MEDICAL POLICY

SUBJECT: OCCUPATIONAL THERAPY (OT)	EFFECTIVE DATE: 10/18/01 REVISED DATE: 08/22/02, 01/22/04, 04/28/05, 04/27/06, 02/22/07, 04/24/08, 04/23/09, 06/24/10, 06/24/11, 08/23/12, 08/22/13, 08/28/14, 08/27/15, 08/25/16, 08/25/17, 08/23/18
POLICY NUMBER: 8.01.17 CATEGORY: Therapy/Rehabilitation	PAGE: 1 OF: 8

- ***If a product excludes coverage for a service, it is not covered, and medical policy criteria do not apply.***
- ***If a commercial product (including an Essential Plan product) or a Medicaid product covers a specific service, medical policy criteria apply to the benefit.***
- ***If a Medicare product covers a specific service, and there is no national or local Medicare coverage decision for the service, medical policy criteria apply to the benefit.***

POLICY STATEMENT:

I. Based upon our criteria and review of the peer-reviewed literature, acute, restorative or habilitative occupational therapy (OT) services have been medically proven to be effective and are therefore, **medically appropriate** when performed to meet the needs of an adult patient that suffers from a medically determinable functional physical impairment due to disease, trauma, congenital anomalies or prior therapeutic intervention(s)., as determined by standardized assessment.

In determining the medical necessity of OT services consideration will be given to the degree/severity of limitation/deficit the impairment poses on the individual and whether the deficit(s) are expected to improve over a short period of time (generally up to two months) with treatment. In order for ongoing treatment to continue to be considered medically necessary significant improvement, as determined with reference to standardized assessment(s) completed during evaluation and repeated on follow up session(s), must be demonstrated in objective measures.

II. Based upon our criteria and review of the peer-reviewed literature, active, restorative or habilitative occupational therapy has been medically proven to be effective and is **medically appropriate** for children suffering from a medically determinable severe or significant impairment, as determined by standardized assessments, resulting from disease, trauma, congenital anomaly or previous therapeutic processes.

A medically determinable severe delay or disorder in a child is identified by a functional impairment/deficit that adversely affects the child's performance or a significant delay or disorder in one or more functional areas, as compared to accepted milestones for child development, which adversely affects the child's ability to learn.

Significant delays or disorders in children, are defined as:

A. A 33% delay in one functional area or a 25% delay in each of two areas; or
B. If appropriate standardized instruments are individually administered in the evaluation process, a score of at least 2.0 standard deviations below the mean in one functional area or score of at least 1.5 standard deviations below the mean in each of two functional areas.

III. Based upon our criteria and review of the peer-reviewed literature, non-skilled services that do not generally require the skills of a qualified provider of OT services are **not medically necessary**. These services may include:

A. passive range of motion (PROM) treatment which is not related to restoration of a specific loss of function;
B. services which maintain function by using routine, repetitive and reinforced procedures (e.g. daily feeding programs once the adaptive procedures are in place), conditioning or land or water-based exercise programs; and
C. crutch training.

IV. Based upon our criteria and review of the peer-reviewed literature, the following OT services have not been proven to be effective are considered **not medically necessary**:

A. Gait analysis,
B. Sensory integration therapy;
C. Work-related or workers compensation programs (e.g., work-evaluation, work reconditioning, work hardening programs, sheltered work programs, vocational training) as these programs are for conditioning primarily for return to work and not treatment of a medical condition.

When OT services are needed to treat a medical or surgical condition in order for a patient to return to work services are covered by the New York State Vocational and Educational Services for Individuals with

Disabilities (VESID) Program.

V. Based upon our criteria and review of the peer-reviewed literature, constraint induced movement therapy (CIMT), as a sole measure of therapy, has not been medically proven to be effective and is considered **investigational** for all indications, including but not limited to, cerebral palsy, congenital hemiplegia, and stroke rehabilitation.

VI. Maintenance programs are programs that consist of activities that preserve the patient's present level of function and prevent regression of that function. Maintenance begins when the therapeutic goals of a treatment plan have been achieved or when no additional functional progress is apparent or expected to occur. Maintenance programs are **not medically necessary**.

Refer to Corporate Medical Policy #2.01.13 regarding Computerized Motion Diagnostic Imaging (CMDI)/Gait Analysis.

Refer to Corporate Medical Policy # 8.01.12 regarding Physical Therapy.

Refer to Corporate Medical Policy# 8.01.19 regarding Cognitive Rehabilitation.

