

DISCLAIMER

This Molina Clinical Policy (MCP) is intended to facilitate the Utilization Management process. Policies are not a supplementation or recommendation for treatment; Providers are solely responsible for the diagnosis, treatment, and clinical recommendations for the Member. It expresses Molina's determination as to whether certain services or supplies are medically necessary, experimental, investigational, or cosmetic for purposes of determining appropriateness of payment. The conclusion that a particular service or supply is medically necessary does not constitute a representation or warranty that this service or supply is covered (e.g., will be paid for by Molina) for a particular Member. The Member's benefit plan determines coverage – each benefit plan defines which services are covered, which are excluded, and which are subject to dollar caps or other limits. Members and their Providers will need to consult the Member's benefit plan to determine if there are any exclusion(s) or other benefit limitations applicable to this service or supply. If there is a discrepancy between this policy and a Member's plan of benefits, the benefits plan will govern. In addition, coverage may be mandated by applicable legal requirements of a State, the Federal government or CMS for Medicare and Medicaid Members. CMS's Coverage Database can be found on the CMS website. The coverage directive(s) and criteria from an existing National Coverage Determination (NCD) or Local Coverage Determination (LCD) will supersede the contents of this MCP and provide the directive for all Medicare members. References included were accurate at the time of policy approval and publication.

OVERVIEW

Occupational therapy (OT) is defined as services provided within the scope of practice of occupational therapists and necessary for the diagnosis and treatment of impairments, functional disabilities or changes in physical function and health status. Occupational therapy is medically prescribed treatment concerned with improving or restoring functions which have been impaired by illness or injury or, where function has been permanently lost or reduced by illness or injury, to improve one's ability to perform those tasks required for independent functioning. (CMS, 2023 & 2022).

The American Occupational Therapy Association (AOTA) (2022) defines the practice of OT as the therapeutic use of everyday life activities (occupations) with individuals or groups for the purpose of participation in roles and situations in home, school, workplace, community, and other settings. The nature of therapy can be restorative/rehabilitative or maintenance. Restorative/rehabilitative therapy is carried out with the purpose to reverse, wholly or partially, a previous loss of function. Maintenance therapy is carried out with the purpose to maintain or to slow deterioration.

Occupational Therapists utilize clinical history, observation, interview, standardized testing, and assessment of activities of daily living (ADLs), work skills, and leisure skills to characterize individuals with impairments, functional limitations, and disabilities. The results of these assessments are used to identify structural impairments and functional limitations and to design an individualized plan of treatment to assist in improving or restoring function. Services must be performed by or under the supervision of a qualified therapist, defined as an individual who is licensed and meets the practice requirements in the state where they are practicing. While the skills of a qualified Occupational Therapist are required to evaluate the patient's level of function and develop a plan of care, implementation of the plan may also be carried out by a qualified Occupational Therapy Assistant functioning under the general supervision of the qualified Occupational Therapist. Some services must be provided by a licensed therapist, not by an assistant – this includes: (CMS, 2023 & 2022).

- Making clinical judgements or decisions
- Developing, managing, or furnishing skilled maintenance programs
- Supervising other clinicians or taking responsibility for the service rendered

State Resources

Early intervention is the process of providing services, education and support to young children who are deemed to have an established condition, those who are evaluated and deemed to have a diagnosed physical or mental condition (with a high probability of resulting in a developmental delay), an existing delay or a child who is at-risk of developing a delay or special need that may affect their development or impede their education. Early Intervention Programs are typically a first option for children who qualify and are up to age 3 years. Each state has special programs available for education and related services. The purpose of early intervention is to lessen the effects of the disability or delay. Services are designed to identify and meet a child's needs in five developmental areas: physical, cognitive, communication, social or emotional, and adaptive. An EIP is available within each State (refer to State-specific criteria).

COVERAGE POLICY

Please review individual State and Federal mandates and applicable health plan regulations before applying the criteria below. Please refer to requirements, criteria, and guidance from the State in which the Member is receiving treatment as the State's documents will supersede this Molina Clinical Policy.

Initial Occupational Therapy Criteria

Occupational Therapy (OT) **may be considered medically necessary** when **ALL** the following are met:

1. Significant improvement is expected within a reasonable time frame, or it is necessary to develop and implement a maintenance program as evidenced by **ONE** of the following:
 - a. There is a reasonable expectation that the Member's condition will significantly improve in a reasonable, predictable timeframe because of the anticipated therapy services; **OR**
 - b. Anticipated therapy services are needed to implement a safe and effective maintenance program to be performed by the Member without ongoing skilled therapy services; services must be proposed for the treatment of a specific illness or injury;

AND

2. Therapy is ordered by a qualified Provider and performed by a licensed/certified OT Provider, under applicable laws of the State where therapy is being provided; **AND**
3. Therapy may be performed for conditions related to a defect, developmental delay*, functional impairment** or pain as evidenced by supporting documentation recorded in medical records submitted for review.

