APPLICATION STATEMENT

The application of the Clinical Coverage Guideline is subject to the benefit determinations set forth by the Centers for Medicare and Medicaid Services (CMS) National and Local Coverage Determinations and state-specific Medicaid mandates, if any.

DISCLAIMER

The Clinical Coverage Guideline (CCG) is intended to supplement certain standard WellCare benefit plans and aid in administering benefits. Federal and state law, contract language, etc. take precedence over the CCG (e.g., Centers for Medicare and Medicaid Services [CMS] National Coverage Determinations [NCDs], Local Coverage Determinations [LCDs] or other published documents). The terms of a member’s particular Benefit Plan, Evidence of Coverage, Certificate of Coverage, etc., may differ significantly from this Coverage Position. For example, a member’s benefit plan may contain specific exclusions related to the topic addressed in this CCG. Additionally, CCGs relate exclusively to the administration of health benefit plans and are NOT recommendations for treatment, nor should they be used as treatment guidelines. Providers are responsible for the treatment and recommendations provided to the member. The application of the CCG is subject to the benefit determinations set forth by the Centers for Medicare and Medicaid Services (CMS) National and Local Coverage Determinations, and any state-specific Medicaid mandates. Links are current at time of approval by the Medical Policy Committee (MPC) and are subject to change. Lines of business are also subject to change without notice and are noted on www.wellcare.com. Guidelines are also available on the site by selecting the Provider tab, then “Tools” and “Clinical Guidelines”.

BACKGROUND

Sensory integration (SI) is a theory of neuropsychological development and function that investigators have attempted to validate for the past 25 years. First postulated by Ayres in the 1960s, SI is defined as the ability of an individual to appropriately organize sensory input for perceiving, responding, or learning. Children with SI dysfunction are theorized to have a disorder in the reception and integration of sensory information from their environment, a condition that proponents of SI therapy believe contributes to up to 70% of learning disabilities. SI therapy seeks to improve perception and integration of sensory information and thereby help learning disabled children improve their sensorimotor skills. In theory, this will result in improved behavior and academic performance. The therapy designed to achieve these goals emphasizes vestibular, proprioceptive, and tactile stimulation for enhanced neurological development. During the course of an individual 60- to 90-minute therapy session, primitive forms of sensation are combined with motor activity. The therapy is usually administered by occupational therapists specifically trained in SI.
techniques and can be provided in one or three sessions per week for several months or years. Data from individual studies and results of two meta-analyses fail to provide evidence that SI therapy is an effective treatment or improves long-term outcomes for children with learning disabilities, Down syndrome, developmental delays, or putative SI disorders. The few studies that assessed SI therapy in children with cerebral palsy or autism provide insufficient evidence to evaluate SI therapy for these indications.¹

Statement from the American Academy of Pediatrics on Sensory Integration Therapy

Sensory integration (SI) therapy often is used alone or as part of a broader program of occupational therapy for children with ASDs. The goal of SI therapy is not to teach specific skills or behaviors but to remediate deficits in neurologic processing and integration of sensory information to allow the child to interact with the environment in a more adaptive fashion. Unusual sensory responses are common in children with ASDs, but there is not good evidence that these symptoms differentiate ASDs from other developmental disorders, and the efficacy of SI therapy has not been demonstrated objectively. Available studies are plagued by methodologic limitations, but proponents of SI note that higher-quality SI research is forthcoming. A 2010 update by the AAP reaffirms the 2007 stance position.¹

Auditory Integration Therapy

Auditory Integration Training (AIT) is proposed to reduce over-sensitivity to sound. It involves listening to music that has been computer modified to remove frequencies to which an individual demonstrates hypersensitivities and to reduce the predictability of auditory patterns. A special device is used to modify the music for the treatment sessions. The treatment program generally consists of 20 half-hour sessions during a 10-12 day period with two sessions daily. Auditory thresholds are determined via audiograms. The audiogram is reviewed for evidence of hyperacusis, an abnormal sensitivity to sound. A clinical history of sound sensitivities and behavior is also reviewed. Audiograms are repeated midway and at the end of the training session to document progress and to determine if further treatment sessions are necessary.²

Facilitated Communication

Facilitated Communication (FC) is a manual prompting, by a trained facilitator, to provide assistance to a non-verbal person in typing out words using a typewriter, computer keyboard or other communication device. FC involves supporting the individual's hand to make it easier to indicate the letters that are chosen, essentially to develop a communicative statement. The patient is allegedly able to communicate through his or her hand to the hand of the facilitator, which then is guided to a letter, word or picture, spelling out words or expressing complete thoughts.