Refer to Corporate Medical Policy # 10.01.02 regarding Chiropractic Care.

Refer to Corporate Medical Policy # 10.01.09 regarding Early Intervention Program services.

Refer to Corporate Medical Policy # 11.01.03 regarding Experimental and Investigational Services.

POLICY GUIDELINES:

I. Occupational therapy must meet all of the following criteria:
   A. meet the functional needs of a patient who suffers from physical impairment due to disease, trauma, congenital anomalies or prior therapeutic intervention;
   B. achieve a specific diagnosis-related goal for a patient who has a reasonable expectation of achieving measurable improvement in a reasonable and predictable period of time;
   C. provide specific, effective, and reasonable treatment for the patients diagnosis and physical condition;
   D. be delivered by a qualified provider of occupational therapy services. A qualified provider is one who is licensed where required and performs within the scope of licensure; and
   E. requires the judgment, knowledge, and skills of a qualified provider of occupational therapy services due to the complexity and sophistication of the therapy and the physical condition of the patient.

II. Occupational therapy office records must contain a written plan of care which should include:
   A. diagnosis including severity level of diagnosis;
   B. specific statements of long and short-term functional based goals;
   C. measurable objectives based on standardized outcome measures defined in evaluation and reassessed during follow up sessions;
   D. a reasonable estimate of when the goals will be reached;
   E. the specific treatment techniques and/or activities to be used in treatment (skilled intervention);
   F. the frequency and duration of treatment; and
   G. Prior Level of Function(PLOF), prior treatment and Current Level of Function(CLOF)

III. Certain contracts only cover short-term OT services for a limited number of visits per condition, per lifetime, or per contract year. These visit limits do not apply when OT is for the treatment of a Mental Disorder (including Autism Spectrum Disorder). Mental disorder as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders.

IV. Coverage is not available for services provided by school districts, as stipulated in the child's (pre-school ages 3-5 years and school-age 5-21 years) Individualized Education Program (IEP) as they are considered free care or a government program.

A. When applicable, an IEP should be completed through the school district before a request for coverage is submitted to the Health Plan.

B. If a child is home schooled an assessment by the school district should be completed prior to submitting a request to the Health Plan for coverage. Requests for services for home schooled children outside New York State will be reviewed on an individual basis in accordance with state regulations for the state in which the child lives.

C. Occupational therapy services denied by the school district, including summer services, and not covered in a child's IEP will be reviewed by the Health Plan for medical necessity in accordance with member's contract.

D. Interim summer programs are provided by school districts for children whose handicapping conditions are severe enough to exhibit the need for a structured learning environment of 12 months duration in order to maintain developmental levels. For preschool children, summer instruction must be available for those whose disabilities are severe enough to exhibit the need for a structured learning environment of 12 months duration to prevent substantial regression.

V. Benefits for habilitative services are contract dependent. Please refer to the member's subscriber contract for specific benefit information.

DESCRIPTION:

Occupational Therapy (OT) is a form of rehabilitation therapy involving the treatment of individuals of all ages with functional deficits resulting from injury, disease, or birth. Occupational therapists assess all components of function (strength, ROM, sensation, coordination, cognition, perception, vision, memory, judgment, safety, etc.) and work with the individual through the use of goal-directed graded activity and exercise to improve skills. When this is not possible, adaptation of technique or equipment is utilized to improve function in areas of activities of daily living (ADL) which may include self-care (e.g., bathing, dressing, toileting, grooming, feeding), homemaking, money management, leisure, play, written communication, community re-entry, etc.

Other related OT services include fabrication and/or selection and training in the use of orthoses, custom therapeutic garments, upper extremity prosthetics and adaptive equipment/assistive technology. Use of superficial heat in preparation for functional activities (paraffin, hot packs, and fluid therapy) may be used.

Sensory integration therapy (SIT) is a form of OT that has been investigated as a treatment of autism, mental retardation or learning disabilities. Sensory integration therapy is aimed at improving the way the brain processes and organizes sensations, as opposed to teaching higher order skills.

Constraint-induced movement therapy is proposed as a method of therapy to help patients with neurological disorders (e.g., cerebral palsy, congenital hemiplegia, stroke) regain the use of dysfunctional limb(s). CIMT involves restraint of the unaffected limb and intensively engaging the affected limb in repetitive exercises; which results in the new neural pathways being generated in the brain.