* Developmental delay describes the condition in which a child is not developing and/or achieving skills according to the expected time frame.

** Functional impairment describes a direct and measurable reduction in physical performance of an organ or body part.

To document medical necessity **ALL** the following should be submitted:

- Diagnosis of the indicated disorder; **AND**
- Date of onset or exacerbation of the indicated disorder; **AND**
- Goals, both long-term and short-term, that are specific, quantitative, and objective; **AND**
- An acceptable estimate of time of when the Member is expected to achieve therapeutic goals; **AND**
- An OT evaluation; **AND**
- Frequency and duration of treatment; **AND**
- Prognosis for rehabilitation or habilitation; **AND**
- Exact treatment techniques and/or exercises to be used in treatment.

Additional Information

Providers of OT services shall possess applicable training, credentialing, licensure, and certification as determined by the State they are providing services in. This includes modalities using physical agents that are applied to produce therapeutic changes to biologic tissue, including (but not limited to) thermal, acoustic, light, mechanical, or electric energy. Modalities can be supervised (not requiring direct one-on-one Provider / Member contact); some modalities may involve constant attendance (requiring direct one-on-one Provider / Member contact). Examples where supervision is appropriate include, but are not limited to:

- Hot or cold packs
- Mechanical traction
- Unattended electrical stimulation
- Vasopneumatic devices
- Whirlpool
- Paraffin bath
- Diathermy

Modalities requiring constant attendance include contrast baths, ultrasound, electrical stimulation, and iontophoresis.

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Continuation of Therapy / Reevaluations

Continued therapy is likely to allow the Member to restore a significant level of function within a reasonable and definable timeframe. Outcomes resulting from therapy cannot reasonably be achieved by continuing a home exercise program alone. Initial requests for continued therapy are for 30 days and do not require prior authorization – additional requests are approved based on guidelines.

1. Member has made functional progress during initial therapy or Member requires maintenance therapy plan to prevent additional decline or preserve current level of functioning; **AND**
2. Therapy goals have not been met; **AND**
3. Member is participating actively in treatment sessions; **AND**
4. Member is compliant with the plan of care.

Reevaluations are distinct from routine therapy assessments. Routine therapy assessments are completed each session pre- and post-therapy to document Member's progress towards goals. Reevaluations should include objective information not included in the routine documentation of therapy assessments.

Indications for a reevaluation include at least ONE of the following:

- a. New clinical findings or diagnoses; **OR**
- b. A significant change in the patient's condition, such as hospitalization; **OR**
- c. Failure to respond to the therapeutic interventions outlined in the plan of care.

Note: Reevaluations are a more comprehensive assessment that must be completed by a licensed therapist and include components of an initial evaluation, such as:

- a. Date of last therapy evaluation
- b. Number of therapy visits authorized, and number of therapy visits attended
- c. Compliance to therapy program
- d. Description of the Member's current deficits and their severity documented using objective data
- e. Identifying the appropriate intervention(s) for new or ongoing goal achievement.
- f. Revision in the Member's plan of care as indicated.

A reevaluation is not a routine, recurring service. Do not bill for routine reevaluations, including those done for the purpose of completing an updated plan of care, a recertification report, a progress report, or a physician progress report. Reevaluation codes are untimed and billable as one unit.

Discharge and Discontinuation of Therapy

A Member may be discharged from OT services when the anticipated goals or expected outcomes have been achieved. Services may be discontinued when the Member cannot continue to progress toward goals or if the Member no longer benefits significantly from OT services. Discontinuation of therapy is appropriate when **ANY** of the following are met:

1. Reasonable goals have been met and member or caregiver is independent with home therapy program
2. A functional plateau has been reached as evidenced by lack of improvement in function or symptoms for the last three (3) visits
3. Member's condition is not expected to improve significantly with further therapy as evidenced by **ONE** of the following:
 - a. In the case of acute illness or injury, prior level of function or maximal functional ability has been achieved
 - b. In the case of chronic condition, maximal functional ability has been achieved
 - c. Member is unable or unwilling to participate in the therapy program
 - d. Member is unable or unwilling to participate in a home exercise program

