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Occupational Therapy

[Clinical Policy Bulletins](#) | [Medical Clinical Policy Bulletins](#)

Number: 0250

Policy

Aetna considers short-term occupational therapy (OT) medically necessary in selected cases when this care is prescribed by a physician, and the following criteria are met:

- To learn or re-learn daily living skills (e.g., bathing, dressing, and eating) or compensatory techniques to improve the level of independence in the activities of daily living; *or to provide task-oriented therapeutic activities designed to significantly improve, develop or restore physical functions lost or impaired as a result of a disease, or injury; and*
- The following criteria are met:
 - The member’s participating physician or licensed health care practitioner has determined that the member’s condition can improve significantly based on objective measures within 1 month of the date that therapy begins or the therapy services proposed must be necessary for the establishment of a safe and effective maintenance program that will be performed by the member without ongoing skilled therapy services. These services must be proposed for the treatment of a specific illness or injury; *and*

Policy History

[Last Review](#)

03/12/2021

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[Review History](#)

[Definitions](#)

Additional Information

[Clinical Policy Bulletin](#)

[Notes](#)

- The OT services provided are intended to cover only episodes of therapy for situations where there must be a reasonable expectation that a member's condition will improve significantly in a reasonable and generally predictable period of time; *and*
- OT services must be ordered by a physician or other licensed health care practitioner and performed by a duly licensed and certified, if applicable, OT provider. All services provided must be within the applicable scope of practice for the provider in their licensed jurisdiction where the services are provided; *and*
- The services provided must be of the complexity and nature to require that they are performed by a licensed professional therapist or provided under their direct supervision by a licensed ancillary person as permitted under state laws. Services may be provided personally by physicians and performed by personnel under their direct supervision as permitted under state laws. As physicians are not licensed as occupational therapists, they may not directly supervise OT assistants; *and*
- OT must be provided in accordance with an ongoing, written plan of care that is reviewed with and approved by the treating physician in accordance with applicable state laws and regulations. The OT plan of care should be of such sufficient detail and include appropriate objective and subjective data to demonstrate the medical necessity of the proposed treatment (see Appendix for documentation requirements).

Occupational therapy services are considered medically necessary only if there is a reasonable expectation that OT will achieve measurable improvement in the member's condition in a reasonable and predictable period of time.

Once maximal therapeutic benefit has been achieved, or transition to a home program could be used for further gains, continuing supervised OT is not considered medically necessary.

Occupational therapy in persons whose condition is neither regressing nor improving is considered not medically necessary.

Occupational therapy in asymptomatic persons or in persons without an identifiable clinical condition is considered not medically necessary.

Notes:

- Standard Aetna policies exclude coverage for educational training or services. Under plans with this exclusion, occupational therapy is not covered when provided in educational settings
- Driver training is not considered treatment of disease because driving an automobile is not a basic activity of daily living.
- Occupational therapy may require precertification in some plan designs. Subject to plan benefit descriptions, coverage of OT may be limited. In many of our HMO plans the benefit is limited to a 60-day treatment period. In these plans, the treatment period of 60 days applies to a specific condition. Once the 60-day treatment period expires, no additional OT benefits will be provided for that condition during the contract year. However, it is possible for a member to receive more than one 60-day treatment course of OT per year as treatment of separate conditions. For example, a surgical procedure causing the need for OT is considered to be the initiation of a new or separate condition in a person who previously received OT for another indication, and so qualifies the member to receive coverage for an additional course of OT as outlined above. An exacerbation or flare-up of a chronic illness is not considered to be a new incident of illness.
- Other HMO and PPO and Indemnity plans have different benefits for OT. In some cases the benefits are defined by a total number of sessions covered per year. In other benefit designs, OT may be covered as an unlimited benefit as long as it is documented that the member is progressing towards a goal. Consult the specific certificates of coverage for details of plan benefits.

Aetna considers home-based OT medically necessary in selected cases based upon the member's needs (i.e., the member must be homebound). This is usually used in the transition of the member from hospital to home and is an extension of case management services.

Note: In Aetna's HMO and QPOS plans, such home-based OT accumulates towards the 60-day limit or other applicable rehabilitation benefit limits. Please check benefit plan descriptions for details.

Background

Occupational therapy (OT) is a health care service that involves the use of purposeful activities to help people regain performance skills lost through injury or illness. Individual programs are designed to improve quality of life by recovering competence, maximizing independence, and prevent injury or disability as much as possible, so that a person can cope with work, home, and social life.