OT is a short-term therapy for which significant, measurable improvements are the expected result. Impairments range in severity from mild to severe and are classified according to their level of severity. A mild impairment is less than 1 standard deviation from normal, a moderate impairment is 1–2 standard deviations from normal, and a severe impairment is more than 2 standard deviations from normal.

Pursuant to New York State law, effective November 1, 2012, each contract providing physician services, medical, major medical, or similar comprehensive-type coverage must provide coverage for the screening, diagnosis, and treatment of Autism Spectrum Disorders when prescribed or ordered by a licensed physician or a licensed psychologist for medically necessary services. Treatment includes services provided by a licensed or certified speech therapist, occupational therapist, physical therapist, and social worker when the policy generally provides such coverage. Therapeutic treatment must include care that is deemed habilitative or non-restorative.

As of January 1, 2014, the Patient Protection and Affordable Care Act (PPACA) requires all health insurers to provide essential health benefits in the individual and small group markets, including habilitative services. According to the PPACA, habilitative services are health care services that help a person keep, learn or improve skills and functioning for daily living and include the management of limitations and disabilities, including services or programs that help maintain or prevent deterioration in physical, cognitive, or behavioral function.

RATIONALE:

Sensory integration therapy – There is not enough evidence to permit conclusions regarding the effectiveness or whether SIT improves the net health outcome in children with autism and developmental impairments. Only one study was published for SIT in autistic children and 3 studies were published for SIT in mentally retarded children; with the validity of all 4 studies being questionable. The evidence indicates that SIT does not improve the net health outcome in learning disabled children when compared to alternative treatments or no treatment at all.

In June 2012, the American Academy of Pediatrics (AAP) issued a policy statement indicating that OT "with the use of sensory-based therapies may be acceptable as one of the components of a comprehensive treatment plan. However, parents should be informed that the amount of research regarding the effectiveness of sensory integration therapy is limited and inconclusive".

Constraint-induced movement therapy - There is not enough evidence to permit conclusions regarding the effectiveness of CIMT for any indication. The majority of studies address the utilization of CIMT in either cerebral palsy, congenital hemiplegia, or stroke rehabilitation. Several studies, systematic reviews and meta-analysis have recently been published and generally conclude that further rigorous, well-designed, randomized, controlled studies addressing CIMT are needed to determine the efficacy of its use.

CODES: Number Description

Eligibility for reimbursement is based upon the benefits set forth in the member's subscriber contract.

CODES MAY NOT BE COVERED UNDER ALL CIRCUMSTANCES. PLEASE READ THE POLICY AND GUIDELINES STATEMENTS CAREFULLY.

Codes may not be all inclusive as the AMA and CMS code updates may occur more frequently than policy updates.

Code Key: Experimental/Investigational = (E/I), Not medically necessary/ appropriate = (NMN).

Note: Reimbursement mechanisms vary by Health Plan Region. Services may be reimbursed on a per modality or a global reimbursement basis.

CPT:	97165	Occupational therapy evaluation, low
	97166	Occupational therapy evaluation, moderate complexity
	97167	Occupational therapy evaluation, high complexity
	97168	Re-evaluation of occupational therapy established plan of care
	97533 **(NMN)**	Sensory integrative techniques to enhance sensory processing and promote adaptive responses to environmental demands, direct (one-on-one) patient contact, each 15 minutes

	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 (eg, 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 **(NMN)**	Community/work reintegration training (eg, shopping, transportation, money management, avocational activities and/or work environment/modification analysis, work task analysis), direct one-on-one contact, each 15 minutes
	97545 **(NMN)**	Work hardening/conditioning; initial 2 hours
	97546 **(NMN)**	each additional hour

HCPCS:	G0129	Occupational therapy requiring the skills of a qualified occupational therapist, furnished as a component of a partial hospitalization treatment program, per session (45 minutes or more)
	S9129	Occupational therapy; in the home, per diem
MODIFIER:	SZ	Habilitative services
	96	Habilitative services
	97	Rehabilitative services
ICD10:	Several	

REFERENCES:

Abo M, et al. Randomized, multicenter, comparative study of NEURO versus CIMT in poststroke patients with upper limb hemiparesis: the NEURO-VERIFY Study. Int J Stroke 2014 Jul;9(5):607-12.

American Academy of Pediatrics. Sensory integration therapies for children with developmental and behavioral disorders. Policy statement. Pediatrics 2012 Jun 1;129(6):1186-9. [http://pediatrics.aappublications.org/content/129/6/1186] accessed 5/24/18.

