



**Clinical Practice Guideline**  
**Therapies for Individuals with Special Health Care Needs**  
**Including:**  
**Cerebral Palsy, Traumatic Brain Injury, Myelomeningocele, Spinal Cord Injury,**  
**Neuromuscular Disease, Juvenile Rheumatoid Arthritis, Arthrogryposis, and Limb**  
**Deficiencies**

**Definition:** **Individuals with Special Health Care Needs (ISHCN):** Individuals with special health care needs that have ongoing conditions, high or complex service utilization, and low to severe functional limitations. ISHCN include Children with Special Health Care Needs under 21 years of age, who have or are at an increased risk for a chronic physical, developmental, behavioral or emotional condition, and who also require health and related services of a type or amount beyond that required by children in general. The guiding principle for this definition is that the children must be at individual risk and have a functional need. <sup>2</sup>

**Background:** The Individuals with Disabilities Education Act (IDEA) requires that schools provide certain services as outlined within the student's Individual Education Plan (IEP). This plan should identify all ancillary services necessary for the member to meet educational goals, and thus should include any needed speech, occupational, physical and behavioral therapies that allow the individual to have success in the classroom. Therapies so included are directed towards educational goals or would otherwise not be provided under the IEP. <sup>1</sup>

### **Therapies Frequently Utilized**

**Physical Therapy:** Physical therapists focus on gross motor skills and functional mobility, including positioning; sitting; transitional movement such as sitting to standing; walking with or without assistive devices (e.g., walkers, crutches) and orthoses (braces) or prostheses (artificial limbs); wheelchair propulsion; transfers between the wheelchair and other surfaces such as a desk chair, toilet, or bath; negotiation of stairs, ramps, curbs, and elevators; and problem-solving skills for accessibility of public buildings. Physical therapists often have responsibilities for procuring adaptive equipment related to ambulation, positioning, and mobility. <sup>3 4</sup>

**Occupational Therapy:** Occupational therapists focus on fine motor, visual-motor, and sensory processing skills needed for basic activities of daily living such as eating, dressing, grooming, toileting, bathing, and written communication (handwriting, keyboard skills).<sup>2</sup> Occupational therapy services may include training in school-related skills and strategies to help children compensate for specific deficits. <sup>3 4</sup>

**Speech Therapy:** Speech-language pathologists address speech, language, cognitive-communication, and swallowing skills in children with disabilities. Speech therapy is the therapy most commonly prescribed by (practitioners). <sup>3 4</sup>