According to the American Occupational Therapy Association (2002), occupational therapists work with adults and children across the lifespan who may suffer from physical, developmental or psychological impairments.

Occupational therapy services emphasize useful and purposeful activities to improve neuromusculoskeletal function and to provide training in activities of daily living (ADL), including bathing, dressing, feeding, personal hygiene and other self-care activities. Other occupational therapy services include the design, fabrication and use of orthoses, and guidance in the selection and use of adaptive equipment. OT also includes specific task oriented therapeutic activities designed to restore physical function of the shoulder, elbow, wrist and/or hand that has been lost as a result of illness or injury.

Occupational therapy is considered medically necessary only when provided to achieve a specific diagnosis-related goal as documented in the plan of care. Occupational therapy should: (i) meet the functional needs of a patient who suffers from physical disability; (ii) 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; (iii) be specific, effective and reasonable treatment for the patient's diagnosis and physical condition; and (iv) be delivered by a qualified provider of

occupational therapy services (i.e., one who is licensed, where required, and is performing within the scope of license).

Medically necessary OT services must be restorative in nature or for the specific purposes of designing and teaching a maintenance program for the patient to carry out at home. The services must also relate to a written treatment plan and be of the level of complexity that requires the judgment, knowledge and skills of an occupational therapist (or medical doctor/doctor of osteopathy) to perform and/or directly supervise these services. The amount, frequency and duration of occupational therapy services must be medically appropriate for the specific treatment regimen and be performed by an occupational therapist. These services must not be of a palliative nature or provided for maintenance of the patient's status.

A qualified occupational therapist for benefit coverage purposes is a person who is licensed as an occupational therapist by the state in which he or she is practicing. An occupational therapy assistant (OTA) is a person who is licensed as an OTA, if applicable, by the state in which he or she is practicing. The services of an OTA must be supervised by a licensed occupational therapist at a level of supervision determined by state law or regulation. The services of an OTA cannot be provided incidental to a physician/appropriately licensed other practitioner as they are not specifically qualified as licensed occupational therapists.

OT is generally covered for members with eligible conditions that require improvement in the ADLs. These include, but may not be limited to: bathing, communication, dressing, feeding, grooming, mobility, personal hygiene, self-maintenance, skin management, and toileting.

Treatments and/or therapies that are intended to specifically improve what are known as Instrumental Activities of Daily Living (IADL) are not covered because they are not considered treatment of disease. These include, but are not limited to: community living skills including balancing a checkbook, use of public transportation; home management skills including meal preparation, laundry; leisure activities including hobbies, sports or recreation of all types even if suggested as part of a

OT treatment plan; motor vehicle driving evaluations and driving instruction - this includes automobiles, trucks, motorcycles and bicycles; or personal safety preparedness.

OT for members whose condition is neither regressing nor improving, is not medically necessary. An exacerbation or flare-up of a chronic condition or illness is not considered a new illness or condition. It is the intent of the OT coverage to have the member receive those services that are medically necessary, who show demonstrated improvement over a reasonable period of time, consistent with the condition under treatment and to achieve the stated treatment goals.

Non-skilled services are certain types of treatment that do not generally require the skills of a qualified occupational therapist. Non-skilled services include, but are not limited to, (i) passive range of motion (PROM) treatment which is not specifically part of a restorative program related to a loss of function and (ii) services which maintain function by using routine, repetitive and reinforced procedures after initial teaching of the patient has taken place. These also include most situations where general conditioning, recovery from an acute medical/surgical illness that caused deconditioning or increased general ability to exercise or walk are undertaken. Services that can be safely and effectively furnished by non-skilled (non-licensed occupational therapists or their assistants under appropriate supervision) personnel are non-skilled services.

Maintenance care consists of activities that generally are intended to preserve the patient's present level of function and/or prevent regression of that level of function. Maintenance begins when the therapeutic goals of the treatment program are achieved or when no further significant progress is made or reasonably seen as occurring. Specifically, these include continued activities for patients who have achieved generally accepted levels of function and/or muscle strength and are at a plateau or have reached "normal" levels. A plateau is a period of four weeks or dependent on the specific condition and/or patient situation, a lesser period of time that is seen as generally accepted.

