National Imaging Associates, Inc.*	
Clinical guidelines OUTPATIENT HABILITATIVE PHYSICAL AND OCCUPATIONAL THERAPY	Original Date: November 2015
Physical Medicine – Clinical Decision Making	Last Revised Date: December 2022
Guideline Number: NIA_CG_603	Implementation Date: July 2023

Policy Statement

Habilitative physical and occupational therapy services may or may not be covered by all clients of this organization. If the service is covered, it may or may not require prior authorization. These guidelines apply to all markets and populations, including teletherapy, contracted with this organization through the corresponding state health plans unless a market-specific health plan has been developed. Services may be covered when provided for the end result of achieving age-appropriate growth/development; correcting or improving a physical condition; or helping a patient acquire, maintain, or regain functional skills for successful participation in everyday activities. These services must be provided by a skilled and licensed therapy practitioner and in a manner that is in accordance with accepted standards of practice for discipline-specific therapies. It must also be clinically appropriate in amount, duration, and scope to achieve their purpose and considered effective treatment for the current injury, illness or condition.

Habilitative physical and occupational therapy should meet the definitions at the end of this document, be provided in a clinic, office, home, or in an outpatient setting and be ordered by either a primary care practitioner or specialist unless otherwise directed by state law or statute.

National Imaging Associates will review all requests resulting in adverse determinations for Medicaid members for coverage under federal Early and Periodic Screening, Diagnostic and Treatment (EPSDT) guidelines.[1,2]

INDICATIONS

Physical and/or occupational therapy evaluation and treatment services are considered medically necessary when the following criteria are met:

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- Have written referral from primary care practitioner or other non-physician practitioner (NPP) if required by state guidelines.
- Physical and occupational therapy initial evaluations and re-evaluations that include patient history such as recent illness, injury, or disability along with diagnosis and date of onset and/or exacerbation of the condition. Prior and current level of function as well as identification of any underlying factors that have impacted current functional performance must also be noted.[3-5]
- Formal testing must be age-appropriate, norm-referenced, standardized, and specific to the therapy provided. Test scores should meet the following criteria to establish presence of a motor or functional delay. Notes should document the following to establish the presence of delays or deficits:
    - The following methods are generally accepted measures that may be considered to support a significant delay:
        - Standardized scores at or below the 10th percentile in at least one subtest area for the patient's age.[6]
        - Standardized scores greater than or equal to 1.5 standard deviations below the mean in at least one subtest area for the patient's age.[1,2,6-10]
        - Functional delays may be established by 25% or greater deficit in age equivalency as indicated by established general guidelines of functional assessments or specific criterion-referenced tests or profiles.[1,2,6-8,11]
- While standardized testing is preferred, scores alone may not be used as the sole criteria for determining a patient's medical need for skilled intervention. Test information must be linked to difficulty with or inability to perform everyday tasks.
- In the absence of standardized testing or when test scores show skills within normal ranges despite functional deficits, the documentation must include detailed clinical observations and objective data to document the degree and severity of the condition, in order to support the medical need for skilled services. A caregiver interview/questionnaire can also support the request.
- Any time standardized testing cannot be completed, the documentation must clearly state the reason formal testing could not be done.
    - If the member's medical or cognitive status does not allow for formal testing, the documentation must clearly state the reason formal testing could not be completed.
    - In the absence of standardized testing or when test scores show skills within normal ranges though functional deficits are present, the report must include detailed clinical observations of current skill sets, parent interview/questionnaire and/or informal assessment supporting Functional Mobility/ADL (Activities of Daily Living) deficits and the medical need for skilled services. The documentation must clearly state the reason formal testing could not be completed.
    - Orthopedic diagnoses not related to functional delay including torticollis and gait deviations such as in-toeing or toe walking should include appropriate tests and measures specific to the deficit and the therapy provided.

