member with a disabling condition to keep, learn, or improve skills and functioning for daily living *when both of the [listed] conditions are met*" with "benefits are provided for Habilitative Services for members to help a member with a disabling condition to keep, learn, or improve skills and functioning for daily living; *Habilitative Services must [include the listed services]"* • Removed language indicating coverage of durable medical equipment and prosthetic devices, when used as a component of Habilitative Services, may require a separate review • Added instruction to refer to the Benefit Interpretation Policy titled *Durable Medical Equipment (DME), Prosthetics, Corrective Appliances/Orthotics (Non-Foot Orthotics), and Medical Supplies* for additional information on coverage of durable medical equipment and prosthetic devices, when used as a component of Habilitative Services *Documentation* • Replaced language indicating "[UnitedHealthcare] may require *that a treatment plan be provided, request medical records, clinical notes, or other necessary data to allow [UnitedHealthcare]* to substantiate that initial or continued medical treatment is needed" with "[UnitedHealthcare] may require *documentation* to substantiate that initial or continued medical treatment is needed" • Added instruction to refer to the Medical Management Guideline titled *Habilitation and Rehabilitation Therapy (Occupational, Physical, and Speech)* for additional information

Date	State(s) Affected	Summary of Changes
		• Removed language indicating [UnitedHealthcare] may request a treatment plan consisting of diagnosis, proposed treatment by type, frequency, anticipated duration of treatment, the anticipated goals of treatment, and how frequently the treatment plan will be updated when the treating provider anticipates that continued treatment is or will be required to permit the member to achieve demonstrable progress *Additional Information* • Replaced language indicating: ○ "Habilitative Services received while in an inpatient setting (e.g., inpatient hospital, inpatient rehabilitation facility, or skilled nursing facility) are covered *as part of that benefit; depending on the inpatient setting, benefits are the same as the applicable inpatient benefit category (hospital inpatient, skilled nursing facility/inpatient rehabilitation facility benefit)*" with "Habilitative Services received while in an inpatient setting (e.g., inpatient hospital, inpatient rehabilitation facility, or skilled nursing facility) are covered *when the member is admitted or the services are authorized by either the member's network medical group or UnitedHealthcare; refer to the member's Evidence of Coverage (EOC)/Schedule of Benefits (SOB) for additional information*" ○ "Eligible physical therapy and occupational therapy received in the home *from* a home health agency is covered under the Home Health Care section of the plan*; the home health care benefit only applies to services that are rendered by a home health agency*" with "eligible physical therapy and occupational therapy received in the home *and provided by* a home health agency is covered under the Home Health Care section of the plan" ○ "Eligible physical therapy and occupational therapy received in the home *from* an independent physical or occupational therapist *(a physical or occupational therapist that is not affiliated with a home health agency)* is covered under the Habilitative Services benefit" with "eligible physical therapy and occupational therapy received in the home *and provided by* an independent physical or occupational therapist is covered under the Habilitative Services benefit" • Removed language indicating cardiac and pulmonary therapy are covered under the rehabilitation services benefit; these are not Habilitative Services **Not Covered** • Revised list of non-covered services: ○ Added "cardiac and pulmonary therapy (these are rehabilitative services); refer to the Benefit Interpretation Policy titled *Rehabilitation Services (Physical, Occupational, and Speech Therapy)* for additional information" ○ Replaced: ▪ "Biofeedback services; refer to the member *specific benefit documents*" with "biofeedback services; refer to the member's *EOC/SOB*" ▪ "Confinement, treatment, services, or supplies that are required only by a court of law or only for insurance, travel, employment, and school or camp purposes; refer to the member *specific benefit document* and state mandates" with "confinement, treatment, services, or supplies that are required only by a court of law or only for insurance, travel, employment, and school or camp purposes; refer to the member's *EOC/SOB* and state mandates" ▪ "A service that does not help the member to meet or maintain functional goals in a treatment plan within a prescribed time frame *is not a Habilitative Service*" with "services that do not help the member to meet or maintain functional goals in a treatment plan within a prescribed time frame"

Date	State(s) Affected	Summary of Changes
		▪ "Services to improve general physical condition in the absence of a disabling condition *are excluded from coverage*" with "services *that are performed* to improve *a member's* general *well-being or* physical condition in the absence of a disabling condition" ▪ "[Services] once the treatment plan goals *are* met" with "*services that are provided* once the treatment plan goals *have been* met" ▪ "When the member does not meet criteria for coverage as indicated in the *Covered Benefits* section [of the policy] *and* member specific benefit document" with "*services that are provided* when the member does not meet criteria for coverage as indicated in the *Covered Benefits* section [of the policy] *or in the* member's *EOC/SOB*" ○ Removed "therapies provided for the purpose of general well-being or conditioning in the absence of a disabling condition" ○ Added instruction to refer to the member's EOC/SOB for services that are beyond any visit limits, if any, if specified in the member specific benefit document **Supporting Information** • Archived previous policy version BIP202.I
	Oklahoma	**Federal/State Mandated Regulations** • Updated reference link to the *Oklahoma Administrative Code Section 365:40-5-21*
	Oregon	**Federal/State Mandated Regulations** • Removed language pertaining to *Revised Code of Washington Section 48.44.450*

Instructions for Use

Covered benefits are listed in three (3) sections: *Federal/State Mandated Regulations*, *State Market Plan Enhancements*, and *Covered Benefits*. All services must be medically necessary. Each benefit plan contains its own specific provisions for coverage, limitations, and exclusions as stated in the member's Evidence of Coverage (EOC)/Schedule of Benefits (SOB). If there is a discrepancy between this policy and the member's EOC/SOB, the member's EOC/SOB provision will govern.