Hoffmann and colleagues (2011) examined if occupational therapy improves functional performance of basic ADL and specific cognitive abilities in people who have cognitive impairment after stroke. In this review, randomized controlled trials (RCTs) and quasi-RCTs that evaluated an occupational therapy intervention focused on providing cognitive retraining to adults with clinically defined stroke and confirmed cognitive impairment were included. Searches up to April 2009 were conducted in: the Cochrane Stroke Group Trials Register, the Cochrane Central Register of Controlled Trials, MEDLINE, EMBASE, CINAHL, PsycINFO, PsycBITE, OTseeker, and Dissertation Abstracts. The search also included a review of the reference lists of relevant studies, a hand-search of relevant occupational therapy journals, and contact with key researchers in the area. Two review authors independently examined the abstracts that might meet the inclusion criteria, assessed the methodological quality, and extracted data. Of 17 trials that appeared to be relevant and were reviewed in full text, only 1 trial (n = 33) was finally included in this review. The study was an RCT of cognitive skills remediation training and there was no difference between groups for the 2 outcomes that were relevant to this review that were measured: improvement in time judgement skills and improvement in basic ADLs on the Barthel Index. The effectiveness of occupational therapy for cognitive impairment post-stroke remains unclear. The potential benefits of cognitive re-training delivered as part of occupational therapy on improving basic daily activity function or specific cognitive abilities, or both, of people who have had a stroke can not be supported or refuted by the evidence included in this review. The authors stated that more research is required.

Spiliotopoulou and Atwal (2012) noted that although occupational therapists are integral to the rehabilitation process of people with amputations, the effectiveness of the occupational therapy intervention for older adults with lower limb amputations has not been investigated. These researchers examined the effectiveness of the occupational therapy interventions with older adults aged 65 years and older with lower limb amputations. A systematic search was conducted in CINAHL, PUBMED, OTSEEKER and OTDBASE from January 1985 to January 2011. The eligible papers were critiqued using a typology, which involved designation of levels of evidence and quality markers. The databases yielded 2,664 potential publications. Of these, only 2 were included in the

final review. These studies suggested that the frequency of the occupational therapy sessions was found to be statistically significantly related to prosthesis use and that service users perceived positive benefits about the provision of stump boards. Both studies had limitations resulting in a need for further investigation in these areas. The authors concluded that research evidence on the occupational therapy interventions with this population is limited and scarce. They stated that occupational therapists need to take urgent action to address the identified evidence-based gaps in order to devise informed targeted rehabilitation programs for this client group. This systematic review has contributed to the understanding of the occupational therapy practice in the rehabilitation of older adults with lower limb amputations. It has highlighted gaps in evidence that occupational therapists need to address urgently in order to inform their rehabilitation programs with this client group.

In a meta-analysis, Kim and colleagues (2012) examined effects of occupational therapy based on sensory stimulation, environmental modification and functional task activity on the behavioral problems and depression of individual with dementia. These investigators performed an extensive search in database such as MEDLINE, CINAHL, ProQuest Medical Library, and Cochrane and occupational therapy-related 11 journals. Two reviewers independently identified studies, extracted data, evaluated methodological quality of the studies. Effect size was estimated using standardized mean difference with 95 % confidence intervals (CI). Significant heterogeneity and publication bias were investigated. A total of 9 studies including 751 people were selected.

Sensory stimulation was effective intervention in improving behavioral problems (0.32; 95 % CI: 0.04 to 0.59). The authors concluded that this review identified that occupational therapy based on sensory stimulation was effective in improving behavioral problems. However, they stated that the number of studies included in this review was limited; more research is needed to enable evidence-based occupational therapy for dementia patients.

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Autism Spectrum Disorder

In a systematic review, Kuhaneck et al (2015) examined the literature published from January 2006 to April 2013 related to the effectiveness of occupational therapy interventions for children with autism spectrum disorder (ASD) and their parents to improve parental stress and self-efficacy, coping, and resilience and family participation in daily life and routines. From the 4,457 abstracts, 34 articles were selected that matched the inclusion criteria. The results were mixed and somewhat inconclusive because this body of literature is in its infancy. The authors concluded that studies of children with ASD do not routinely measure parental and family outcomes. They recommended that future studies should emphasize on family measures other than parental stress and a greater focus on measures of parental and family functioning to better understand the impact of interventions in a wider context.

