



**Oregon Guidelines for  
Medically-based Outpatient  
Physical Therapy and  
Occupational Therapy for  
Children with Special  
Health Needs in the  
Managed Care Environment**

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# Oregon Guidelines for Medically-based Outpatient Physical Therapy (PT) and Occupational Therapy (OT) for Children with Special Health Needs in the Managed Care Environment

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**I. GUIDELINE TABLES FOR MEDICALLY-BASED OUTPATIENT PT AND OT FOR CHILDREN WITH SPECIAL HEALTH NEEDS**

Application of these guidelines must remain flexible to accommodate special circumstances. The explanatory text (pp. 5-10) includes statement of issues, definitions of italicized words, clarification of funding and billing issues, discussion of differentiation and coordination of *medically-based and educationally-based therapy services*, and provision of therapy services. The Appendices (pp. 13-24) contain vignettes of applied usage and descriptions of therapy evaluation and assessment strategies, and the Supplements (pp. 25-30) contain the applicable Oregon Administrative Rules.

These guidelines posit that children with special health needs are best served when funds for *medically-based therapy services* are used for periodic and episodic courses of treatment that will improve specific functional deficits. Many of these episodes can be anticipated. Treatment periods alternate with *periodic steady states of sensorimotor functioning* when *other community resources* may effectively help generalize gains made in treatment and more appropriately meet the child's evolving sensorimotor needs. This model differs from previous models in which treatment was diagnosis-driven and continuous, or from models of treatment for acute or sub-acute orthopedic injuries.

These guidelines are not applicable to educationally-based therapy services. The Oregon Administrative Rules (pp. 26-29) delineate the eligibility criteria for *educationally-based therapy services*; they specify that services are provided at no cost to parents and are driven by the IEP/IFSP process to address educational access (ages 3-21) or developmental milestones (ages 0-3). Third party funds should be used exclusively for *medically-based therapy services* as a health care service requiring physician referral and authorization to address specific emerging or *periodic life issues* identified in the Guideline Tables. Because of these differences, the need for *medically-based therapy services* usually should be considered independently of whether the child is receiving *educationally-based therapy*.

PT and OT in pediatrics overlap, especially in early childhood. Both evaluate and treat issues related to sensorimotor function in the developing child, though each has specific expertise, reflected in the recommended service in the format column of the Guideline Tables. Sometimes one discipline can serve in place of the other, according to the availability, training, experience and skill of the particular therapists.

Use Table 1 for the child newly diagnosed, and Table 2 thereafter. Determine whether the child has emerging or *periodic life issues* (first column) for which *medically-based therapy services* might be warranted. Read across that row for examples of functional need, and recommended format, frequency and progress review date. Frequency will typically be the low end of recommended ranges; occasionally potential for functional improvement warrants higher frequencies.

**Guidelines Table 1 For the Child in the Diagnostic Period**

<b>Emerging Life Issues</b>	<b>Examples of Functional Need</b>	<b>Format</b>	<b>Frequency</b>	<b>Progress Review Date</b>
<b>Immediate Post-Diagnostic Period</b>	Sensorimotor dysfunction due to Neuro-Musculo-Skeletal (NMS) impairment (e.g., spastic weakness, movement disorders, hypotonia with weakness, disorders of perception or processing)	PT and OT direct service as needed; Home program emphasis; Referral to other community resources	Varies from 1-3 times weekly	Six months
<b>Developmental Delay</b>	Sensorimotor delay as part of global delay	PT and OT evaluation/consultation as needed for home program and other community resources	No direct treatment; evaluation as needed	Re-evaluate at request of PCP

**Guidelines Table 2 For the Child following the Diagnostic Period or with a Previously Established Diagnosis**

<b>Periodic Life Issues</b>	<b>Examples of Functional Need</b>	<b>Format</b>	<b>Frequency</b>	<b>Progress Review Date</b>
<b>Periodic Steady State</b>	Sensorimotor functioning is stable; no need	PT and OT evaluation/consultation as needed for home program and other community resources	No direct treatment; evaluation as needed	Re-evaluate at request of PCP
<b>Mobility</b>	Access to household and community activities impaired by sensorimotor dysfunction; Equipment and training	PT or OT direct service; Home program emphasis	Varies from 1-3 times weekly	Four months
<b>Manipulation</b>	Reach, prehension or object manipulation impaired by sensorimotor dysfunction; Equipment and training	OT or PT direct service; Home program emphasis	Varies from 1-3 times weekly	Four months
<b>Pre or Post-Medical/Surgical</b>	Pharmacologic, Orthopedic or Neurosurgical intervention affecting sensorimotor functioning; Equipment and training	PT or OT direct service; Home program emphasis	Varies from 1-3 times weekly	Four months
<b>Assistive Technology</b>	Access to written or augmentative communication, powered mobility, environmental controls; Adaptive positioning; Equipment and training	OT or PT direct service; Home program emphasis	Varies from weekly to monthly following delivery of equipment	Four months
<b>Feeding</b>	Oral-motor skills impaired by sensorimotor dysfunction; Transition to oral feeding; Equipment and training	Specialized OT or PT (or Sp-Lg Pathology) direct service; Home program emphasis	Varies from weekly direct to monthly consult	Four months
<b>Growth</b>	Progression toward contracture of tendons, joints; Equipment and training	PT or OT direct service; Home program emphasis	Varies from weekly direct to monthly consult	Four months
<b>Obesity</b>	Progression toward obesity that threatens steady state of sensorimotor functioning	PT or OT evaluation/consultation as needed for home program and other community resources	No direct treatment; evaluation as needed	Re-evaluate at request of PCP
<b>Activities of Daily Living</b>	Personal care, homemaking, and community living skills impaired by sensorimotor dysfunction; Equipment and training	OT or PT direct service; Home program emphasis	Varies from 1-3 times weekly	Four months

## II. EXPLANATORY TEXT *Italicized words are defined in Section C (1 - 11)*

**A. Purpose:** This document will provide a treatment model and reference tool that physicians, therapists, and managed care plans can use to:

1. advocate that *children with special health needs* receive appropriate therapy services;
2. discuss with individuals and their families appropriate parameters for therapy, including format, frequency, and review of progress; and
3. direct the responsible use of *medically-based outpatient physical therapy (PT) and occupational therapy(OT)*.

The document also will seek to clarify the delivery of PT and OT services for *children with special health needs* in Oregon. The guidelines focus primarily upon managed care and accordingly emphasize the central coordinating role of the primary care physician. However, the guidelines should be pertinent in indemnity plans in which orthopedists, developmental pediatricians, physiatrists, or neurologists prescribe in coordination with the primary care physician.

**B. Best Practice in PT and OT in the Managed Care Environment:** Primary care physicians (PCP), managed care plans, therapists, and families have all cited the need for therapy guidelines. There is widespread acceptance that the services of PT and OT are pertinent, appropriate, and beneficial for *children with special health needs*. In the managed care environment there is heightened need to demonstrate the benefits received from intervention in light of the costs of providing that intervention. PT and OT services that use health care dollars should meet this standard of practice by following guidelines as outlined in this document. Therapy resources are most responsibly allocated when they are driven not simply by the existence of a sensorimotor diagnosis but rather by their potential to improve sensorimotor function.