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- In the case of feeding difficulties, the notes must clearly indicate a functional feeding delay as a result of underlying impairments.
    - This may include gagging/choking, oral motor or upper extremity coordination deficits, or maladaptive behaviors due to a food intolerance/aversion preventing adequate oral intake that contribute to malnutrition or decreased body mass index.
    - Fine motor and/or sensory testing, as well as detailed clinical observations of oral motor skills, should also be included in the documentation if functional feeding delays are a result of these component parts of the overall task.
    - Parent report of limited food choices is not adequate to support the medical need for feeding therapy.
    - There must also be evidence of ongoing progress and a consistent home regimen to facilitate carry-over of target feeding skills; strategies; and education of patient, family, and caregiver.
    - Therapies for picky eaters who can eat and swallow normally meeting growth and developmental milestones, eat at least one food from all major food groups (protein, grains, fruits, etc.) and more than 20 different foods is not medically necessary.
- Re-evaluations must be performed annually at a minimum to show progress, support ongoing delays or functional deficits and medical necessity for continued services. Re-evaluations should include updated formal testing that is age-appropriate, norm-referenced, standardized, and specific to the type of therapy provided (see Record Keeping and Documentation Standards, NIA Clinical Guideline 606-01 for additional information regarding re-evaluation requirements). More frequent objective measures may be needed to show progress and support ongoing delays (see progress note section below).
- Retesting with norm-referenced standardized test tools for re-evaluations must occur yearly and may occur every 180 days. Tests must be age appropriate for the child being tested and providers must use the same testing instrument as used in the initial evaluation. If reuse of the initial testing instrument is not appropriate, i.e., due to change in member status or restricted age range of the testing tool, the provider should explain the reason for the change.
- When skilled services are also being provided by other community service agencies and/or school systems, the notes must show how the requested services are working in coordination with these agencies and not duplicating services. The extent or lack of these additional services must be indicated in the documentation.
- Measurable short and long-term functional goals should be SMART: specific, measurable, attainable, relevant, and timed. Individualized targeted outcomes that are linked to functional limitations outlined in the most recent evaluation/assessment.[12] These goals should include the date in which the goal was established, as well as the date in which the goal is expected to be met. Goals of intervention should target the functional deficits identified by the skilled therapist during the assessment and promote

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attainment of age-appropriate developmental milestones, functional mobility and/or ADL skills appropriate to the patient's age and circumstances.[13]

    - Although identified as component parts of participation, underlying factors, performance skills, client factors or the environment should not be the targeted outcome of long-term goals.
    - In like manner, underlying factors such as strength, range of motion, or cognition should not be the sole focus of short-term goals.[14] When documenting interventions, an explicit connection must be made to what participation outcome the intervention will target.
- Intervention selections must be evidence-based, chosen to address the targeted goals, and representative of the best practices outlined by the corresponding national organizations.[3,5]
    - The ultimate focus of interventions[15] must be to promote motor learning or relatively permanent differences in motor skill capability that can be transferred and generalized to new learning situations.
- The plan of care must include goals detailing type, amount, duration, and frequency of therapy services required to achieve targeted outcomes. The frequency and duration must also be commensurate with the patient's level of disability, medical and skilled therapy needs as well as accepted standards of practice while reflecting clinical reasoning and current evidence.[16]
- Frequency and duration of skilled services must also be in accordance with the following:
    - Intense frequencies (3x/week or more, for a short duration of 2-6 weeks[17]) will require additional documentation and testing supporting a medical need to achieve an identified new skill or recover function with specific, achievable goals within the requested intensive period.[16] Details on why a higher frequency is more beneficial than a moderate or low frequency must be included. Higher frequencies may be considered when delays are classified as severe as indicated by corresponding testing guidelines used in the evaluation. More intensive frequencies may be necessary in the acute phase; however, progressive decline in frequency is expected within a reasonable time frame.
        - On a case-by-case basis, a high frequency requested for a short-term period (4 weeks or less) which does not meet the above criteria may be considered with all of the following documentation
            - Letter of medical need from the prescribing provider documenting the member's rehabilitation potential for achieving the goals identified.
            - Therapy summary documenting all of the following:
                - Purpose of the high frequency requested (e.g., close to achieving a milestone)
                - Identification of the functional skill which will be achieved with high frequency therapy