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Limitations and Exclusions

All other requests for treatment that do not meet the above criteria **are considered not medically necessary or experimental, investigational, and/or unproven**. This includes **ALL** the following:

1. Member's condition is not expected to improve (or has not improved) with therapy.
2. Improvement of function could reasonably be expected as the Member slowly resumes normal activities, without the aid of therapy services. Examples include: an individual who suffered a temporary loss or reduction in function that is likely reversible and expected to recover as they resume normal activities or an individual who did not have difficulty functioning and develops temporary weakness due to bed rest following surgery.
3. Services that do not require the skills of a licensed or certified OT provider such as:
 - a. Activities that benefit an individual overall such as: general exercises (e.g., basic aerobic, strength, flexibility, or aquatic programs) to promote overall fitness/conditioning; services that focus on enhancing athletic or recreational sports; massages and whirlpools for the purposes of relaxation; and public education classes.
 - b. Repetitive gait or other activities that can be practiced individually and self-administered or that require routine supervision (not the skills of an OT provider) as well as home exercise programs to continue therapy.
4. Insufficient documentation to objectively verify subjective, objective, and functional progress over a reasonable and predictable period.
5. Modalities that are physical in nature are not preparatory for other procedures.
6. Treatments and modalities that lack evidence of efficacy and/or clinical value separate or apart from (or within) a comprehensive treatment plan for the Member's condition and/or not considered to be a current standard of care. This includes, but is not limited to, infrared light therapy and vasopneumatic device.
7. Services that are duplicative and expected to have the same therapeutic outcomes including, but not limited to:
 - a. Procedures with multiple modalities or have intersecting physiologic effects (e.g., multiple forms of superficial or deep heating modalities).
 - b. Services that are similar and provided as part of an authorized therapy program through another therapy discipline.

In addition, the following are considered experimental and investigational:

- Dry needling
- Dry hydrotherapy, aquamassage, and hydromassage
- Elastic therapeutic tape or taping (e.g., Kinesio™ tape, KT TAPE, KT TAPE PRO™, Spidertech™ tape)
- Hippotherapy (or equestrian therapy)
- H-WAVE®
- Intensive Model of Constraint-Induced Movement Therapy (CIMT)
- Intensive Model of Therapy (IMOT) programs
- The Interactive Metronome Program
- Low-level laser therapy (LLLT)
- MEDEK Therapy
- Microcurrent Electrical Nerve Stimulation (MENS)
- Non-invasive Interactive Neurostimulation (e.g., InterX®)

The following are also considered non-covered and not medically necessary as they are educational and non-clinical:

- Returning to school
- Driving safety or driver training
- Vocational rehabilitation programs (or similar programs focused on assisting an individual to return to work)
- Work hardening programs

Additionally, many benefit plans have exclusion language and/or limitations that impact coverage of occupational Therapy. Please refer to the individual benefit plan for details.

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Specific Rehabilitation Criteria

Providers can access the most current MCG criteria listed below by visiting the Molina Provider Portal (login and password required).

- Arthroplasty Rehabilitation
- Fracture Rehabilitation
- Neurologic Rehabilitation
- Osteoarthritis Rehabilitation
- Pain Rehabilitation
- Soft Tissue Dysfunction Rehabilitation (Lower Extremity)
- Soft Tissue Dysfunction Rehabilitation (Spine)
- Soft Tissue Dysfunction Rehabilitation (Upper Extremity)
- Systematic Rehabilitation

DOCUMENTATION REQUIREMENTS. Molina Healthcare reserves the right to require that additional documentation be made available as part of its coverage determination; quality improvement; and fraud; waste and abuse prevention processes. Documentation required may include, but is not limited to, patient records, test results and credentials of the provider ordering or performing a drug or service. Molina Healthcare may deny reimbursement or take additional appropriate action if the documentation provided does not support the initial determination that the drugs or services were medically necessary, not investigational, or experimental, and otherwise within the scope of benefits afforded to the member, and/or the documentation demonstrates a pattern of billing or other practice that is inappropriate or excessive.

SUMMARY OF MEDICAL EVIDENCE

Adults

Fields & Smallfield (2022) performed a systematic review of 102 articles to develop practice recommendations for OT providers to educate their patients regarding self-management interventions for those with chronic conditions. (These interventions would supplement therapy provided in person). The review included the following conditions: heart disease, chronic lung conditions, diabetes, and kidney disease. Self-management interventions addressed ADLs and sleep and rest; Instrumental Activities of Daily Living (IADLs); education, work, volunteering, leisure, and social participation; and the caregiver role. Evidence was strong to moderate in support of clinical recommendations for the use of self-management interventions. The authors recommend the use of a multimodal approach with a focus on the components of education, goal setting, and problem solving. This approach would extend over a period to assist patients in establishing routines using self-management interventions.