Allocation of therapy services in the managed care environment is not necessarily detrimental to the well-being of children with special health needs. In fact, cost containment in the managed care environment and best practice in PT and OT for children with special health needs can be compatible.

Best practice in PT and OT avoids learned helplessness and dependence on therapy. Best practice in PT and OT:

- fosters the child's competence in his or her environment;
- prevents secondary complications and disability;
- strives for and acknowledges *periodic steady states of sensorimotor functioning*; and
- uses *home programs* and *other community resources* to promote self-determination and optimal societal inclusion.

**C. Definitions** (for purposes of this document, in relation to PT and OT)

1. ***Children with special health needs*** are persons diagnosed in the developmental period (birth through twenty-one years of age) with a static or progressive neuro-musculo-skeletal (NMS) impairment that threatens structural integrity or functional capabilities. Examples of NMS impairment include spina bifida, cerebral palsy, cerebellar ataxia, developmental dyspraxia, visual-perceptual dysfunction, muscular dystrophy, hemophilia, spinal muscle atrophies, metabolic diseases with sensorimotor impairment, traumatic brain injuries with sensorimotor impairment, and arthrogryposis.

2. ***Sensorimotor dysfunction*** is the inability of the child to perform in a developmentally appropriate or safe manner because of NMS impairment. Determination and documentation include:

- functional significance for the child, expressed in terms of the *periodic life issues*;
- performance on standardized testing;
- magnitude of disproportion between sensorimotor and global developmental status.

For those aspects of sensorimotor function for which there are standardized tests, significant dysfunction is commonly indicated by performance that is moderately to severely delayed or 1.5 standard deviations or more below the mean. *Medically-based therapy services* do not usually accelerate developmental progress when the sensorimotor delay is commensurate with global delay. *Direct PT or OT treatment* typically is indicated when the ratio of sensorimotor age to global developmental age is .77 or lower.

3. ***Periodic life issues*** represent recurrent episodes in the lives of *children with special health needs* when sensorimotor functioning is adversely affected by changes resulting from emerging issues of health, growth, development, environment, or family context. Examples of periodic life issues include: pre-and post-surgical needs; mobility, manipulation, activities of daily living, or feeding; access to assistive technology; and, contracture or decubitus development.

4. ***Periodic steady state of sensorimotor functioning*** occurs when the sensorimotor dysfunction of *children with special health needs* either remains stable or changes so slowly that no effect is measurable at the functional level. *Direct PT or OT treatment* at such time will not likely result in changes in the level of the child's sensorimotor functioning beyond what would accrue from everyday experiences and developmental progress.

5. ***Medically-based therapy services*** means PT and OT referred and authorized as medically necessary by the primary care physician to address specific functional problems encountered within the *periodic life issues*. These therapy services are responsive to changing medical and surgical conditions and emphasize developing and monitoring *home programs* to be implemented in their residence (e.g., at home with family or in nursing facility). Medically-based therapy services are provided in hospitals, clinics, nursing facilities, rehabilitation centers, private practices, and home health settings. Actual funding depends upon the coverage provided by an

individual's policy.

The periodic and episodic nature of medically-based therapy services for *children with special health needs* differs from the traditional treatment model, as exemplified with acute and sub-acute orthopedic injuries. In the traditional model intensive therapy is provided in concentrated blocks of time; e.g., 20 sessions over 2 months. For most *periodic life issues* these same 20 treatment sessions are usually more appropriate for *children with special health needs* when extended over a 4 month period, as suggested by the Guideline Tables. Occasionally potential for functional improvement warrants more intensive episodes requiring greater frequency of treatment.

**6. PT or OT direct treatment**, provided by a by a licensed PT or OT, is one-to-one intervention with the child focused on achieving treatment goals related to *periodic life issues*.

**7. PT or OT evaluation/consultation** is a detailed assessment (see Appendix B, page 22) of NMS structure and function provided by a licensed PT or OT coupled with instruction and/or training provided to the child, the family, and *other community resources*.

**8. Home programs** are indispensable elements of PT and OT intervention, amplifying the effects of therapy and promoting generalization of acquired skills to functional applications. These programs are developed by PTs or OTs and are implemented by parents, caregivers, or peer tutors. They may also be self-directed apropos the child's developmental maturity and skill level.

- During times of *direct treatment*, the home program is adjunct to treatment, and requires regular review and updating apropos the child's status and the emphases of therapy.
- During the *steady states of sensorimotor functioning* the home program serves to sustain the child's structural and functional status. The therapist recommends to the primary care physician anticipated need for *evaluation/consultation* to monitor the home program's implementation, evaluate its appropriateness for the child's status, and update it as necessary.

Home programs that are implemented and monitored appropriately represent containment of possible future health care costs. For example, flexibility exercises to sustain range of motion of the tendoachilles may minimize the need for subsequent *direct treatment*, orthoses, or surgery.

**9. Educationally-based therapy services** are health related services provided and funded through the educational system enabling children to have access to free and appropriate education. The Oregon Administrative Rules define educationally-based therapy services and describe determination of eligibility (see Supplement, pp. 26 - 29). PT and OT services delivered through the educational system for *children with special health needs* are pertinent and beneficial within restricted mandates. The educational system has neither the mandate nor the resources to provide the full array of medically necessary PT and OT services.

**Early Intervention (EI)** programs provide PT and OT, for children who are eligible, from birth to three years of age at no cost to the parents or third party payors. These therapy services must be designed to meet the developmental needs. Children receiving therapy service through EI include:

- Those who have motor delay and who do not warrant *medically-based therapy*; and,
- Those who have NMS impairment that will likely result in *periodic life issues* that will warrant *medically-based therapy* in addition to EI services.

For children three to twenty one, therapy services provided through the educational system are restricted: to assist a child with a disability to benefit from special education. Educationally-based therapy services are provided by:

- **Regional Programs for Children with Orthopedic Impairments (OI)**: for children with severe disability from birth to twenty-one years of age;
- **Early Childhood Special Education (ECSE)**: for children with mild to moderate disability, from three to five years of age;
- **Local school districts**: for children with mild to moderate disability, from five to twenty-one years of age.

In these programs, licensed PTs or OTs, licensed physical therapist assistants (PTAs), certified occupational therapist assistants (COTAs), or aides, provide services that typically range from direct treatment to consultation.

There are some children whose mild sensorimotor disability does not impede educational access or performance who therefore might not be eligible for educationally-based therapy but who could benefit from *medically-based therapy*. Eligibility for *medically-based therapy* should be determined independently of whether the child is receiving educationally-based therapy.

