Name of Policy:
Sensory Integration Therapy, Auditory Integration Therapy and Facilitated Communication

Policy #: 333
Category: Therapy

Latest Review Date: December 2013
Policy Grade: B

Background/Definitions:
As a general rule, benefits are payable under Blue Cross and Blue Shield of Alabama health plans only in cases of medical necessity and only if services or supplies are not investigational, provided the customer group contracts have such coverage.

The following Association Technology Evaluation Criteria must be met for a service/supply to be considered for coverage:

1. The technology must have final approval from the appropriate government regulatory bodies;
2. The scientific evidence must permit conclusions concerning the effect of the technology on health outcomes;
3. The technology must improve the net health outcome;
4. The technology must be as beneficial as any established alternatives;
5. The improvement must be attainable outside the investigational setting.

Medical Necessity means that health care services (e.g., procedures, treatments, supplies, devices, equipment, facilities or drugs) that a physician, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury or disease or its symptoms, and that are:

1. In accordance with generally accepted standards of medical practice; and
2. Clinically appropriate in terms of type, frequency, extent, site and duration and considered effective for the patient’s illness, injury or disease; and
3. Not primarily for the convenience of the patient, physician or other health care provider; and
4. Not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient’s illness, injury or disease.
**Description of Procedure or Service:**
Sensory integration (SI) therapy has been proposed as a treatment of developmental disorders in patients with established dysfunction of sensory processing, e.g., children with autism, attention deficit hyperactivity disorder (ADHD), brain injuries, fetal alcohol syndrome, and neurotransmitter disease. Sensory integration therapy may be offered by occupational and physical therapists who are certified in sensory integration therapy.

The goal of sensory integration (SI) therapy is to improve the way the brain processes and adapts to sensory information, as opposed to teaching specific skills. Therapy usually involves activities that provide vestibular, proprioceptive, and tactile stimuli, which are selected to match specific sensory processing deficits of the child. For example, swings are commonly used to incorporate vestibular input, while trapeze bars and large foam pillows or mats may be used to stimulate somatosensory pathways of proprioception and deep touch. Tactile reception may be addressed through a variety of activities and surface textures involving light touch. A related method, auditory integration therapy, involves ten hours of listening to electronically modified music over the course of ten days.

Treatment sessions are usually delivered in a one-on-one setting by occupational therapists with special training from university curricula, clinical practice, and mentorship in the theory, techniques, and assessment tools unique to SI theory. Two organizations currently offer certification for SI therapy; Sensory Integration International (SII), a nonprofit branch of the Ayres Clinic in Torrance, Calif, and Western Psychological Services, a private organization that has a collaborative arrangement with University of Southern California (USC), Los Angeles, to offer sensory integration training through USC’s Department of Occupational Science and Therapy. The sessions are often provided as part of a comprehensive occupational therapy or cognitive rehabilitation therapy and may last for more than one year.

**Policy:**

Sensory Integration Therapy (SIT) does not meet Blue Cross and Blue Shield of Alabama’s medical criteria for coverage and are considered investigational.

*Blue Cross and Blue Shield of Alabama does not approve or deny procedures, services, testing, or equipment for our members. Our decisions concern coverage only. The decision of whether or not to have a certain test, treatment or procedure is one made between the physician and his/her patient. Blue Cross and Blue Shield of Alabama administers benefits based on the members' contract and corporate medical policies. Physicians should always exercise their best medical judgment in providing the care they feel is most appropriate for their patients. Needed care should not be delayed or refused because of a coverage determination.*

**Key Points:**
This policy was originally based on a 1999 TEC Assessment that compared the outcomes of sensory integration (SI) therapy with that of standard occupational/physical therapy among children with autism, mental retardation, or learning disabilities. The literature at that time consisted of one study that focused on the use of SI therapy in patients with autism and three
studies that focused on patients with mental retardation; these three studies were inconsistent in their results regarding the superiority of SI therapy. Eleven studies were identified that in total included more than 600 learning-disabled children. Studies that used random assignment and blinded assessors suggested that SI therapy was not superior to conventional therapy and, in many cases, was not even demonstrably superior to any treatment at all. A 1999 meta-analysis also reported that the most recent studies of SI therapy did not seem to support its effectiveness. Periodic literature searches using the MEDLINE database have been performed regularly since the 1999 TEC Assessment. These updates, with the most recent conducted through September 2013, have primarily identified small case series. Systematic reviews and comparative studies are described here.