In a systematic review, Tanner et al (2015) noted that people with ASD commonly experience difficulties with social participation, play, and leisure along with restricted and repetitive behaviors that can interfere with occupational performance. These investigators evaluated current evidence for interventions within the occupational therapy scope of

practice that address these difficulties. Strong evidence was found that social skills groups, the Picture Exchange Communication System, joint attention interventions, and parent-mediated strategies can improve social participation. The findings were less conclusive for interventions to improve play and leisure performance and to decrease restricted and repetitive behaviors, but several strategies showed promise with moderately strong supporting evidence. The authors concluded that occupational therapists should be guided by evidence when considering interventions to improve social participation, play, leisure, and restricted and repetitive behaviors in people with ASD; additional research using more robust scientific methods is needed for many of the currently available strategies.

In a systematic review, Watling and Hauer (2015) evaluated the literature published from January 2006 through April 2013 related to the effectiveness of Ayres Sensory Integration® (ASI) and sensory-based interventions (SBIs) within the scope of occupational therapy for people with ASD to improve performance in ADLs and occupations. Of the 368 abstracts screened, 23 met the inclusion criteria and were reviewed. Moderate evidence was found to support the use of ASI; the results for sensory-based methods were mixed. The authors recommended that future research should include performing higher level studies with larger samples, using the fidelity measure in studies of ASI, and using carefully operationalized definitions and systematic methods in examination of SBIs.

In a systematic review, Weaver (2015) examined interventions addressing work, ADLs, instrumental ADLs (IADLs), education, and sleep for people with ASD. A total of 23 studies were identified, and 9 work-, 11 ADL/IADL-, and 3 education-related interventions were examined. No sleep studies were identified. Use of mobile and tablet technologies for vocational skills was supported. Support for ADL/IADL intervention is variable, with indications that cognitive orientation to occupational performance, sensory integration, and contextual interventions may increase occupational performance. Preliminary evidence suggested that daily yoga and brief exercise may improve classroom performance and behavior; group physical activities may assist with school readiness variables. Evidence for using technologies for IADLs was limited, as was evidence determining effective interventions for feeding and eating

issues. The authors concluded that studies investigating interventions related to sleep are lacking; more studies are needed in all areas, presenting opportunities for the expansion of science-driven occupational therapy practice and research for people with ASD.

Chronic Pain

Hesselstrand et al (2015) stated that the use of interventions based on the best available evidence in occupational therapy is essential, and evaluation of research is part of an evidence-based practice. These researchers examined the quality of studies describing and evaluating the effects of occupational therapy interventions on chronic pain; they performed a systematic review of studies with diverse designs. A quality assessment was conducted, and the level of evidence was defined using the Research Pyramid Model. Of 19 included studies, 3 received the highest evidence level, and 3 were considered to be of high quality. The clinical recommendations that can be derived from this study were as follows: (i) occupational therapy interventions should start from the identified needs of the person with chronic pain; (ii) no support exists for the effectiveness of electromyographic biofeedback training as a supplement, more studies are needed to confirm this result; (iii) the effectiveness of instructions on body mechanics was significant during work-hardening treatment; and (iv) occupational therapists need to perform and present more clinical studies of high quality and high-evidence level to build up a trustworthy arsenal of evidence-based interventions (e.g., in persons with chronic pain).

Dementia

Ojagbemi and Owolabi (2017) stated that OT interventions have shown positive effects on physical functioning in persons with dementia (PWD). However, their effect on quality of life (QOL) has been inconsistent in individual clinical trials. These investigators evaluated current evidence for the use of OT interventions in improving QOL of PwD. Records in the Cochrane Database, Medline, Embase, PsycINFO, and Cumulative Index to Nursing and Allied Health Literature were searched for relevant citations, and PubMed was searched for in-process articles. Additional searches of the reference lists of retrieved articles were undertaken. A total of 10 studies involving 1,002 PwD met the criteria for syntheses; OT

intervention produced small non-significant improvements in overall QOL. The authors concluded that the evidence from the present review did not support the specific use of OT interventions for the improvement of QOL in PwD under pragmatic clinical conditions at this time. They may be best used as part of a comprehensive range of interventions for PwD.