**10. Other community resources** are indispensable adjuncts to PT and OT intervention, amplifying the effects of therapy and promoting generalization of acquired skills to functional applications. Examples include:

- **Educationally-based therapy services** in EI, ECSE, OI, and local school districts.
- **Recreational activities** including Parks and Recreation Programs (such as Oregon Games for the Physically Challenged and Special Olympics), school-based athletics, and private sport and recreation programs;
- **Other support services** including parent groups, social service agencies, case management resources, respite services, counseling, behavioral intervention, and vocational services;
- **Other health care providers** including consulting physicians (e.g., developmental pediatricians, orthopedists, neurologists, neurosurgeons, and psychiatrists), speech-language pathologists, psychologists, audiologists, nutritionists, public health nurses, and private duty nurses.

**11. Oregon licensure for PT and OT** (See Appendix C, page 24)

**D. Funding and Billing Issues for Educationally-based Therapy** PT and OT services provided in the educational setting are primarily funded by educational dollars. According to Oregon's Rehabilitative Services Option, OI and school district programs are able to bill a Medicaid waiver program to offset the costs of providing limited health related services for children who are enrolled in OI or special education and are eligible for Medicaid. Such health

related services reimbursable by Medicaid include PT and OT provided according to educational guidelines. Medicaid dollars allocated for therapy services in the educational setting are separate and distinct from the Medicaid funds that managed care plans administer. Managed care plans continue to bear the financial responsibility for *medically-based therapy services*.

**E. Differentiation and Coordination of *Educationally-based and Medically-based Therapy*:** Therapy services in the educational setting overlap and complement *medically-based therapy*. For the sake of clarity therapists in both settings should differentiate therapy addressing medical needs from therapy for educational access, or, in the case of EI, for developmental milestones. When educationally-based therapists identify therapy needs that exceed the scope of the educational mandate they should be able to recommend to primary care physicians referral for *medically-based therapy* without incurring school district responsibility to provide or fund that therapy. Conversely, when a child's needs are sufficiently or more appropriately met by *other community resources*, tapering or discontinuation of *medically-based therapy services* is warranted.

Communication between therapists in the different settings is imperative for optimal coordination of service. Communication with families and primary care physicians will foster understanding of the roles of *educationally-based and medically-based therapies, home programs, and other community resources*.

For example a small number of children in Oregon reside in nursing facilities and receive *educationally-based therapy services*. Many will need additional periodic and episodic medically-based therapy service to respond to their changing medical and surgical conditions. There are two funding structures for *medically-based therapy services* delivered in nursing facilities (see Supplement, p.29):

- For facilities with therapists on staff, *medically-based therapy service* is reimbursed by the all-inclusive rate from the Senior and Disabled Services Division;
- For facilities without therapists on staff, *medically-based therapy service* is provided by outside contractors who then bill third party payors directly.

**F. Provision of Service:** The primary care physician coordinates *medically-based therapy services*. Therapists and consulting physicians collaborate with the primary care physician to determine the need for clinical re-evaluation of the child's development and functional neuro-musculo-skeletal status. Frequency of re-evaluation and composition of an interdisciplinary team should reflect the anticipated needs of the child. Recommendations for re-evaluation should specify purpose, e.g., anticipation of emerging *periodic life issues*. At any time families also might request re-evaluation based on their interim concerns.

*Children with special health needs* typically have multiple, complex, and sometimes subtle issues, all of which may preclude optimal functioning. Medically-based interdisciplinary developmental teams have expertise in anticipating and evaluating these issues over the lifespan, and are available to assist the primary care physician in managing such challenging children. Treating therapists might appropriately request that the primary care physician refer a child to a tertiary center for consultation regarding challenging diagnostic or treatment issues.

**Medically-based therapy services** will be periodic and episodic to address specific functional problems related to emerging issues of health, growth, development, environment, and family context. Frequency and duration of treatment typically diminishes with age but new issues may emerge over the lifespan. Treatment is appropriate when it has potential to improve the child's functional level within 4 to 6 months. Treatment also may be appropriate in a child with a progressive disorder when it has potential to prevent the loss of a functional skill, or enhance the adaptation to such functional loss. Treatment will be:

- reviewed formally by the treating therapist six months after initial diagnosis, and every four months thereafter if the child continues to meet the eligibility criteria for treatment.
- continued for a child who is not in a *steady state of sensorimotor functioning* and when there are attainable functional goals as identified in the *periodic life issues*;
- discontinued when the goals for that treatment have been attained or when a *steady state of sensorimotor functioning* has yielded no measurable functional progress. Treatment is not appropriate when the child is in a *steady state of sensorimotor functioning*, though re-evaluation may be needed to monitor NMS concerns, to monitor *home programs*, to facilitate transition to *other community resources*, and to assure families that the *steady state of sensorimotor functioning* is not deteriorating.

**Durable medical equipment** includes (but is not limited to) wheelchairs, orthotics, prosthetics, communication boards, environmental control units, and assistive devices. PTs and OTs provide primary care physicians with assessment of need for, and prescriptive description of, medically necessary equipment. Equipment vendors should have expertise in serving *children with special health needs*. The vendor is responsible to supply the equipment or device as prescribed. The therapist should provide evaluation at the time of delivery to ensure that the equipment or device meets the needs of the child and that there is appropriate training in its use and maintenance.

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#### IV. ENDORSEMENTS AND STATEMENTS OF SUPPORT

The Oregon Pediatric Society has reviewed and endorsed these guidelines.

We are seeking review and statements of support from other professional groups and agencies in Oregon who are responsible for the oversight or provision of therapy services for children with special health needs.

#### V. AUTHORSHIP

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# Appendices

## **APPENDIX A:** Vignettes of Applied Use of the Guideline Tables

1. Child with spastic diplegia cerebral palsy with moderate sensorimotor dysfunction
2. Child with Down Syndrome, with moderate hypotonia and associated weakness
3. Child with osteogenesis imperfecta
4. Child with moderate developmental dyspraxia

## **APPENDIX B:** Therapy Evaluations and Assessment Strategies

1. Therapy Evaluation for *Children with Special Health Needs*
2. Pediatric PT and OT Assessment Strategies
3. Discipline specific PT and OT Issues

## **APPENDIX C:** Oregon Licensure for PT and OT

**APPENDIX A: Vignettes of applied use of the guidelines**

(Italicized words are defined in the explanatory text, pp. 6 - 8)

**1. Child with spastic diplegia cerebral palsy with moderate sensorimotor dysfunction**

A child with moderate sensorimotor dysfunction resulting from spastic diplegia will have high intensity therapy needs that recur throughout childhood. The table represents how such a child might receive service using the guidelines. In this example therapy is depicted as starting at the time of diagnosis (at ten months of age) and proceeds intermittently through fourteen years of age. There are times when both PT and OT are being provided. Likewise there are times when neither is provided. During the *periodic steady states of sensorimotor functioning* interval re-evaluation is highly recommended.

Please note that this depiction is only an illustrative example. Some children with spastic diplegia will need more therapy than is depicted here; and some might require less.