Children and Adolescents

Clark and Kingsley (2020) developed a practice guideline for OT interventions in children ages birth through five years. Development of cognitive, motor, social-emotional, and self-care skills is important during this period as they are a foundation of key life occupations (e.g., eating, dressing, play, learning, social participation, rest and sleep, and chores). The authors synthesized systematic reviews on these areas of development to promote decision making for and high-quality interventions with this population. In total, four systematic reviews were analyzed with respect to cognition, mental health, motor function, and ADLs (publication dates ranged from 2010–2017 and were located from electronic databases such as MEDLINE, PsycINFO, CINAHL, ERIC, OTseeker, and Cochrane). In total, 196 articles were reviewed and guided the development of the final clinical recommendations. Several interventions have been found to support the development of cognitive, social-emotional, motor, and self-care skills. While some are usually implemented by OT providers, some interventions can be applied by parents after appropriate training or by teams working in preschool settings.

Cahill and Beisbier (2020) analyzed data from three systematic reviews of interventions that are activity and occupation based. Through this review, a practice guideline was developed to lead decision making and support best practices in providing OT services for children and youth ages 5 to 21 in settings such as the home, at school, and in the community. Recommendations are also made for education, practice, and research. In total, 158 articles were included in the systematic review and studied the evidence for interventions to promote ADLs, IADLs, play and leisure, and rest and sleep; to improve mental health, positive behavior, and social participation; and to enhance learning, academic achievement, and successful participation in school. In addition, the review indicates the importance of involving the patient's family and caregivers. Evidence also supports models that are group service-based and those that include

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peer mediation – these models may promote participation across areas of occupation. Skills-based training is also recommended over isolated sensorimotor approaches.

Houtrow and Murphy (2019) published an article in consultation with the Council on Children with Disabilities. The authors note the vital role of ensuring that children and youth with disabilities are receiving appropriate community-based services. Without adequate training, general pediatric providers may not be equipped to prescribe appropriate therapy in the appropriate setting for the patient. The report includes the framework of the International Classification of Functioning, Disability and Health (ICF) for understanding the interaction between health conditions and personal and environmental factors that result in disability; , children with disabilities and the goals of habilitation and rehabilitation services; the types of therapy services available with their general indications; the locations in which children may receive therapy services and potential facilitators and barriers to securing therapy services; the existing literature regarding the benefits of therapy and how therapy may be dosed to optimize functional outcomes; and recommendations for writing therapy prescriptions.

National and Professional Organizations

The **American Occupational Therapy Association (AOTA)** (2021) published *Standards of Practice for Occupational Therapy* to address the physical, cognitive, psychosocial, sensory-perceptual, and other aspects of one's performances in various contexts. The aim is to support the individual's engagement and performance in occupations that affects physical and mental health as well as one's quality of life. A summary of the following standards can be found [here](#).

- Professional Standing and Responsibility
- Service Delivery
- Screening, Evaluation, and Reevaluation
- Intervention Process
- Outcomes, Transition, and Discontinuation

The AOTA (2019) published a practice advisory on *Occupational Therapy Practitioners in Early Intervention*. It highlights the importance of OT practitioners in the care of infants and toddlers. This includes promotion of a child's development, partnering with the child's family to advocate for their needs, and enhancing the caregiving capacity for the child.

SUPPLEMENTAL INFORMATION

Habilitative / Maintenance Therapy. A program designed to maintain or to slow deterioration and must meet criteria to be considered reasonable and necessary. Treatment approaches include, but are not limited to (CMS, 2021):

- Evaluation; **OR**
- Basic activities of daily living training; **OR**
- IADLs training; **OR**
- Muscle reeducation/strengthening/coordination; **OR**
- Cognitive training; **OR**
- Perceptual motor training; **OR**
- Orthotics (splinting); **OR**
- Adaptive equipment fabrication and training; **OR**
- Environment modification recommendations/training; **OR**
- Patient/caregiver education/training; **OR**
- Transfer training; **OR**
- Functional modality training; **OR**
- Manual therapy; **OR**
- Physical agent modality

Rehabilitative / Restorative Therapy. The purpose of this type of skilled therapy is to reverse, in whole or in part, a previous loss of function (CMS, 2021).