Barzel A, et al. Home-based constraint-induced movement therapy for patients with upper limb dysfunction after stroke (HOMECIMT): a cluster-randomised, controlled trial. Lancet Neurol 2015 Sep;14(9):893-902.

BlueCross BlueShield Association. Gait analysis - archived. Medical Policy Reference Manual Policy #2.01.03. 2014 Feb 13.

*BlueCross BlueShield Association. Occupational therapy- archived. Medical Policy Reference Manual Policy #8.03.03. 2011 Jun 9.

BlueCross BlueShield Association. Sensory integration therapy and auditory integration therapy. Medical Policy Reference Manual Policy #8.03.13 2018 March 08.

*BlueCross BlueShield Association. Work hardening programs - archived. Medical Policy Reference Manual Policy #8.03.06. 2011 Feb 10.

*BlueCross BlueShield Association TEC Assessment Program. Sensory integration therapy. 2000 Feb;14(22).

Case-Smith J, et al. Systematic review of interventions used in occupational therapy to promote motor performance for children ages birth-5 years. Am J Occup Ther 2013 Jul-Aug;67(4):413-24.

Case-Smith J. Systematic review of interventions to promote social-emotional development in young children with or at risk for disability. Am J Occup Ther 2013 Jul-Aug;67(4):395-404.

Chen YP, et al. Effectiveness of constraint-induced movement therapy on upper-extremity function in children with cerebral palsy: a systematic review and meta-analysis of randomized controlled trials. Clin Rehabil 2014 Oct;28(10):939-53.

Corbetta D, et al. Constraint-induced movement therapy for upper extremities in people with stroke. Cochrane Database Syst Rev 2015 Oct 8;(10):CD004433.

*Deane KHO, et al. Occupational therapy for Parkinson's disease (Cochrane Review). In: The Cochrane Library, Issue 4, 2004. Chichester, UK: John Wiley & Sons, Ltd.

Désiron HA, et al. Occupational therapy and return to work: a systematic literature review. BMC Public Health 2011 Aug 2;11:615.

*Dixon L, et al. Occupational therapy for patients with Parkinson's disease. Cochrane Database Syst Rev. 2007 Jul 18;(3):CD002813.

Ekelman BA, et al. Occupational therapy interventions for adults with rheumatoid arthritis: an appraisal of the evidence. Occup Ther Health Care 2014 Oct;28(4):347-61.

Eliasson AC, et al; European network for Health Technology Assessment (EUnetHTA). Guidelines for future research in constraint-induced movement therapy for children with unilateral cerebral palsy: an expert consensus. Dev Med Child Neurol 2014 Feb;56(2):125-37.

Ferrarello F, et al. Tools for observational gait analysis in patients with stroke: a systematic review. Phys Ther 2013 Dec;93(12):1673-85.

Fleet A, et al. Modified constraint-induced movement therapy for upper extremity recovery post stroke: what is the evidence? Top Stroke Rehabil 2014 Jul-Aug;21(4):319-31.

Frolek Clark GJ and Schlabach TL. Systematic review of occupational therapy interventions to improve cognitive development in children ages birth-5 years. Am J Occup Ther 2013 Jul-Aug;67(4):425-30.

Hand C, et al. Occupational therapy interventions for chronic diseases: a scoping review. Am J Occup Ther 2011 Jul-Aug;65(4):428-36.

*Handoll HH, et al. Rehabilitation for distal radial fractures in adults. Cochrane Database Syst Rev 2006 Jul 19;3:CD003324.

*Hoare BJ, et al. Constraint-induced movement therapy in the treatment of the upper limb in children with hemiplegic cerebral palsy. Cochrane Database Syst Rev 2007;(2):CD004433.

*Hoffmann T, et al. Occupational therapy for cognitive impairment in stroke patients. Cochrane Database Syst Rev 2010 Sep 8;(9):CD006430.

*Huang HH, et al. Bound for success: a systematic review of constraint-induced movement therapy in children with cerebral palsy supports improved arm and hand use. Phys Ther 2009 Nov;89(11):1126-41.

*Legg LA, et al. Occupational therapy for patients with problems in activities of daily living after stroke. Cochrane Database Syst Rev 2006;(4):CD003585.

McIntyre A, et al. Systematic review and meta-analysis of constraint-induced movement therapy in the hemiparetic upper extremity more than six months post stroke. Top Stroke Rehabil 2012 Nov-Dec;19(6):499-513.

*Myers SM, et al. Management of children with autism spectrum disorders. Pediatrics 2007 Nov;120(5):1162-82.