Parkinson's Disease

Clarke and colleagues (2016) evaluated the clinical effectiveness and cost-effectiveness of individualized physical therapy (PT) and OT in Parkinson's disease (PD). A total of 762 patients with mild-to-moderate PD reporting limitations in ADL were included in this study. Patients were randomized online to either both PT and OT NHS services (n = 381) or no therapy (n = 381). Therapy incorporated a patient-centered approach with individual assessment and goal setting. The primary outcome was instrumental ADL measured by the patient-completed Nottingham Extended Activities of Daily Living (NEADL) scale at 3 months after randomization. Secondary outcomes were health-related QOL [Parkinson's Disease Questionnaire-39 (PDQ-39); European Quality of Life-5 Dimensions (EQ-5D)], adverse events (AEs), resource use and carer QOL (Short Form questionnaire-12 items). Outcomes were assessed before randomization and at 3, 9 and 15 months after randomization. Data from 92 % of the participants in each group were available at the primary time point of 3 months, but there was no difference in NEADL total score [difference 0.5 points, 95 % CI: -0.7 to 1.7; p = 0.4] or PDQ-39 summary index (0.007 points, 95 % CI: -1.5 to 1.5; p = 1.0) between groups. The EQ-5D quotient was of borderline significance in favor of therapy (-0.03, 95 % CI: -0.07 to -0.002; p = 0.04). Contact time with therapists was for a median of 4 visits of 58 minutes each over 8 weeks (mean dose of 232 minutes). Repeated measures analysis including all time-points showed no difference in NEADL total score, but PDQ-39 summary index (curves diverging at 1.6 points per annum, 95 % CI: 0.47 to 2.62; p = 0.005) and EQ-5D quotient (0.02, 95 % CI: 0.00007 to 0.03; p = 0.04) showed significant but small differences in favor of the therapy arm. Cost-effective analysis showed that therapy was associated with a slight but not significant gain in quality-adjusted life-years (QALY; 0.027, 95 % CI: -0.010 to 0.065) at a small incremental cost (£164, 95 % CI: -£141 to £468), resulting in an incremental cost-effectiveness ratio of under £4,000 (£3,493, 95 % CI: -£169,371 to

£176,358). There was no difference in AEs or serious AEs. The authors concluded that NHS PT and OT did not produce immediate or long-term clinically meaningful improvements in ADL or QOL in patients with mild-to-moderate PD. Moreover, they stated that the evidence does not support the use of low-dose, patient-centered, goal-directed PT and OT in patients in the early stages of PD; future research should include the development and testing of more structured and intensive PT and OT programs in patients with all stages of PD.

In a systematic review and meta-analysis, Tofani and colleagues (2020) examined the effectiveness of OT interventions on QOL in patients with PD. These researchers followed the international guidelines of the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) checklist. Databases (PubMed, Physiotherapy Evidence Database, OTseeker, Scopus, Cinhal, and Web of Science) were searched to identify RCTs of OT interventions in patients with PD up to 2019 and with no restriction on language. The primary outcome of the meta-analysis was the evaluation of QOL following OT interventions.

Because of the heterogeneity of the studies, these investigators examined the data by using a random effect model. They identified 15 RCTs that met the inclusion criteria, and 4 of these were included in the meta-analysis. Studies with a follow-up of 2 to 3 months showed that OT interventions significantly improved the QOL in patients with PD, with a mean difference (MD) of -2.08 (95 % CI: -2.52 to -1.64; $p < 0.00001$).

Studies reporting a longer follow-up (6 to 12 months) also showed that OT interventions improved the QOL, with a mean difference (MD) of -2.56 (95 % CI: -3.52 to -1.61; $p < 0.00001$). The authors concluded that different OT interventions may be effective in improving the QOL in patients with PD; however, because of the limited number of studies available, the strength of the evidence should be considered moderate.

Stroke-Related Disabilities

In a pragmatic, parallel-group, cluster randomized controlled trial with economic evaluation, Sackley and co-workers (2016) evaluated the clinical effectiveness and cost-effectiveness of a targeted course of OT in maintaining functional activity and reducing further health risks from inactivity for United Kingdom care home residents living with stroke-related disabilities. Cluster randomization occurred at the care-home