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        - Specific measurable goals related to the high frequency requested and the expected date the goal will be achieved.
    - Moderate frequency (2x/week) should be consistent with moderate delays as established in the general guidelines of formal assessments used in the evaluation. Therapy provided two times a week may be considered when documentation shows one or more of the following:
        - The member is making very good functional progress toward goals
        - The member is in a critical period to gain new skills or restore function or is at risk of regression.
        - The licensed therapist needs to adjust the member's therapy plan and home program weekly or more often than weekly based on the member's progress and medical needs.
        - The member has complex needs requiring ongoing education of the responsible adult.
    - Low frequency (at or less than 1x/week)
        - Therapy provided one time per week or less may be considered when the documentation shows one or more of the following[16]:
            - The member is making progress toward their goals, but the progress has slowed, or documentation shows the member is at risk of deterioration due to the member's medical condition.
            - The licensed therapist is required to adjust the member's therapy plan and home program weekly to every other week based on the member's progress.
            - Every other week therapy is supported for members whose medical condition is stable, they are making progress, and it is anticipated the member will not regress with every other week therapy.
            - Frequencies less than every other week may be appropriate for those children who cannot yet tolerate more frequent therapy sessions. They may also have needs that are addressed on a periodic basic as part of comprehensive management in a specialty clinic. Occasional consultation may be appropriate to ensure gains continue, to address emerging concerns, or to help order equipment and train in its use.
    - All requested frequencies must be supported by skilled treatment interventions regardless of level of severity of delay.[18]
- Documentation should clearly reflect why the skills of a therapist are medically necessary. There must be evidence as to whether the services are considered reasonable, effective treatments requiring the skills of a therapist or whether they can be safely and effectively carried out by non-skilled personnel without the supervision of qualified professionals.

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- Clinical updates that include current objective measures, progress towards goals, and requested frequency and duration of care are expected at regular intervals or when additional care is requested. Documentation should include:
  - The patient's current level of function, any conditions that are impacting his/her ability to benefit from skilled intervention.
  - Objective measures of the patient's overall functional progress relative to each treatment goal as well as a comparison to the previous progress report.[19]
    - Outcomes should assist in functional skill acquisition is sustained over time.
  - Skilled treatment techniques that are being utilized in therapy as well as the patient's response to therapy and why there may be a lack thereof.
  - An explanation of any significant changes in the plan of care and clinical rationale for why the ongoing skills of a PT/OT are medically necessary.
  - In the case of maintenance programs, clear documentation of the skilled interventions rendered and objective details of how these interventions are preventing deterioration or making the condition more tolerable must be provided. The notes must also clearly demonstrate that the specialized judgment, knowledge, and skills of a qualified therapist (as opposed to a non-skilled individual) are required for the safe and effective performance of services in a maintenance program.
- Maintenance Level/Prevent Deterioration
  - This frequency level (e.g., every other week, monthly, every 3 months) is used when the therapy plan changes very slowly, the home program is at a level that may be managed by the member or the responsible adult/caregiver, or the therapy plan requires infrequent updates by the skilled therapist.
    - Documentation must show that the habilitative plan of care has ended, and a new plan of care established for maintenance.
  - Goals in the plan of care must be updated to reflect that care is focused on maintaining the current level of functioning and preventing regression, rather than progressing or improving function
  - A maintenance level of therapy services may be considered when a member requires skilled therapy for ongoing periodic assessments and consultations and the member meets one of the following criteria:
    - Progress has slowed or stopped, but documentation supports that ongoing skilled therapy is required to maintain the progress made or prevent deterioration.
    - The submitted documentation shows that the member may be making limited progress toward goals or that goal attainment is extremely slow.
    - Factors are identified that inhibit the member's ability to achieve established goals (e.g., the member cannot participate in therapy sessions due to behavior issues or issues with anxiety).
    - Documentation shows the member and the responsible adult have a continuing need for education, a periodic adjustment of the home