**Systematic Reviews**
Case-Smith and Arbesman reviewed the evidence for SI therapy as part of a systematic review of interventions for autism used in occupational therapy in 2008. The authors identified one level-I study, which was a systematic review from 2002 that had found only lower quality evidence (levels III and IV, with small sample size and lack of control groups), suggesting that SI intervention was associated with positive changes in social interaction, purposeful play, and decreased sensitivity. It was concluded that “although each of these studies had positive findings, when combined, the evidence remains weak and requires further study.”

May-Benson and Koomar published a systematic review of SI therapy in 2010. The review identified 27 research studies (13 level-I randomized trials) that met the inclusion criteria. Most of the studies had been performed in children with learning or reading disabilities; there were two case reports/small series on the effect of SI therapy in children with autism. The review concluded that although the SI approach may result in positive outcomes, findings may be limited because of small sample sizes, variable intervention dosage, lack of fidelity to intervention, and selection of outcomes that may not be meaningful or may not change with the treatment provided.

A 2011 Cochrane review evaluated auditory integration training along with other sound therapies for autism spectrum disorders. Included were six randomized controlled trials of auditory integration therapy and one of Tomatis therapy, involving a total of 182 subjects aged 3 to 39 years. For most of the studies, the control condition consisted of listening to unmodified music for the same time as the active treatment group. Allocation concealment was inadequate for all studies, and five of the trials had fewer than 20 participants. Meta-analysis could not be conducted. Three studies did not demonstrate any benefit of auditory integration therapy over control conditions, and three studies had outcomes of questionable validity or outcomes that did not achieve statistical significance. The review found no evidence that auditory integration therapy is an effective treatment for autism spectrum disorders; however, evidence was not sufficient to prove that it is not effective.

**Controlled Trials**
The Sensory Processing Disorders Scientific Workgroup has discussed the methodologic challenges of conducting intervention effectiveness studies of dynamic interactional processes, the lack of scientific evidence to support current practice, and methods for improving the quality of research in this area. In 2007, members of the workgroup also reported results from a single
institution randomized pilot study for a proposed multicenter trial. Thirty families (of approximately 140 who met the inclusion/exclusion criteria) agreed to participate over a three year period. The children had a clinical diagnosis of sensory modulation disorder following a comprehensive evaluation with standardized and clinical testing (including responses to sensory stimuli, attempts by the child to self-regulate, behavioral disorganization, and somatic responses to the testing situations). The 24 children who began treatment were randomly assigned to one of three groups consisting of occupational therapy with SI (two times per week for ten weeks, n=7), equivalent activity control sessions (n=10), or a waiting-list control group (n=7). Functional improvements were assessed by five validated/standardized parental rating scales. Significant improvements relative to both control groups were obtained for Goal Attainment Scaling (37 vs. 14 vs. 7, consecutively). A number of the other outcome measures (Leitner International Performance Scale, Short Sensory Profile, and Internalizing on the Child Behavior Checklist) showed trends for improvement in this small study. Additional study with a larger number of subjects is needed.

Another pilot study, reported in 2011, randomized 37 children with a sensory processing disorder (21 with autism and 16 with pervasive developmental disorder not otherwise specified) to SI interventions or to fine motor interventions (18 treatments over six weeks). Fidelity to SI interventions was verified with a fidelity measure developed for research by Parham et al. Blinded evaluation at the conclusion of the intervention found no significant difference between the two groups on the Quick Neurological Screening Test (QNST) or sensory processing scores except for Autistic Mannerisms (e.g., stereotyped or self-stimulatory behavior) subscale. The SI group demonstrated greater improvement than the fine motor group on individualized Goal Attainment Scaling. Post hoc analysis found that more children in the SI group were able to complete parts of the standardized QNST after the intervention. This finding is limited by the post hoc analysis and the difference in the two groups at baseline.