level. Homes were stratified according to trial administrative center and type of care provided (nursing or residential), and they were randomized 1 : 1 to either the intervention or the control arm. The setting was 228 care homes which were local to 11 trial administrative centers across England and Wales. Care home residents with a history of stroke or transient ischemic attack, including residents with communication and cognitive impairments, not receiving end-of-life care. Personalized 3-month course of OT delivered by qualified therapists. Care workers participated in training work-shops to support personal ADL. The control condition consisted of usual care for residents. Outcome data were collected by a blinded assessor. The primary outcome at the participant level was the Barthel Index of Activities of Daily Living (BI) score at 3 months. The secondary outcomes included BI scores at 6 and 12 months post randomization, and the Rivermead Mobility Index, Geriatric Depression Scale-15 and European Quality of Life-5 Dimensions, 3 levels, questionnaire scores at all time-points. Economic evaluation examined the incremental cost per QALY gain. Costs were estimated from the perspective of the NHS and Personal Social Services. Overall, 568 residents from 114 care homes were allocated to the intervention arm and 474 residents from another 114 care homes were allocated to the control arm, giving a total of 1,042 participants. Randomization occurred between May 2010 and March 2012. The mean age of participants was 82.9 years, and 665 (64 %) were female. No AEs attributable to the intervention were recorded. Of the 1,042 participants, 870 (83 %) were included in the analysis of the primary outcome (intervention, n = 479; control, n = 391). The primary outcome showed no significant differences between groups. The adjusted mean difference in the BI score between groups was 0.19 points higher in the intervention arm [95 % CI: -0.33 to 0.70, p = 0.48; adjusted intra-cluster correlation coefficient 0.09]. Secondary outcome measures showed no significant differences at all time-points. Mean incremental cost of the OT intervention for residents with stroke living in United Kingdom Care Homes intervention was £438.78 (95 % CI: -£3,360.89 to £1,238.46) and the incremental QALY gain was 0.009 (95 % CI: -0.030 to 0.048). The authors concluded that a 3-month individualized course of OT showed no benefit in maintaining functional activity in an older care home population with stroke-related disabilities.

Handwriting Skills

Seo (2018) examined the effect that fine motor skills have on handwriting legibility in children of pre-school age. Subjects of this study were 52 children of normal growth and development. In order to determine handwriting legibility, a Korean alphabet writing assessment was used; to measure fine motor skills, fine motor precision and manual dexterity, sub-items of BOT-2 were measured. Furthermore, in order to measure in-hand manipulation skills, a Functional Dexterity Test was conducted. The results of the study showed a high level of correlation between fine motor skills and handwriting legibility. The study revealed that the accuracy of hand and in-hand manipulation skills was factors that have an effect on handwriting legibility. The authors concluded that through the current research, occupational therapists could provide activities that assist the development of fine motor precision and in-hand manipulation skills for children during the instruction and treatment of handwriting to pre-school age children, which aided in conducting better legibility in their handwriting.

The main drawback of this study of this study was that it was unable to take into consideration numerous variables that affect handwriting legibility, as it only evaluated fine motor skills in assessing handwriting legibility. Furthermore, the participants of this study were only partially sampled from one region; as such, there were difficulties in generalizing the results of this study. These researchers stated that future studies must consider other variables that could influence handwriting legibility and also sample from a wider and more various population of research subjects.

Kadar and colleagues (2020) noted that handwriting skills play a significant role in all stages of an individual's life. Writing interventions should be considered at a younger age to ensure proper development of writing skills. In a systematic review, these researchers examined the available evidence of OT interventions in handwriting skills for 4 to 6 year old children. Published literature was systematically searched according to PRISMA guidelines using specific key terms. Initial search identified 785 studies; however only 7 met the inclusion criteria and were assessed for final review. Studies were methodologically appraised using the McMaster Critical Review Form-Quantitative Studies. The review found no RCT study design pertaining to the reviewed area. However, it can be observed that OT interventions for writing skills in 4 to 6 year old children

managed to increase the targeted skills. The results were similar across samples with or without disabilities. An effective integration of OT interventions into educational curriculum was found to save both time and cost. The authors concluded that long-term benefit from these interventions and the effects of these interventions on a broader spectrum of fine motor abilities need to be explored further with stronger research designs. Moreover, these researchers stated that the lack of studies adopting high level study designs (i.e., RCT designs) meant that results need to be approached with caution by occupational therapists when implementing handwriting skills intervention in practice.