New York State Education Department. Regulations of the Commissioner of Education. Part 200 – Students with disabilities. Updated 2018 Jan 12 [http://www.p12.nysed.gov/specialed/lawsregs/part200.htm] accessed 5/24/18.

Nijland R, et al. Constraint-induced movement therapy for the upper paretic limb in acute or sub-acute stroke: a systematic review. Int J Stroke 2011 Oct;6(5):425-33.

Peurala SH, et al. Effectiveness of constraint-induced movement therapy on activity and participation after stroke: a systematic review and meta-analysis of randomized controlled trials. Clin Rehabil 2012 Mar;26(3):209-23.

Pollock A, et al. Interventions for improving upper limb function after stroke. Cochrane Database Syst Rev 2014 Nov 12;11:CD010820.

Pulman J, et al. A meta-analysis evaluating the effectiveness of two different upper limb hemiparesis interventions on improving health-related quality of life following stroke. Top Stroke Rehabil 2013 Mar-Apr;20(2):189-96.

Pulman J and Buckley E. Assessing the efficacy of different upper limb hemiparesis interventions on improving health-related quality of life in stroke patients: a systematic review. Top Stroke Rehabil 2013 Mar-Apr;20(2):171-88.

Sakzewski L, et al. Randomized trial of constraint-induced movement therapy and bimanual training on activity outcomes for children with congenital hemiplegia. Dev Med Child Neurol 2011 Apr;53(4):313-20.

*Sakzewski L, et al. Systematic review and meta-analysis of therapeutic management of upper-limb dysfunction in children with congenital hemiplegia. Pediatrics. 2009 Jun;123(6):e1111-22.

*Schonstein E, et al. Work conditioning, work hardening and functional restoration for workers with back and neck pain. Cochrane Database Syst Rev 2003;(1):CD001822.

Shi YX, et al. Modified constraint-induced movement therapy versus traditional rehabilitation in patients with upper-extremity dysfunction after stroke: a systematic review and meta-analysis. Arch Phys Med Rehabil 2011 Jun;92(6):972-82.

*Sirtori V, et al. Constraint-induced movement therapy for upper extremities in stroke patients. Cochrane Database Syst Rev 2009 Oct 7;(4):CD004433.

*Steultjens EMJ, et al. Occupational therapy for multiple sclerosis (Cochrane Review). In: The Cochrane Library, Issue 4, 2004. Chichester, UK: John Wiley & Sons, Ltd.

*Steultjens EMJ, et al. Occupational therapy for rheumatoid arthritis (Cochrane Review). In: The Cochrane Library, Issue 4, 2004. Chichester, UK: John Wiley & Sons, Ltd.

Stock R, et al. Early versus late-applied constraint-induced movement therapy: A multisite, randomized controlled trial with a 12-month follow-up. Physiother Res Int. 2017 Jul 7. doi: 10.1002/pri.1689. [Epub ahead of print]

Thrane G, et al. A meta-analysis of constraint-induced movement therapy after stroke. J Rehabil Med 2014 Oct;46(9):833-42.

United States Department of Education. Individuals with Disabilities Education Act (IDEA). Public Law 94-142 [http://idea.ed.gov] accessed 5/24/18.

van Delden AL, et al. Unilateral versus bilateral upper limb training after stroke: the Upper Limb Training After Stroke clinical trial. Stroke 2013 Sep;44(9):2613-6.

Veerbeek JM, et al. Effects of Robot-Assisted Therapy for the Upper Limb After Stroke. Neurorehabil Neural Repair. 2017 Feb;31(2):107-121.

Wren TA, et al. Efficacy of clinical gait analysis: A systematic review. Gait Posture 2011 Jun;34(2):149-53.

KEY WORDS:

Constraint-induced movement therapy (CIMT)**,** Gait analysis, Occupational therapy, OT, Sensory integration therapy, SIT.

CMS COVERAGE FOR MEDICARE PRODUCT MEMBERS

There is currently a Local Coverage Determination (LCD) and a supplemental article addressing Outpatient Physical and Occupational Therapy Services. Please refer to the following websites for Medicare Members:
https://www.cms.gov/medicare-coverage-database/details/lcd-details.aspx?LCDId=33631&ver=26&CoverageSelection=Both&ArticleType=All&PolicyType=Final&s=New+York+-+Entire+State&KeyWord=occupational+therapy&KeyWordLookUp=Title&KeyWordSearchType=And&bc=gAAAABABAAAA&