In this example the child receives a total of two hundred (200) sessions of **physical therapy** over fourteen years. This yields an average of slightly more than 14 physical therapy sessions per year.

Summary of physical therapy episodes and *periodic steady states of sensorimotor functioning*:

Periods of High-Intensity PT	Number of Treatment Sessions	Number of Treatment Sessions Annually
Initial Diagnostic and Early Mobility Periods (10 months to 24 months)	112	96
Pre- and post-Medical Intervention (42 months to 54 months)	52	26
Pre-and post-Surgical Intervention (6 years 6 months to 7 years)	32	32
Mobility (14 years to 14 years 1 month)	4	4
	<b>Subtotal:</b>	<b>Annual Average:</b>
	<b>200</b>	<b>14</b>
<b>Periods of Steady State of Sensorimotor Functioning</b>		
28 months to 42 months	None	0
54 months to 6 years 6 months	None	0
7 years to 14 years	None	0
Beyond 14 years 1 month	None	0
	<b>Subtotal:</b>	<b>Annual Average:</b>
	<b>0</b>	<b>0</b>
	<b>Total Number of Sessions:</b>	<b>Total Annual Average:</b>
	<b>200</b>	<b>14</b>

In this example the child also receives a total of one hundred and forty-two (142) **occupational therapy** sessions over the fourteen years. Because intervention began at age two this yields an average of 12 occupational therapy sessions per year.

Summary of occupational therapy episodes and *periodic steady states of sensorimotor functioning*:

<b>Periods of High-Intensity OT</b>	<b>Number of Treatment Sessions</b>	<b>Number of Treatment Sessions Annually</b>
Early Childhood Manipulation (24 months to 32 months)	32	32
Activities of Daily Living (42 months to 44 months)	6	6
Manipulation (48 months to 60 months)	48	48
Assistive Technology and Manipulation (5 years, 6 months to 6 years, 6 months)	48	24
Activities of Daily Living (6 years 10 months to seven years)	4	28
Activities of Daily Living (14 years to 14 years 1 month)	4	4
	<b>Subtotal:</b> 142	<b>Annual Average:</b> 12
<b>Periods of Steady State of Sensorimotor Functioning</b>		
32 months to 42 months	None	0
44 months to 48 months	None	0
5 years to 5 years, 6 months	None	0
6 years 6 months to 6 years, 10 months	None	0
7 years to 14 years	None	0
Beyond 14 years, 1 month	None	0
	<b>Subtotal:</b> 0	<b>Annual Average:</b> 0
	<b>Total Number of Sessions:</b> 142	<b>Total Annual Average:</b> 12

**I. Vignette of applied use of the guidelines for a child with spastic diplegia cerebral palsy who has:**

- ▶ moderate sensorimotor involvement in the lower extremities
- ▶ mild sensorimotor involvement of the upper extremities
- ▶ visual perceptual dysfunction
- ▶ diminishing mobility and increasing weight gain at adolescence

**Medically-based Physical Therapy treatment vignette for child with spastic diplegia cerebral palsy immediately following diagnosis**

Emerging Life Issue	Examples of Functional Need	Format	Frequency	Progress Review Date
<b>Immediate Post-Diagnostic Period</b>	Ten month old; unable to sit or crawl; diminished and abnormal movement in lower extremities	Direct treatment; Home program emphasis; Referral to EI and other community resources	Twice weekly	Six months

**Medically-based Physical Therapy treatment vignettes for child with spastic diplegia cerebral palsy following the diagnostic period**

Periodic Life Issue	Examples of Functional Need	Format	Frequency	Progress Review Date
<b>Mobility</b>	Sixteen months; pulling to stand	Direct treatment; Home program emphasis; Community-based activities	Twice weekly	Four months
<b>Mobility</b>	Twenty months; beginning to walk; orthotic management	Direct treatment; Home program emphasis; Community-based activities	Weekly	Four months
<b>Mobility</b>	Twenty-four months; progress review documents good progress and potential for further gain	Direct treatment; Home program emphasis; Community-based activities	Weekly	Four months
<b>Periodic Steady State</b>	Twenty-eight months; walking safely with orthotics in all environments	Home program updated; Initiate community recreational swimming program	No direct treatment	Re-evaluate in six months at PCP request
<b>Periodic Steady State</b>	Thirty-four months; re-evaluation reveals continuation of steady state	Home program updated; Community-based activities	No direct treatment	Re-evaluate in one year at PCP request
<b>Growth</b>	Forty-two months; tightening of tendo-Achilles discerned by parents and PCP	Direct treatment; Home program emphasis; Community-based activities	Weekly	Four months

Medically-based Physical Therapy treatment vignettes for child with spastic diplegia cerebral palsy following the diagnostic period (continued)

Periodic Life Issue	Examples of Functional Need	Format	Frequency	Progress Review Date
<b>Pre or Post-Medical/Surgical</b>	Forty-six months; progression of tendo-Achilles tightening despite direct PT; Administration of BOTOX®	Direct treatment; Home program emphasis; Community-based activities	Twice weekly	Four months
<b>Growth</b>	Fifty months; abiding tightness of tendo-Achilles responding to direct PT after the BOTOX®	Evaluation/consultation; Home program emphasis; Community-based activities	Monthly	Four months
<b>Periodic Steady State</b>	Fifty-four months; restoration of ankle flexibility and pre-existing gait with orthotics	No direct treatment; Home program updated; Community-based activities	No direct treatment	Re-evaluate in six months at PCP request
<b>Periodic Steady State</b>	Re-evaluations at five years and six years reveal continuation of steady state	No direct treatment; Home program updated; Transition to school based service; Community recreational soccer program	No direct treatment	Re-evaluate annually at PCP request
<b>Growth</b>	Six years, eight months; tightening of tendo-Achilles discerned by parents and PCP	Direct treatment; Home program emphasis; Community-based activities	Weekly	Four months
<b>Pre or Post-Medical/Surgical</b>	Seven years; progression of tendo-Achilles tightening despite direct PT; Orthopedic surgery performed; Orthotic management	Direct treatment (following cast removal); Home program emphasis; Community-based activities	Weekly	Four months
<b>Periodic Steady State</b>	Re-evaluations at seven years, four months and annually thereafter reveal continuation of steady state	No direct treatment; Home program updated; Community-based activities	No direct treatment	Re-evaluate annually at PCP request
<b>Obesity</b>	Twelve-and-a-half years of age; increasing weight gain and diminishing mobility exemplified by inability to participate in recreational soccer	No direct treatment; Evaluation/consultation; Home program updated; Collaboration with Nutritionist; Return to swimming or other community activity, e.g., bicycling	No direct treatment	Re-evaluate in six months at PCP request
<b>Mobility</b>	Fourteen years of age; diminishing strength-to-weight ratio compromising community mobility	Evaluation/consultation re: need and prescriptive description of manual wheelchair, assessment of wheelchair when delivered, and training in use	Weekly for 4 weeks	Re-evaluate annually at PCP request