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Individuals with Disabilities Act (IDEA) and State Resources for Children and Adolescents. The Act is a federally mandated program that provides free and appropriate public education for children with diagnosed learning disabilities throughout the nation and ensures special education and related services to those children.** Funding is governed by IDEA and determines how States and public agencies (such as schools) provide early intervention, special education, and related services to over 7.5 million eligible infants, toddlers, children, and youth with disabilities.

- Children and youth ages 3 through 21 receive special education and related services under IDEA Part B.
- Infants and toddlers (birth through age 2) with disabilities and their families receive early intervention services under IDEA Part C.
- Formula grants are awarded to States to support special education and related services and early intervention services.
- Discretionary grants are awarded to State educational agencies, institutions of higher education, and other non-profit organizations to support research, demonstrations, technical assistance and dissemination, technology development, personnel development, and parent-training and -information centers.

Services provided include, but are not limited to social workers, speech therapists, occupational therapists, school nurses, school psychologists, and/or health or other support staff (e.g., aides). Congress reauthorized the IDEA in 2004 and amended the IDEA through the Every Student Succeeds Act in December 2015.

** Refer to State guidance regarding coverage of speech therapy for the conditions noted above.

CODING & BILLING INFORMATION

CPT Codes

CPT	Description
97165	Occupational therapy evaluation, low complexity, requiring these components: An occupational profile and medical and therapy history, which includes a brief history including review of medical and/or therapy records relating to the presenting problem; An assessment(s) that identifies 1-3 performance deficits (e.g., relating to physical, cognitive, or psychosocial skills) that result in activity limitations and/or participation restrictions; and Clinical decision making of low complexity, which includes an analysis of the occupational profile, analysis of data from problem-focused assessment(s), and consideration of a limited number of treatment options. Patient presents with no comorbidities that affect occupational performance. Modification of tasks or assistance (e.g., physical or verbal) with assessment(s) is not necessary to enable completion of evaluation component. Typically, 30 minutes are spent face-to-face with the patient and/or family.
97166	Occupational therapy evaluation, moderate complexity, requiring these components: An occupational profile and medical and therapy history, which includes an expanded review of medical and/or therapy records and additional review of physical, cognitive, or psychosocial history related to current functional performance; An assessment(s) that identifies 3-5 performance deficits (e.g., relating to physical, cognitive, or psychosocial skills) that result in activity limitations and/or participation restrictions; and Clinical decision making of moderate analytic complexity, which includes an analysis of the occupational profile, analysis of data from detailed assessment(s), and consideration of several treatment options. Patient may present with comorbidities that affect occupational performance. Minimal to moderate modification of tasks or assistance (e.g., physical or verbal) with assessment(s) is necessary to enable patient to complete evaluation component. Typically, 45 minutes are spent face-to-face with the patient and/or family.
97167	Occupational therapy evaluation, high complexity, requiring these components: An occupational profile and medical and therapy history, which includes review of medical and/or therapy records and extensive additional review of physical, cognitive, or psychosocial history related to current functional performance; An assessment(s) that identifies 5 or more performance deficits (e.g., relating to physical, cognitive, or psychosocial skills) that result in activity limitations and/or participation restrictions; and Clinical decision making of high analytic complexity, which includes an analysis of the patient profile, analysis of data from comprehensive assessment(s), and consideration of multiple treatment options. Patient presents with comorbidities that affect occupational performance. Significant modification of tasks or assistance (e.g., physical or verbal) with assessment(s) is necessary to enable patient to complete evaluation component. Typically, 60 minutes are spent face-to-face with the patient and/or family.

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97168	Re-evaluation of occupational therapy established plan of care, requiring these components: An assessment of changes in patient functional or medical status with revised plan of care; An update to the initial occupational profile to reflect changes in condition or environment that affect future interventions and/or goals; and A revised plan of care. A formal reevaluation is performed when there is a documented change in functional status or a significant change to the plan of care is required. Typically, 30 minutes are spent face-to-face with the patient and/or family.
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
97010	Application of a modality to 1 or more areas; hot or cold packs
97012	Application of a modality to 1 or more areas; traction, mechanical
97016	Application of a modality to 1 or more areas; vasopneumatic devices
97018	Application of a modality to 1 or more areas; paraffin bath
97022	Application of a modality to 1 or more areas; whirlpool
97024	Application of a modality to 1 or more areas; diathermy (e.g., microwave)
97032	Application of a modality to 1 or more areas; electrical stimulation (manual), each 15 minutes
97033	Application of a modality to 1 or more areas; iontophoresis, each 15 minutes
97034	Application of a modality to 1 or more areas; contrast baths, each 15 minutes
97035	Application of a modality to 1 or more areas; ultrasound, each 15 minutes