Sensory Integration for Autism

A 2011 Hayes update found support from the American Occupational Therapy Association (AOTA) Commission on Practice recognizes SIT as one of several frames of reference that a therapist may use and apply in the process of occupational therapy for students who show deficits in sensory integration that contribute to a significant, documented discrepancy in their skills within an educational program. The AOTA also states that some of its members do not advocate treatment with a sensory integration framework, whereas other members are convinced that it offers benefits for certain children.¹

The American Speech Language Hearing Association (ASHA) stated in the organization’s official policy in 2003 that AIT is experimental and has not adequately met the scientific standards for treatment efficacy that would justify its practice by audiologists and speech-language pathologists. According to the working group, several concerns have yet to be resolved, including the lack of evidence-based guidelines regarding patient selection criteria, variability in protocols for the administration of AIT, and the overall lack of evidence documenting treatment effectiveness.¹
Given the lack of scientific evidence, the following therapies are considered experimental and investigational for the treatment of children with learning disabilities and developmental delays, including autism:

- Sensory integration therapy
- Auditory integration therapy
- Facilitated communication.

**Coverage**

**Applicable To:**
- Medicaid – Georgia

The following therapies are covered and considered medically necessary for the treatment of children with learning disabilities and developmental delays, including autism.

- Occupational Therapy services include but are not limited to sensory or perceptual motor development and integration; AND
- Physical Therapy services include but are not limited to sensory motor and related central nervous system function.

**NOTE:** Sensory Integration Therapy is covered for Georgia Medicaid as an adjunct therapy modality.

**CODING**

**Covered CPT® Code (for Georgia Medicaid Only)**

97533  Sensory integrative techniques to enhance sensory processing and promote adaptive responses to environmental demands; direct (one-on-one) patient contact by the provider, each 15 minutes

**HCPCS Level II Code** – No applicable codes.

**Covered ICD-10 Diagnosis Codes (for Georgia Medicaid Only)**

- F43.24  Adjustment disorder with disturbance of conduct
- F43.25  Adjustment disorder with mixed disturbance of emotions and conduct
- F48.9  Nonpsychotic mental disorder and behavioral disorders
- F63.0 – F63.9  Communication and conduct disorders
- F80.0 – F80.9  Developmental disorder of speech and language, unspecified
- F81.0 - F81.9  Specific development disorders of scholastic skills
- F82  Specific developmental disorder of motor function
- F84.0 - F84.9  Pervasive development disorders
- F88  Other disorders of psychological development
- F90.0 - F90.9  Attention-deficit hyperactivity disorders
- F91.0 - F91.9  Conduct disorders
- F93.8 – F93.9  Childhood emotional disorder, unspecified
- F94.0 – F94.9, F98.8  Disturbance of emotions specific to childhood and adolescence
- H93.25  Central auditory processing disorder
- Q99.2  Fragile X chromosome; Fragile X syndrome
- R45.1,R45.81,R45.82  Communication disorder
- R62.50-R62.59  Unspecified lack of expected normal physiological development in childhood
- Z03.810,Z03.89,Z72.811  Observation for suspected mental conditions
- Z86.59  Personal history of other mental and behavioral disorders

Coding information is provided for informational purposes only. The inclusion or omission of a CPT, HCPCS, or ICD-10 code does not imply member coverage or provider reimbursement. Consult the member’s benefits that are in place at time of service to determine coverage (or non-coverage) as well as applicable federal / state laws.

**REFERENCES**


### MEDICAL POLICY COMMITTEE HISTORY AND REVISIONS

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<td>Approved by MPC. No changes; coverage for Georgia Medicaid only.</td>
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<tr>
<td>3/1/2012</td>
<td>Approved by MPC. Included reaffirmation of 2007 AAP guideline; does not impact current WellCare guideline. New Hayes reference; no changes to guideline. Included supporting statement from AOTA and ASHA.</td>
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