**Medically-based Occupational Therapy treatment vignettes for child with spastic diplegia cerebral palsy following the diagnostic period**

<b>Periodic Life Issue</b>	<b>Examples of Functional Need</b>	<b>Format</b>	<b>Frequency</b>	<b>Progress Review Date</b>
<b>Manipulation</b>	Twenty-four month old; difficulty using hands for play	Direct treatment; Home program emphasis; Community-based activities	Weekly	Four months
<b>Manipulation</b>	Twenty-eight months; progress review documents gains in fine motor play (manipulation of toys and simple puzzles)	Direct treatment; Home program emphasis; Community-based activities	Weekly	Four months
<b>Periodic Steady State</b>	Thirty-two months; progress review reveals stable NMS status of upper extremities; consolidation of skills but no further gains with toy manipulations	No direct treatment; Home program updated; Community-based activities	No direct treatment	Re-evaluate in six months at PCP request
<b>Periodic Steady State</b>	Thirty-eight months; re-evaluation reveals continuation of steady state.	No direct treatment; Home program updated; Community-based activities	No direct treatment	Re-evaluate in one year at PCP request
<b>Activities of Daily Living</b>	Forty-two months; parents noting impairments in dressing skills related to lower extremities	Evaluation/consultation; Home program emphasis; Community-based activities	Weekly for 2 weeks	Re-evaluate in six months at PCP request
<b>Manipulation</b>	Forty-eight months; re-evaluation reveals impairments in pre-handwriting graphic skills, and impairments in visual motor problem solving related to graphic skills and fine motor play	Direct treatment; Home program emphasis; Community-based activities	Weekly	Four months
<b>Manipulation</b>	Fifty-two months; progress review documents good progress in therapy related to puzzle discrimination, and coloring and drawing skills, with potential for further gain	Direct treatment; Home program emphasis; Community-based activities	Weekly	Four months
<b>Manipulation</b>	Fifty-six months; progress review documents continued good progress related to visual motor problem solving; pre-handwriting skills show good consolidation but no further gains	Direct treatment; Home program emphasis; Community-based activities	Weekly	Four months

**Medically-based Occupational Therapy treatment vignettes for child with spastic diplegia cerebral palsy following the diagnostic period (continued)**

<b>Periodic Life Issue</b>	<b>Examples of Functional Need</b>	<b>Format</b>	<b>Frequency</b>	<b>Progress Review Date</b>
<b>Periodic Steady State</b>	Five years; progress review documents good consolidation but tapering of further gains related to visual motor problem solving skills	No direct treatment; Home program updated; Community-based activities	No direct treatment	Re-evaluate in one year at PCP request
<b>Assistive Technology and Manipulation</b>	Five years, six months; difficulty with graphic skills related to impairments in fine motor and visual motor problem solving skills; sustained difficulty anticipated	Direct treatment; Computer training; Home program emphasis	Weekly	Four months
<b>Assistive Technology and Manipulation</b>	Five years, ten months; progress review documents improved graphic and computer skills	Direct treatment; Computer training; Home program emphasis	Weekly	Four months
<b>Assistive Technology and Manipulation</b>	Six years, two months; progress review documents continuing improvements in visual motor problem solving; widening developmental gap between graphic skills and performance expectations	Direct treatment; Computer training; Home program emphasis	Weekly	Four months
<b>Periodic Steady State</b>	Six years, six months; progress review reveals no further gains but consolidation of visual perceptual problem solving skills; using computer skills to augment handwriting and graphic skills	No direct treatment; Home program updated; Community-based activities	No direct treatment	Re-evaluate in one year at PCP request
<b>Activities of Daily Living</b>	Six years, ten months; difficulty with personal hygiene related to mild fine motor impairments (bathing, grooming, tooth brushing)	Evaluation/consultation; Equipment considerations for home use; Home program emphasis; Community-based activities	Twice monthly for 2 months	Re-evaluate in one year at PCP request
<b>Periodic Steady State</b>	Seven years; using adapted strategies for developmentally appropriate personal care skills	No direct treatment; Home program updated; Community-based activities	No direct treatment	Re-evaluate in one year at PCP request
<b>Personal Care</b>	Fourteen years of age; difficulty accomplishing chores and leisure skills, but with plans for eventual emancipation	Evaluation/consultation; Home program emphasis; Community-based activities	Weekly for 4 weeks	Re-evaluate annually at PCP request

## 2. Child with Down Syndrome, with moderate hypotonia and associated weakness

Most children with Down Syndrome have sensorimotor delay commensurate with delays affecting other developmental domains and do not need *medically-based therapy services*. However, such services are appropriate for those children who have disproportionate sensorimotor involvement. The child depicted in this example has moderate hypotonia and associated weakness.

At twenty-four months this child is not making progress toward pre-walking mobility. Functional levels are at twelve months in other developmental areas but only at eight months in gross motor skills (represented by independent sitting). Thus gross motor performance is only 67% of the global developmental state. Physical therapy is initiated for a four month period with goals of crawling, transitioning in and out of sitting, and pulling to stand.

After four months the child has met those goals. Emphasis on developing a *home program* allows the parents to implement activities to consolidate the gains made in *direct treatment*. A recommendation is made to initiate community-based activities, such as a toddler exercise program or mother-toddler swim program. At this time treatment is discontinued with recommendation to the PCP for PT re-evaluation in four months, to reassess the child's gross motor status.

Re-evaluation reveals that during the hiatus the child has made no progress toward supported walking with gross motor level stalling at 10 months, i.e., 63% of global developmental level of 16 months. Therefore treatment is resumed. During the next four months the child makes gross motor progress indicated by safe independent walking and transition skills into and out of standing. Emphasis on the *home program* again allows the family to consolidate the gains made in *direct treatment* in the more natural environment. *Medically-based therapy service* is discontinued at this time, with recommendation to the PCP to consider return to PT for re-evaluation in six months. At that time the PCP notes continued progress with stair creeping, climbing, squatting and arising, and decides that re-evaluation is not necessary.

## 3. Child with osteogenesis imperfecta

Children with osteogenesis imperfecta will usually have periodic needs for *direct treatment* from occupational therapy and physical therapy related to intermittent pathologic fractures, and the cumulative NMS impairment and disability.

*Direct treatment* usually addresses the sub-acute recovery from the fracture. The efficacy of treatment is usually demonstrated within the four month reporting periods of the guidelines. Frequently the goals of treatment can be reached with fewer treatment sessions and in less time than four months.

*Direct treatment* is needed also to address *periodic life issues* related to cumulative NMS impairment and related functional disability. These are likely to be discrete episodes of treatment whose efficacy similarly can be measured and documented within the four month reporting schedule.

In both treatment scenarios with the child with osteogenesis imperfecta emphases are placed on implementing a *home program* and adapting community activities to extend the benefits of *direct treatment*.