HCPCS Codes

HCPCS	Description
G0129	Occupational therapy services requiring the skills of a qualified occupational therapist, furnished as a component of a partial hospitalization treatment program, per session (45 minutes or more)
G0152	Services performed by a qualified occupational therapist in the home health or hospice setting, each 15 minutes
G0158	Services performed by a qualified occupational therapist assistant 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 occupational therapy maintenance program, each 15 minutes
S9129	Occupational therapy, in the home, per diem

CODING DISCLAIMER. Codes listed in this policy are for reference purposes only and may not be all-inclusive. Deleted codes and codes which are not effective at the time the service is rendered may not be eligible for reimbursement. Listing of a service or device code in this policy does not guarantee coverage. Coverage is determined by the benefit document. Molina adheres to Current Procedural Terminology (CPT®), a registered trademark of the American Medical Association (AMA). All CPT codes and descriptions are copyrighted by the AMA; this information is included for informational purposes only. Providers and facilities are expected to utilize industry standard coding practices for all submissions. When improper billing and coding is not followed, Molina has the right to reject/deny the claim and recover claim payment(s). Due to changing industry practices, Molina reserves the right to revise this policy as needed.

APPROVAL HISTORY

4/13/2023	Policy reviewed, criteria wording updated for clarification and included information regarding re-evaluations, discharge, and discontinuation of therapy.
4/13/2022	New policy.

REFERENCES

Government Agency

- Centers for Medicare and Medicaid Services (CMS). Pub. 100-02, Chapter 15, sections 220: Coverage of outpatient rehabilitation therapy services (physical therapy, occupational therapy, and speech-language pathology services) under medical insurance and section 230. Updated. Accessed March 1, 2023. <http://www.cms.hhs.gov/manuals/Downloads/bp102c15.pdf>.
- Centers for Medicare and Medicaid Services (CMS). Outpatient occupational therapy (LCD L34427). Effective October 1, 2015. Revised December 8, 2022. Accessed March 1, 2023. <https://www.cms.gov/medicare-coverage-database/search.aspx>.

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Peer Reviewed Publications

1. Cahill SM, Beisbier S. Occupational therapy practice guidelines for children and youth ages 5-21 years. *Am J Occup Ther.* Jul/Aug 2020;74(4):7404397010p1-7404397010p48. doi: 10.5014/ajot.2020.744001. PMID: 32602457.
2. Clark GF, Kingsley KL. Occupational therapy practice guidelines for early childhood: Birth-5 years. *Am J Occup Ther.* May/Jun 2020;74(3):7403397010p1-7403397010p42. doi: 10.5014/ajot.2020.743001. PMID: 32365324.
3. Fields B, Smallfield S. Occupational therapy practice guidelines for adults with chronic conditions. *Am J Occup Ther.* 2022 Mar 1;76(2):7602397010. doi: 10.5104/ajot.2022/762001. PMID: 35299240.

National and Specialty Organizations

1. American Occupational Therapy Association (AOTA). Definition of occupational therapy practice for the AOTA Model Practice Act. Published 2021. Published 2021. Accessed March 1, 2023. <https://www.aota.org/-/media/Corporate/Files/Advocacy/State/Resources/PracticeAct/OT-Definition-for-AOTA-Model-Practice-Act.pdf>.
2. American Occupational Therapy Association (AOTA). Standards of practice for occupational therapy. *Am J Occup Ther.* 2021;75(Supplement 3), 7513410030. Accessed March 1, 2023. <https://doi.org/10.5014/ajot.2021.75S3004>.
3. American Occupational Therapy Association (AOTA). AOTA practice advisory: Occupational therapy practitioners in early intervention. Published October 2019. Accessed March 1, 2023. <https://www.aota.org/-/media/Corporate/Files/Practice/Children/Practice-Advisory-Early-Intervention.pdf>.
4. Houtrow A, Murphy N, Council on Children with Disabilities, Kuo DZ, Apkon S, Brei TJ, et al. Prescribing physical, occupational, and speech therapy services for children with disabilities. *Pediatrics.* 2019 Apr;143(4):e20190285. doi: 10.1542/peds.2019-0285. PMID: 30910917.