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program, or regular modification of equipment to meet the member's needs.
        - Clear documentation of the skilled interventions rendered and objective details of how these interventions are preventing deterioration or making the condition more tolerable must be provided. The notes must also clearly demonstrate that the specialized judgment, knowledge, and skills of a qualified therapist (as opposed to a non-skilled individual) are required for the safe and effective performance of services in a maintenance program.
- If the patient is not progressing, then documentation of a revised treatment plan is necessary. Discontinuation of therapy may be considered in one or more of the following situations:
    - Member no longer demonstrates functional impairment or has achieved goals set forth in the treatment plan or plan of care
    - Member has returned to baseline function
    - Member can continue therapy with a home treatment program and deficits no longer require a skilled therapy intervention and, for members who are 20 years of age and younger only, maintain status
    - Member has adapted to impairment with assistive equipment or devices
    - Member is able to perform ADLs with minimal to no assistance from caregiver
    - Member has achieved maximum functional benefit from therapy in progress or will no longer benefit from additional therapy
    - Member is unable to participate in the treatment plan or plan of care due to medical, psychological, or social complications; and responsible adult has had instruction on the home treatment program and the skills of a therapist are not needed to provide or supervise the service
    - Testing shows member no longer has a developmental delay
    - Plateau in response to therapy/lack of progress towards therapy goals
    - Non-compliance due to poor attendance and with member or responsible adult, non-compliance with therapy and home treatment program
    - Member has achieved the maximum therapeutic value of a treatment plan, no additional functional improvement is apparent or expected to occur, and the provision of services for a condition cease to be of therapeutic value.
- It is expected that a discharge plan, with the expected treatment frequency and duration, must be included in the plan of care. The discharge plan must indicate the plan to wean services once the patient has attained their goals, if no measurable functional improvement has been demonstrated, or if the program can be carried out by caregivers or other non-skilled personnel.
- Development of an age-appropriate home regimen to facilitate carry-over of targeted skills and strategies as well as patient, family, and caregiver education in home exercises and self-monitoring should be evident in the documentation. Indication of compliance of the home regimen should be documented to show maximum benefit of care.
- For patients no longer showing functional improvement, a weaning process of one to two months should occur. If the patient shows signs of regression in function, the need

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for skilled physical or occupational therapy can be re-evaluated at that time. Periodic episodes of care may be needed over a lifetime to address specific needs or changes in condition resulting in functional decline.[20,21]

BACKGROUND

Definitions

<u>Habilitative Physical or Occupational Therapy</u>

Treatment provided by a state-regulated physical or occupational therapist designed to help a person learn, obtain, maintain, prevent deterioration of or improve age-appropriate skills and functioning for daily living.[4,14] These skills may have never been present, lost, or impaired due to a congenital, genetic, or early acquired condition. There must be measurable improvement and progress towards functional goals within an anticipated timeframe toward a patient's maximum potential. Treatment may also be appropriate in an individual with a progressive disorder when it has the potential to prevent the loss of a functional skill or enhance the adaptation to such functional loss. Ongoing treatment is not appropriate when a steady state of sensorimotor functioning has yielded no measurable functional progress.

<u>Rehabilitative Physical or Occupational Therapy</u>

Treatment provided by a state-regulated physical or occupational therapist designed to help a person recover from an acute injury or exacerbation of a chronic condition that has resulted in a decline in functional performance. The specific impact of injury or exacerbation on the patient's ability to perform in their everyday environment must be supported by appropriate tests and measures in addition to clinical observations. Services must be provided within a reasonable time frame (frequency/duration) to restore lost function or to teach compensatory techniques if full recovery of function is not possible.

<u>Maintenance Program</u>

A program established by a licensed therapist that consists of activities and/or mechanisms that will assist the patient in optimizing or maintaining the progress he or she has made during therapy or to prevent or slow further deteriorations due to a disease or illness.

<u>Medical Necessity</u>

Reasonable or necessary services that require the specific training, skills, and knowledge of a physical or occupational therapist in order to diagnose, correct, or significantly improve/optimize as well as prevent deterioration or development of additional physical and mental health conditions. These services require a complexity of care that can only be safely and effectively performed by or under the general supervision of a skilled therapist. Services shall not be considered reasonable and medically necessary if they can be omitted without adversely affecting the member's condition or the quality of medical care. A service is also not considered a skilled therapy service merely because it is furnished by a therapist or by a therapy assistant under the direct or general supervision, as applicable, of a therapist. If a service can be

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self-administered or safely and effectively carried out by an unskilled person, without the direct supervision of a therapist, as applicable, then the service cannot be regarded as a skilled therapy service even though a therapist actually rendered the service. Similarly, the unavailability of a competent person to provide a non-skilled service, notwithstanding the importance of the service to the patient, does not make it a skilled service when a therapist renders the service.