## 4. Child with moderate developmental dyspraxia

Children with developmental dyspraxia have difficulty organizing complex motor tasks, such as handwriting, dressing, self care, recreation, and sometimes speech. They have difficulties taking in and organizing sensory information, as well as organizing and executing motor skills. Within the spectrum of developmental dyspraxia there are some children who are unable to function in a developmentally appropriate or safe manner with respect to the *periodic life issues* of mobility, manipulation or activities of daily living. These children warrant *medically-based therapy services*.

For example this child is a six year old in first grade, and is having trouble forming letters, although recognition, sounding, and combinations of letters for language are at grade level. This child does not qualify for more than consultative therapy in school because of the lack of an eligible diagnosis, and the otherwise high level of school functioning. The PCP refers to medically-based OT for evaluation and possible treatment.

OT assessment reveals delays with bilateral coordination (BC) and upper limb coordination (ULC) skills

both at (-1.7) standard deviations (SD), and visual-motor (VM) performance (-2.1) SD; all are disproportionate to cognitive skills, which are normal. Medically-based OT is initiated for a six month period, with goals of achieving competence in handwritten formation of letters as well as developing keyboard mastery to augment handwriting as necessary. A home program is developed and implemented to practice and refine the handwriting and keyboarding exercises.

Re-assessment reveals progress: BC skills at (-.8) SD and ULC skills at (-1.0) SD, and VM (-1.2) SD; however, the child is still having functional difficulties forming letters. OT treatment is continued for another four months, after which re-assessment reveals: BC skills at (-.8) SD, ULC skills at (-.9) SD, and VM (-1.2) SD. However, the child can form letters adequately for basic classroom work and has sufficient keyboard skills to augment handwriting needs. The family and the OT concur in their observations that the rate of progress has slowed. This suggests the onset of a *periodic steady state of sensorimotor functioning*, and medically-based OT treatment is therefore discontinued, with recommendation to consider re-evaluation in four months.

At nine years of age, a swimming instructor notes safety concerns related to timing and coordination. The parents report that the child was motorically frustrated during a prior attempt at recreational soccer. Although motivation remains high for swimming, bicycling and rollerblading, the child has made no discernible progress toward gaining independent skill in these activities. The PCP requests therapy re-evaluation.

Standardized testing confirms delays with balancing (B) skills at (-1.9) SD, and ULC at (-1.6) SD, and BC at (-1.5) SD. The PCP then authorizes four months of therapy to improve these skills. The therapist measures significant functional progress after this period and requests an additional four months to promote generalization to age appropriate activities and settings. At the end of this second period the child is able to swim, bicycle, and rollerblade safely and independently, with age appropriate supervision. The therapist discontinues treatment and does not make a specific recommendation for re-evaluation.

## APPENDIX B Therapy Evaluations and Assessment Strategies

### 1. Therapy evaluation for *children with special health needs*

- A complete and accurate initial PT evaluation typically requires one to two sessions lasting a total of one to two hours of direct contact; OT evaluation might be longer, namely two to three hours, depending upon the issues to be addressed. Another hour is typically required for scoring, interpretation of results, and writing of report.
- Direct evaluation might be complemented or augmented by information gathered in the course of treatment, or from other sources.
- Evaluation takes into account relevant information about the child and family. Examples include: developmental status in other realms, such as cognition, language, or behavior; family issues; and related health issues, including past, concurrent, or anticipated medical or surgical interventions.
- Evaluation results in a comprehensive written assessment of the child's status, leading to recommendations that include whether therapy is indicated, i.e., whether treatment represents potential to improve the child's functional status within four to six months;
  - *if so*, the treating therapist, in conjunction with the child's family, develops goals; the guidelines provide a structure for format, frequency, and progress review date;
  - *if not*, consideration will be given for subsequent re-evaluation by PT or OT, or for referral to other community resources.

### 2. Pediatric PT and OT assessment strategies

The practices of PT and OT in pediatrics overlap. Both evaluate and treat issues related to sensorimotor functional capabilities in the developing child. The disciplines differ in emphases and specific skills. The emphases in PT are gross motor and postural control, and locomotion. The emphases in OT are upper extremity function, activities of daily living, and sensorimotor and visual-perceptual functioning. With their respective emphases, both PT and OT evaluate:

#### A. Musculoskeletal Assessment

- Range of motion: active and passive
- Alignment: trunk and limbs
- Joint integrity: joint, capsular, and ligamentous status

#### B. Neuromotor Assessment

- Muscle tone: resting muscle tone (resistance felt to passive movement in resting muscle); spectrum includes varying degrees of exaggerated, reduced, or fluctuating stiffness
- Reflex status: integration, persistence, or re-emergence of primitive reflexes; emergence of mature reflexes; deep tendon reflexes; clonus
- Postural control: timing and excursions of responses; awareness of dynamic position; functional balancing capability
- Motor control: qualitative assessment of movement: isolated control; presence of abnormal or adventitious movements, or synergistic patterns
- Strength: Manual Muscle Testing; representative functional strength testing; dynametrics;
- Coordination: timing, grading, and smoothness of movement; presence of tremulousness, dysmetria
- Endurance: cardio-pulmonary measures; functional and distance measures

#### C. Equipment Issues

- Assessment of current equipment: state of repair and fit; functional use; appropriateness to existing environmental challenges
- Assessment of need for other equipment to meet existing or emerging environmental challenges

## **D. Standardized Instruments**

**Developmental tests** might include:

- Bruininks and Oseretsky Test of Motor Proficiency (B & O)
- Alberta Infant Motor Scales (AIMS)
- Movement Assessment of Infants (MAI)
- Peabody Developmental Motor Scales (PDMS)

**Sensorimotor tests** might include:

- Developmental Test of Visual Motor Integration (VMI)
- Motor-Free Visual Perception Test (MVPT)
- Sensory Integration and Praxis Test (SIPT)
- Test of Visual Perceptual Skills (Non-Motor; TVPS)

**Functional tests** might include:

- Pediatric Evaluation of Disability Inventory (PEDI)
- WeeFIM (Adaptation for children of the functional independence measure (FIM) in adults)
- Gross Motor Functional Measure (GMFM)

## **E. Pre-vocational and Vocational Assessment**

- Sensorimotor, perceptual, or adaptive skills related to performing independent living or vocational tasks
- Environmental issues related to independent living or vocational tasks

## **3. Discipline specific PT and OT Issues**

**A. PT in particular evaluates:**

**Gait** (clinical gait analysis or gait lab analysis) This includes kinematic and kinetic analysis of gait deviations; analysis of temporal issues, e.g., cadence, speed, and smoothness of forward progression; functional capabilities and safety issues (e.g., community or household; terrain, stairs, slopes); fit, use, and appropriateness of orthotic and assistive gait devices; assessment of alternative forms of locomotion, e.g., rolling, crawling; and, assessment of need for mobility equipment.