In a 2003 study of 45 children with Down’s syndrome divided into three treatment groups (sensory integrative therapy alone, vestibular stimulation combined with sensory integrative therapy, and neurodevelopmental therapy), Uyanik and colleagues reported greater improvements in outcomes in the vestibular stimulation with SI therapy group and in the neurodevelopmental therapy group when compared to the SI therapy alone group. Outcomes assessed were the Ayres Southern California Sensory Integration Test, Pivot Prone Test, Gravitational Insecurity Test, and Pegboard Test along with physical assessment. The authors concluded all methods of treatment should be considered when planning rehabilitation therapies for children with Down’s syndrome, even though sensory integrative therapy alone was not shown to be superior to the other therapy groups.

Summary
Overall, the evidence remains insufficient to evaluate the effect of this treatment on health outcomes. As noted by Kratz, “there exists very little research that supports the effectiveness of any intervention for children with chronic or mild disabilities across all disciplines.” Due to the individual nature of sensory integration (SI) therapy and the large variation in individual therapists and patients, large multicenter randomized controlled trials are needed to evaluate the efficacy of this intervention. Therefore, the policy statement remains investigational.
Practice Guidelines and Position Statements

A 2012 policy statement by the AAP on SI therapies for children with developmental and behavioral disorders states that “occupational therapy 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.” The AAP indicates that these limitations should be discussed with parents, along with instruction on how to evaluate the effectiveness of a trial period of SI therapy.

In 2009, the American Occupational Therapy Association (AOTA) stated that the AOTA recognizes sensory integration (SI) as one of several theories and methods used by occupational therapists and occupational therapy assistants working with children in public and private schools to improve a child’s ability to access the general education curriculum and to participate in school-related activities. In 2011, the AOTA published evidence-based occupational therapy practice guidelines for children and adolescents with challenges in sensory processing and sensory integration. AOTA gave a level C recommendation for sensory integration therapy for individual functional goals for children, for parent-centered goals, and for participation in active play in children with sensory processing disorder, and to address play skills and engagement in children with autism. A level C recommendation is based on weak evidence that the intervention can improve outcomes, and the balance of the benefits and harms may result either in a recommendation that occupational therapy practitioners routinely provide the intervention or in no recommendation because the balance of the benefits and harms is too close to justify a general recommendation. Specific performance skills evaluated were motor and praxis skills, sensory-perceptual skills, emotional regulation, and communication and social skills. There was insufficient evidence to provide a recommendation on sensory integration for academic and psychoeducational performance (e.g., math, reading, written performance).

Key Words:
Sensory integration therapy (SIT), auditory integration therapy (AIT), facilitated communication (FC) therapy

Approved by Governing Bodies:
Not applicable

Benefit Application:
Coverage is subject to member’s specific benefits. Group specific policy will supersede this policy when applicable.
ITS: Home Policy provisions apply
FEP contracts: FEP does not consider investigational if FDA approved. Will be reviewed for medical necessity.
Pre-certification requirements: Not applicable
Pre-determination requirements: Pre-determinations will be performed as a courtesy review at the request of the physician and/or subscriber.

Coding:
CPT Codes: 97533  Sensory integrative technique to enhance sensory processing and promote adaptive responses to environmental demand, direct (one-on-one) patients contact by the provider, each 15 minutes

References:

Policy History:
Medical Policy Group, October 2008 (3)
Medical Policy Administration Committee, November 2008
Available for comment November 20, 2008-January 5, 2009
Medical Policy Group, October 2010 (1) Key points update, no policy statement change
Medical Policy Group, October 2011 (1) Update to Key Points and References related to SIT; no change to policy statement.
Medical Policy Group, December 2013 (2) Deleted “Auditory Integration Therapy and Facilitated Communication” from title, description, and policy statement. Key Points and References updated to reflect findings from literature search through September 2013.

This medical policy is not an authorization, certification, explanation of benefits, or a contract. Eligibility and benefits are determined on a case-by-case basis according to the terms of the member’s plan in effect as of the date services are rendered. All medical policies are based on (i) research of current medical literature and (ii) review of common medical practices in the treatment and diagnosis of disease as of the date hereof. Physicians and other providers are solely responsible for all aspects of medical care and treatment, including the type, quality, and levels of care and treatment.

This policy is intended to be used for adjudication of claims (including pre-admission certification, pre-determinations, and pre-procedure review) in Blue Cross and Blue Shield’s administration of plan contracts.