Activities of Daily Living (ADLs)
Essential activities oriented toward taking care of one's own body (also referred to as basic and/or personal activities of daily living). Such activities are fundamental to living in a social world as well as enabling basic survival and well-being. Specific examples include bathing/showering, toileting, dressing, swallowing/eating, feeding, functional mobility, personal device care, personal hygiene/grooming, and the functional mobility necessary to perform these activities. The initial evaluation and corresponding plan of care should document baseline impairments as they relate to ADL performance deficits with targeted functional outcomes/goals that are measurable, sustainable, and time specific. Subsequent plans should clearly document functional progress toward attainment of these goals in perspective to the patient's potential ability as well as skilled interventions used to target functional outcomes.[3,5,22]

Functional Mobility Skills
They are considered necessary activities of daily life such as ambulation, transfers, and fine motor skills. The initial plan of care documents baseline impairments as they relate to functional skills with specific goals developed that are specific, measurable, attainable, relevant, and time-based (SMART format). Subsequent plans of care document progress toward attainment of these goals in perspective to the patients' potential ability.

Sensory Integration Disorder
Sensory integration involves perceiving, modulating, organizing, and interpreting internal sensations from within the body as well as external sensations from the surrounding environment to optimize occupational performance and participation. Deficits in sensory integration can pose challenges in performing activities of daily living, in addition to development, learning, playing, working, socializing, and exhibiting appropriate behavior. Differences in interpretation of stimuli can impact motor skills and coordination, further limiting engagement and participation. Sensory processing difficulties can occur across the lifespan. Sensory integrative therapy and evidence-based interventions provide neuroscience-based, cognitive, and/or behavioral approaches that support successful adaptive responses.[23]

POLICY HISTORY

Date	**Summary**
December 2022	• Modified the standardized testing requirements • Clarified requirements for picky eaters • Added goals should be written in SMART format • Clarified the need for clinical update documentation

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	• Added the section for goals in the Maintenance Level/Prevent Deterioration section • Clarified the formal testing section and added additional references to support the accepted measures of a significant delay • Minor editorial changes
December 2021	• Added "General Information" statement • Added "resulting in adverse determinations" within the EPSDT statement for clarification • Added "if required" for written referral under the Indication for evaluation and treatment section • Added medical or cognitive status exceptions under the Indications for evaluation and treatment section • Added orthopedic diagnosis expectations under the Indication for evaluation and treatment section • Added clarification for re-evaluation and retesting requirements • Added focus of intervention under intervention section • Added clarification of high, moderate, and low frequency under frequency and duration for skilled services section as this was adapted from the Superior Health Plan Policy • Added Maintenance Level/Prevent Deterioration section • Added clarification for Discontinuation of therapy services section
October 2020	• Added indication of home program compliance for max benefit of therapy as part of updated POC • Added additional resource which supports episodic care and appropriate frequencies • Added EPSDT language in policy statement section • Added annual tests be performed at a minimum of once a year and formalized progress assessment with updated measures at routine intervals may also be needed prior to the one-year mark from previous testing. • Removed "physician-prescribed" from the medical necessity definition in the background • Added qualifier for proof of skilled treatment for requested frequencies regardless of level of severity of delay • Added clarification on need for documentation to support ongoing requested frequencies with showing effective outcomes and reasonable time frames • Added clarification for when test scores are within normal, yet functional delays are present • Added teletherapy to the policy statement

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January 2020	• No content changes following review of the evidence base. Minor copyediting changes.
July 2019	• Definitions were moved to the background so pertinent information was readily available at the beginning of the document. • Existing definitions were revised to include greater detail with new definitions for *rehabilitative therapy* (for comparative purposes), *medical necessity* and *maintenance program* included. • Criteria for delay was revised to include clearer and more detailed specifications for functional delays, preferred scoring, and what is required in the absence of standardized testing. • Criteria for feeding delays were added. • Additional specifications included for linking testing to the treatment goals, inclusion of functional treatment goals, utilizing appropriate dosing of therapy and specifying skilled interventions.