**Trunk** This includes clinical structural assessment of the spine; and, postural control of the trunk.

**B. OT in particular evaluates:**

**Upper Extremity Function** This includes musculoskeletal and neuromotor assessment of the hand, including grasping patterns, individual and coordinated muscle control for in-hand manipulations, strength dynamometry, and general motor control of the hands; and, functional assessment of hand use, including handwriting, self-care activities, and activities related to school, work, or independent living.

**Sensorimotor Functioning** This includes functional assessment of somatosensory systems (tactile, proprioceptive/kinesthetic, and vestibular, as well as processing of visual, auditory, and olfactory information); visual-perceptual skills; and, perceptual-motor skills.

## APPENDIX C: Oregon Licensure Regulations

1. **Physical therapy** is professional service provided by a Physical Therapist with a current license, issued by the Oregon State Licensing Board, to practice in the State of Oregon. Physical Therapy Licensing Board ORS 688.010 to 688.235 and Standards of Practice for Physical Therapy as well as the Standards of Ethical Conduct for the Physical Therapist Assistant established by the American Physical Therapy Association will govern the practice of physical therapy.

**"Licensed physical therapist"** means a professional physical therapist licensed as provided in ORS 688.010 to 688.220.

**"Physical therapist assistant"** means a person who assists a licensed physical therapist in the administration of physical therapy.

**"Physical therapy"** means the evaluation, treatment and instruction of a human being to assess, prevent, correct, alleviate and limit the signs and symptoms of physical disability, bodily malfunction and pain. . . .

**"Physical therapy"** includes:

A. The performance of tests and measurements as an aid to evaluation of function and the administration, evaluation and modification of treatment and instruction, including the use of physical measures, activities and devices, for preventive and therapeutic purposes; and

B. The provision of consultative, educational and other advisory services for the purpose of reducing the incidence and severity of physical disability, bodily malfunction, and pain.

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2. **Occupational therapy** is professional service provided by an Occupational Therapist with a current license, issued by the Oregon State Licensing Board, to practice in the State of Oregon. Occupational Therapy Licensing Board ORS 675.210 to 675.340 and the Uniform Terminology for Occupational Therapy established by the American Occupational Therapy Association, Inc. will govern the practice of occupational therapy.

**"Occupational therapist"** means a person licensed to practice occupational therapy under ORS 675.210 to 675.340.

**"Occupational therapist assistant"** means a person licensed to assist in the practice of occupational therapy under the supervision of, or with the consultation of, an occupational therapist

**"Occupational therapy"** means the analysis and use of purposeful activity with individuals who are limited by physical injury or illness, developmental or learning disabilities, psychosocial dysfunction or the aging process in order to maximize independence, prevent disability and maintain health. The practice of occupational therapy encompasses evaluation, treatment and consultation. Specific occupational therapy services includes but is not limited to: Activities of daily living (ADL); perceptual motor and sensory integrated activities; development of work and leisure skills; the design, fabrication or application of selected orthotics or prosthetic devices; the use of specifically designed crafts; guidance in the selection and use of adaptive equipment; exercises to enhance functional performance; prevocational evaluation and training; performing and interpreting manual muscle and range of motion tests; and appraisal and adaptation of environments for people with mental and physical disabilities. The services are provided individually, in groups, or through social systems.

# **Supplement: Oregon's Administrative Rules (OARs): Excerpts Related to Therapy Services for Children**

## **1. Educational Definitions**

**581-15-900** Early Intervention and Early Childhood Special Education

**581-15-005** Special Education Definitions

## **2. Educational Eligibility**

**581-15-946** Evaluation and Minimum Criteria for Early Intervention

**581-15-942** Evaluation and Minimum Criteria for Early Childhood Special Education

**581-15-051** Evaluation and Minimum Criteria for Special Education Students

## **3. Pediatric Nursing Facilities**

**411-70-452** Pediatric Nursing Facilities

**411-70-085** Services covered by nursing facilities "all-inclusive rate" (Medicaid)

**411-70-359** Allowable Costs

**411-86-060** Comprehensive Assessment and Care Plan

## 1. EDUCATIONAL DEFINITIONS

### **Early Intervention and Early Childhood Special Education (Excerpted from OAR 581-15-900):**

(25) **“Related Services”** includes transportation and such developmental, corrective, and other supportive services (including speech pathology and audiology, psychological services, physical and occupational therapy, special equipment, reader service, volunteer service to enhance special educational programs, recreation, counseling services, including rehabilitation counseling services, social work services in schools, parent counseling and training, school health services and medical services) as are required to assist a child with a disability to benefit from special education, and includes early identification and assessment of disabling conditions in children. Medical services shall be for diagnostic and evaluation purposes only. (Underlining added - Ed.)

(8) **“Early Intervention Services”** means services for preschool children with disabilities from birth until three years of age that are:

- (a) Designed to meet the developmental needs of children with disabilities and the needs of the family related to enhancing the child’s development;
- (b) Selected in collaboration with the parents;
- (c) Provided:
  - (A) Under public supervision,
  - (B) By personnel qualified in accordance with criteria established by rules of the State Board of Education, and
  - (C) In conformity with an individualized family service plan,
- (d) At no cost to parents; and
- (e) Meet all applicable state requirements.

(5) **“Early Childhood Special Education”** means free, specially designed instruction to meet the unique needs of a preschool child with a disability, three years of age until the age of eligibility for kindergarten, where instruction is provided in any of the following settings: home, hospitals, institutions, special schools, classrooms, and community child care or preschool settings, or both.

.....  
**Special Education (Excerpted from OAR 581-15-005):**

(20) **“Related Services”** includes transportation and such developmental, corrective, and other supportive services (including speech pathology and audiology, psychological services, physical and occupational therapy, special equipment, reader service, volunteer service to enhance special educational programs, recreation, counseling services, including rehabilitation counseling services, social work services in schools, parent counseling and training, school health services and medical services) as are required to assist a child with a disability to benefit from special education, and includes early identification and assessment of disabling conditions in children. Medical services shall be for diagnostic and evaluation purposes only. (Underlining added - Ed.)

(5) **“Children with Disabilities”** means children who require special education because of mental, physical, emotional or learning problems including . . . orthopedic or other health impairments . . .

- (g) **“Orthopedic Impairment”** means a motor disability caused by an anomaly, disease

or impairment by other conditions (e.g., cerebral palsy, spina bifida, muscular dystrophy or traumatic injury) where the child requires specialized and integrated services in order to benefit from an educational program.

(h) **“Other Health Impairment”** means limited strength, vitality, or alertness, due to chronic or acute health problems such as a heart condition, tuberculosis, rheumatic fever, nephritis, asthma, sickle cell anemia, hemophilia, epilepsy, lead poisoning, leukemia, or diabetes, which adversely affect a child’s educational performance.