Appendix

Documentation Requirements

The following care plan is required to document the medical necessity of occupational therapy:

- I. Occupational therapy must be provided in accordance with an ongoing, written plan of care. The purpose of the written plan of care is to assist in determining medical necessity.
- II. The plan of care must include sufficient information to determine the medical necessity of treatment. The plan of care must be specific to the diagnosis, presenting symptoms, and findings of the occupational therapy evaluation.
- III. The plan of care must be signed by the member's attending physician and occupational therapist.
- IV. The plan of care should include:
 - A. A reasonable estimate of when the goals will be reached;
 - B. Quantitative objectives;
 - C. Specific statements of long-term and short-term goals;
 - D. The date of onset or exacerbation of the disorder/diagnosis;
 - E. The frequency and duration of treatment; and

F. The specific treatment techniques and/or exercises to be used in treatment.

The plan of care should be ongoing (i.e., updated as the member's condition changes) and treatment should demonstrate reasonable expectation of improvement (as defined below):

The member should be re-evaluated regularly (at least monthly), and there should be documentation of progress made toward the goals of occupational therapy.

The treatment goals and subsequent documentation of treatment results should specifically demonstrate that occupational therapy services are contributing to such improvement.

The services provided must be of the complexity and nature to require that they are performed by a licensed professional therapist or provided under their direct supervision by a licensed ancillary person as permitted under state laws.

CPT Codes / HCPCS Codes / ICD-10 Codes

Information in the [brackets] below has been added for clarification purposes. Codes requiring a 7th character are represented by "+"

Code	Code Description
CPT codes covered if selection criteria are met:	
97140	Manual therapy techniques (e.g., mobilization/manipulation, manual lymphatic drainage, manual traction), one or more regions, each 15 minutes
97165 - 97168	Occupational therapy evaluation or reevaluation
97535	Self-care/home management training (e.g., activities of daily living (ADL) and compensatory training, meal preparation, safety procedures, and instructions in use of assistive technology devices/adaptive equipment) direct one-on-one contact by provider, each 15 minutes
HCPCS codes covered if selection criteria are met:	

Code	Code Description
G0129	Occupational therapy requiring the skills of a qualified occupational therapist, furnished as a component of a partial hospitalization treatment program, per day
G0152	Services performed by a qualified occupational therapist in the home health or hospice setting, each 15 minutes
G0160	Services performed by a qualified occupational therapist, in the home health setting, in the establishment or delivery of a safe and effective therapy maintenance program, each 15 minutes
S9129	Occupational therapy, in the home, per diem
Other HCPCS codes related to the CPB:	
G0158	Services performed by a qualified occupational therapist assistant in the home health or hospice setting, each 15 minutes
G2169	Services performed by an occupational therapist assistant in the home health setting in the delivery of a safe and effective occupational therapy maintenance program, each 15 minutes
ICD-10 codes covered if selection criteria are met (not all-inclusive):	
A80.0 - A80.9	Acute poliomyelitis
B91	Sequelae of poliomyelitis
G12.21	Amyotrophic lateral sclerosis
G14	Postpolio syndrome
G24.1	Genetic torsion dystonia
G24.02 - G24.09 G24.2, G24.8	Acquired torsion dystonia
G35	Multiple sclerosis
G80.0 - G80.9	Cerebral palsy
Q05.0 - Q05.9	Spina bifida
Q07.01, Q07.03	Arnold-Chiari syndrome with spina bifida
Z51.89	Encounter for other specified aftercare [occupational therapy when home program could be used for further gains or condition is neither regressing nor improving]
ICD-10 codes not covered for plans that exclude developmental delay:	

Code	Code Description
F70 - F79	Intellectual disabilities
F80.0 - F84.9	Pervasive and specific developmental disorders
F90.8	Attention-deficit hyperactivity disorder, other type
R27.0 - R27.9	Other lack of coordination
R47.9	Unspecified speech disturbances
R48.0	Dyslexia and alexia
R62.0 - R62.59	Lack of expected normal physiological development in childhood

The above policy is based on the following references:

1. American Occupational Therapy Association. Occupational therapy practice framework: Domain and process. *Am J Occup Ther.* 2002;56: 609–639.
2. American Occupational Therapy Association. Standards of practice for occupational therapy. *Am J Occup Ther.* 1994;48(11):1039-1043.
3. Arbesman M, Sheard K. Systematic review of the effectiveness of occupational therapy-related interventions for people with amyotrophic lateral sclerosis. *Am J Occup Ther.* 2014;68(1):20-26.
4. Beckers LW, Schnackers ML, Janssen-Potten YJ, et al. Feasibility and effect of home-based therapy programmes for children with cerebral palsy: A protocol for a systematic review. *BMJ Open.* 2017;7(2):e013687.
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