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REFERENCES

1. Early and Periodic Screening, Diagnostic and Treatment (EPSDT) – A Guide for States. Coverage in the Medicaid Benefit for Children and Adolescents (2014). Centers for Medicare and Medicaid Services. December 2, 2022. https://www.medicaid.gov/sites/default/files/2019-12/epsdt_coverage_guide.pdf
2. Early and Periodic Screening, Diagnostic, and Treatment. Centers for Medicare and Medicaid Services. Updated June 29, 2022. Accessed December 2, 2022. https://www.medicaid.gov/medicaid/benefits/early-and-periodic-screening-diagnostic-and-treatment/index.html
3. Occupational Therapy Practice Framework: Domain and Process (3rd Edition). *The American Journal of Occupational Therapy*. 2014;68(Supplement_1):S1-S48. doi:10.5014/ajot.2014.682006
4. American Physical Therapy Association. Physical Therapy Documentation of Patient and Client Management. American Physical Therapy Association (APTA). Updated April 30, 2019. Accessed August 4, 2022. https://www.apta.org/your-practice/documentation
5. Association AOT. Standards of practice for occupational therapy. *The American Journal of Occupational Therapy*. 2021;75(Supplement_3)
6. Maine Department of Education. Severity Rating Scales/Guidelines for Speech/Language Communication Services - Language Severity Rating Scale. Updated August 1, 2020. Accessed December 2, 2022. https://www.maine.gov/doe/sites/maine.gov.doe/files/2022-09/PROCEDURAL%20MANUAL%20Update%208-1-2020.pdf
7. Maryland State Department of Education (MSDE), Division of Special Education/Early Intervention Services. Guidelines for the Use of the Developmental Delay (DD) Eligibility Category. Children Ages Birth through Seven Years. Updated March 2012. Accessed December 2, 2022.
8. Georgetown University Center for Child and Human Development. Contemporary Practices in Early Intervention: Developmental Delay and IDEA Primer (2011). Accessed December 2, 2022. https://www.teachingei.org/disabilities/primers/Developmental_Delay.pdf
9. Bélanger SA, Caron J. Evaluation of the child with global developmental delay and intellectual disability. *Paediatrics & child health*. 2018;23(6):403-410.
10. Mithyantha R, Kneen R, McCann E, Gladstone M. Current evidence-based recommendations on investigating children with global developmental delay. *Arch Dis Child*. Nov 2017;102(11):1071-1076. doi:10.1136/archdischild-2016-311271
11. Voigt RG. Clinical Judgment and Child Development, Revisited. *Pediatrics*. Mar 1 2022;149(3)doi:10.1542/peds.2021-054835
12. Bowman J, Mogensen L, Marsland E, Lannin N. The development, content validity and inter-rater reliability of the SMART-Goal Evaluation Method: A standardised method for evaluating clinical goals. *Aust Occup Ther J*. Dec 2015;62(6):420-7. doi:10.1111/1440-1630.12218
13. Houtrow A, Murphy N. Prescribing Physical, Occupational, and Speech Therapy Services for Children With Disabilities. *Pediatrics*. Apr 2019;143(4)doi:10.1542/peds.2019-0285
14. Amini D, Furniss J. The Occupational Therapy Practice Framework: A Foundation for Documentation. American Occupational Therapy Association (AOTA). Updated October 2018.