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## 2. EDUCATIONAL ELIGIBILITY

### Evaluation of and Minimum Criteria for Early Intervention (Excerpted from OAR 581-15-946):

- (3) For a child from birth through two years of age suspected of being eligible for early intervention, the child shall meet the following minimum criteria:
    - (a) The child has a diagnosed physical or mental condition that has a high probability of resulting in developmental delay, as documented by a physician licensed by a State board of Medical Examiners; or,
    - (b) The child experiences a developmental delay of two standard deviations or more below the mean in one or more of the following developmental areas, or 1.5 standard deviations below the mean in two or more of the developmental areas:
      - (A) Cognitive development
      - (B) Physical development
      - (C) Communication development
      - (D) Social or emotional development
      - (E) Adaptive development
  - (4) Children found eligible under subsection (3)(a) or (b) of this rule shall be eligible for regional services if they also meet criteria under OAR 581-15-051 for . . . severe orthopedic impairment. (See below).
  - (5) For a child to be eligible for early intervention services, the child’s multidisciplinary team shall determine that:
    - (a) The child’s disability, as documented by a physician, has a high probability of resulting in a developmental delay described in section (3)(a) of this rule; or
    - (b) The child needs early intervention services as a result of the delay described in section (3)(b) of this rule.
- .....

### Evaluation and Minimum Criteria for Early Childhood Special Education (Excerpted from OAR 581-15-942):

- (3) For a child suspected of being eligible for early childhood special education, the child shall meet the following minimum criteria:
  - (a) The child meets the criteria for one of the disability categories in OAR 581-15-051 (see below); or

- (b) The child experiences a developmental delay of 1.5 standard deviation or more below the mean in two or more of the developmental areas listed in OAR 581-15-946(3)(a)(A)-(E) (see description, above).
- (4) For a child to be eligible for early childhood special education, the child's multidisciplinary team shall determine that:
  - (a) The child's disability has an adverse impact on the child's development; and
  - (b) The child needs special education services as a result of the disability.

**Evaluation of and Minimum Criteria for Special Education Students (Excerpted from OAR 581-15-051):**

**9. Orthopedic Impairment**

- (a) If a child is suspected of having an orthopedic impairment, the following evaluation shall be conducted:
  - (A) A medical statement or a health assessment statement indicating a diagnosis of an orthopedic or neuromotor impairment or a description of the motor impairment;
  - (B) A standardized motor assessment, including the areas of fine motor, gross motor and self-help, when appropriate, by a specialist knowledgeable about orthopedic or neuromotor development;
  - (C) Assessments to help determine the impact of the suspected disability:
    - (i) On the child's educational performance when the child is at the age of eligibility for kindergarten through age 21, or
    - (ii) On the child's development progress when the child is age three through the age of eligibility for kindergarten; and
  - (D) Additional evaluations or assessments that are necessary to identify the child's educational needs.
- (b) For a child suspected of having an orthopedic impairment, the child shall meet all of the following minimum criteria:
  - (A) The child has a motor impairment which results in deficits in the quality, speed, or accuracy of movement. These deficits must be accompanied by a score of two or more standard deviations below the mean in one or more of the three motor areas set forth in section (9)(a)(B) of this rule, or functional deficits in at least two of the three motor areas; and
  - (B) The child's condition is permanent or is expected to last more than 60 calendar days.
- (c) For a child to be eligible for special education services as a student with an orthopedic impairment, the child's multidisciplinary team shall determine that:
  - (A) The child's disability has an adverse impact:
    - (i) On the child's education performance when the child is at the age of eligibility for kindergarten through age 21, or
    - (ii) On the child's developmental progress when the child is age three through the age of eligibility for kindergarten; and
  - (B) The child needs special education as a result of the disability.

**(10) Other Health Impairment**

- (a) If a child is suspected of having an other health impairment, the following evaluation shall be conducted:
  - (A) A medical statement or a health assessment, indicating a diagnosis of a health impairment or a description of the impairment, and a statement that the child's condition is permanent or is expected to last more than 60 calendar days;
  - (B) Assessments to determine the impact of the suspected disability:
    - (i) on the child's educational performance when the child is at the age of eligibility for kindergarten through age 21; or
    - (i) on the child's developmental progress when the child is age three through the age of eligibility for kindergarten; and
  - (C) Additional evaluations or assessments that are necessary to identify the child's educational needs.
- (b) For a child suspected of having an other health impairment, the child shall meet all of the minimum criteria:
  - (A) The child's condition shall be permanent or expected to last more than 60 calendar days; and
  - (B) The child's condition adversely affects the child's educational performance.
- (c) For a child to be eligible for special education as a child with an other health impairment, the child's multidisciplinary team shall determine that:
  - (A) The child's disability has an adverse impact:
    - (i) on the child's educational performance when the child is at the age of eligibility for kindergarten through age 21; or
    - (i) on the child's developmental progress when the child is age three through the age of eligibility for kindergarten; and
  - (B) The child needs special education services as a result of the disability.

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**3. PEDIATRIC NURSING FACILITIES**

**Pediatric Nursing Facilities (Excerpted from OAR 411-70-452):**

- (1) Pediatric Nursing Facility
    - (a) A pediatric nursing facility is a licensed nursing facility at least 50 percent of whose residents entered the facility before the age of 14 and all of whose residents are under the age of 21;
  - (2) Licensed Nursing Facility with a Self-Contained Pediatric Unit
    - (a) A nursing facility with a self-contained pediatric unit is a licensed nursing facility that cares for pediatric residents (residents under the age of 21) in a separate and distinct unit within or attached to the facility with staffing costs separate and distinct from the rest of the nursing facility. All space within the pediatric unit must be used primarily for purposes related to the care of pediatric residents and alternate uses must not interfere with the primary uses.
- .....

**All-Inclusive Rate (Excerpted from OAR 411-70-085):**

2. Services and Supplies

(a) The following services and supplies required to provide care in accordance with each resident's care plan are included in the all-inclusive rate, except as modified by OAR 411-70-359(3):

(N) If allowed under OAR 411-70-359, therapy services provided by on-staff therapists

(b) The following services and supplies are NOT included in the all-inclusive rate:

(A) Therapy services provided to residents by outside providers;

.....

**Allowable Costs (Excerpted from OAR 411-70-359):**

3. Third Party Payors. The purpose of this section is to assure that facilities are not paid twice, once through the Medicaid all-inclusive rate and again through a third party payor, for providing a service. This section includes both allowed and non-allowed costs.

(h) The cost of services incurred for therapy services performed by non-employee therapists are reimbursable through a third party payor or the Office of Medical Assistance Programs (OAR 411-70-355) and are non-allowable on the Nursing Facility Financial Statement.

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**Comprehensive Assessment and Care Plan (Excerpted from OAR 411-86-060)**

2. Care Plan Preparation and Implementation. The facility, through the nursing services department and the interdisciplinary staff, shall provide services to attain or maintain the highest practical physical, mental and psychological well-being of each resident in accordance with a written, dated, care plan.

(b) The plan shall describe the medical, nursing, and psychosocial needs of the resident and how the facility will actively meet those needs. The description of needs shall include measurable objectives and time frames in which the objectives will be met.

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The Oregon Administrative Rules are accessible on-line. The address is: <http://arcweb.sos.state.or.us/oarsos.html>