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Accessed August 4, 2022. https://www.aota.org/~/media/Corporate/Files/Publications/CE-Articles/CE-Article-October-2018.pdf
15. Levac D, Wishart L, Missiuna C, Wright V. The application of motor learning strategies within functionally based interventions for children with neuromotor conditions. *Pediatr Phys Ther*. Winter 2009;21(4):345-55. doi:10.1097/PEP.0b013e3181beb09d
16. Bailes AF, Reder R, Burch C. Development of guidelines for determining frequency of therapy services in a pediatric medical setting. *Pediatr Phys Ther*. Summer 2008;20(2):194-8. doi:10.1097/PEP.0b013e3181728a7b
17. Hanson H, Harrington AT, Nixon-Cave K. Implementing treatment frequency and duration guidelines in a hospital-based pediatric outpatient setting: administrative case report. *Phys Ther*. Apr 2015;95(4):678-84. doi:10.2522/ptj.20130360
18. American Physical Therapy Association. Intensity of Service in an Outpatient Setting for Children With Chronic Conditions. American Physical Therapy Association (APTA). Updated 2012. Accessed August 2, 2022. https://pediatricapta.org/includes/fact-sheets/pdfs/12%20Intensity%20of%20Service.pdf
19. Lucas BR, Elliott EJ, Coggan S, et al. Interventions to improve gross motor performance in children with neurodevelopmental disorders: a meta-analysis. *BMC Pediatr*. Nov 29 2016;16(1):193. doi:10.1186/s12887-016-0731-6
20. Alotaibi M, Long T, Kennedy E, Bavishi S. The efficacy of GMFM-88 and GMFM-66 to detect changes in gross motor function in children with cerebral palsy (CP): a literature review. *Disabil Rehabil*. 2014;36(8):617-27. doi:10.3109/09638288.2013.805820
21. Trahan J, Malouin F. Intermittent intensive physiotherapy in children with cerebral palsy: a pilot study. *Dev Med Child Neurol*. Apr 2002;44(4):233-9. doi:10.1017/s0012162201002006
22. Guidelines for Documentation of Occupational Therapy. *Am J Occup Ther*. Nov/Dec 2018;72(Supplement_2):7212410010p1-7212410010p7. doi:10.5014/ajot.2018.72S203
23. Kinnealey M, Riuli V, Smith S. Case study of an adult with sensory modulation disorder. *Sens Integr Spec Interest Sec Q*. 2015;38:1-4.

ADDITIONAL RESOURCES

1. American Occupational Therapy Association. Habilitative Services are Essential Health Benefits: An Opportunity for Occupational Therapy Practitioners and Consumers. American Occupational Therapy Association (AOTA). Updated June 6, 2014. Accessed August 2, 2022. https://www.aota.org/-/media/Corporate/Files/Advocacy/Health-Care-Reform/Essential-Benefits/Habilitative%20Services%20Fact%20Sheet.pdf
2. American Physical Therapy Association. APTA Guide to Physical Therapist Practice. American Physical Therapy Association (APTA). Accessed August 2, 2022. https://guide.apta.org/
3. American Speech-Language-Hearing Association. Guidelines for Speech-Language Pathologists Providing Swallowing and Feeding Services in Schools. American Speech-Language-Hearing Association (ASHA). Updated 2007. Accessed August 2, 2022. https://www.psha.org/pdfs/asha-feeding-qa.pdf
4. Ayres AJ. Sensory integration and learning disorders. Western Psychological Services; 1972.
5. Rehabilitation Therapies Episodes of Care in Childhood and Adolescence. Gillette Children's Specialty Healthcare (GCSH). Updated March 2016. Accessed August 2, 2022.

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https://www.gillettechildrens.org/assets/uploads/care-and-conditions/Episodes_of_Care-English.pdf
6. Ong C, Phuah KY, Salazar E, How CH. Managing the 'picky eater' dilemma. Singapore Med J. 2014;55(4):184-190. doi:10.11622/smedj.2014049
7. Uher R, Rutter M. Classification of feeding and eating disorders: review of evidence and proposals for ICD-11. World Psychiatry. 2012;11(2):80-92. doi:10.1016/j.wpsyc.2012.05.005
8. The Management and Rehabilitation of Post-Acute Mild Traumatic Brain Injury Work Group. VA/DoD clinical practice guideline for the managment and rehabilitation of post-acute mild traumatic brain injury, Version 3.0. Department of Veterans Affars/Department of Defense. Updated June 2021. Accessed August 2, 2022. https://www.healthquality.va.gov/guidelines/Rehab/mtbi/VADoDmTBICPGFinal508.pdf

Reviewed/Approved by NIA Clinical Guideline Committee

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GENERAL INFORMATION

It is an expectation that all patients receive care/services from a licensed clinician. All appropriate supporting documentation, including recent pertinent office visit notes, laboratory data, and results of any special testing must be provided. If applicable: All prior relevant imaging results and the reason that alternative imaging cannot be performed must be included in the documentation submitted.

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