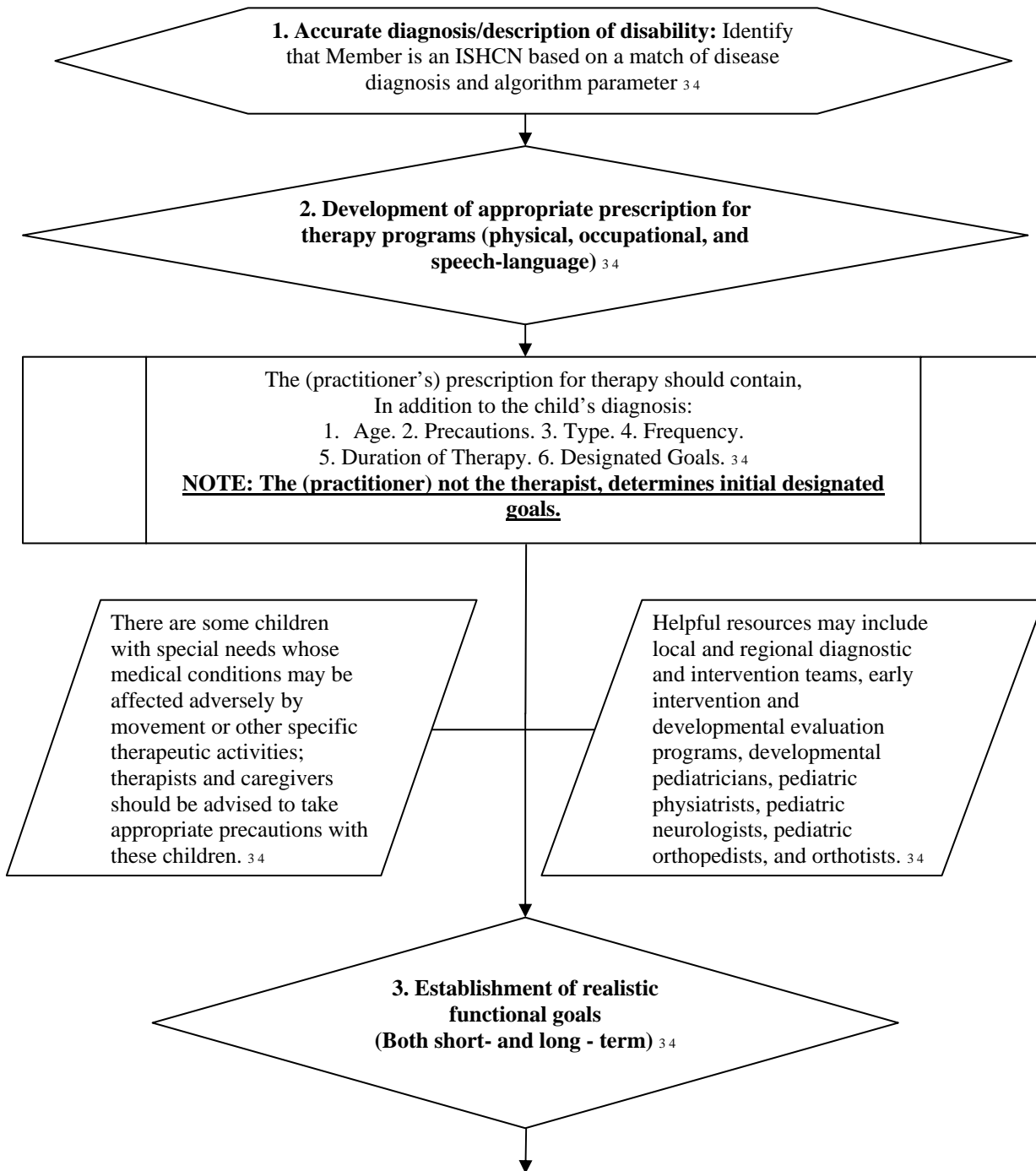
The services that can be provided by physical and occupational therapists and speech-language pathologists overlap. For example, a physical or occupational therapist can address motor delay or dysfunction in the very young child. Depending on the community, occupational therapists or speech-language pathologists may address deficits in oral motor skills associated with feeding dysfunction related to motor disability. Occupational therapists and/or speech-language pathologists provide expert consultation related to adaptive equipment, environmental modifications, and assistive technology devices such as environmental control units, augmentative communication systems, adapted computers, and adaptive toys. <sup>3 4</sup>

Adapted from Michaud LJ. Prescribing therapy services for children with motor disabilities. *Pediatrics* 2004 Jun; 113(6):1836-8. [23 references] Clinical Quality Improvement Committee (CQIC) Adopted Date: 6/05, Review/Approval Date: 4/06, 5/06, 10/07, 11/08. Quality Improvement Committee (QIC) Review Approval Date: 4/09

All CPG's are routinely reviewed at least every two years. Reviews will occur more frequently when new scientific evidence or national standards are published before the two-year review date.

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**Algorithm:  
Identification and Management of ISHCN  
Including:  
Cerebral Palsy, Traumatic Brain Injury, Myelomeningocele, Spinal Cord Injury,  
Neuromuscular Disease, Juvenile Rheumatoid Arthritis, Arthrogryposis, and Limb  
Deficiencies** <sup>3 4</sup>



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Goals for physical, occupational, and speech-language therapy do not depend solely on the diagnosis or age of the child, and they are most appropriate when they address the functional capabilities of the individual child and are relevant to the child's age-appropriate life roles (school, play, work) <sup>3 4</sup>

**4. Regular communication among parents and other caregivers, therapists, educators, and prescribing (practitioners)**

The (practitioner) should work with the family, child, therapists, school personnel, developmental diagnostic or rehabilitation team, and other (practitioners) to establish realistic functional goals. <sup>3 4</sup>

**Medical Assistance Division (MAD) 8.305.9.13 COORDINATION OF SERVICES WITH SCHOOLS:**

The MCO/SE shall implement policies and procedures regarding coordination with the public schools for members receiving medicaid services excluded from managed care, as specified by an individual education plan (IEP) or individualized family service plan (IFSP). If the member receives case management through the IEP or IFSP, the primary responsibility for the case management function remains with the school, and the MCO/SE shall assist with care coordination. Coordination between the schools and the MCO/SE shall ensure that members receive medically necessary services that complement the IEP or IFSP services and promote the highest level of function for the child. The MCO/SE shall be responsible for implementing policies and procedures for coordination of services for children returning to school after extended absences, which may be due to inpatient, residential treatment services or treatment foster care placement. <sup>1</sup>

**5. Parent and caregiver education** The (practitioner) can assist families in identifying the short- and long-term goals of treatment, establishing realistic expectations of therapy outcomes, and understanding that therapy will usually help the child adapt to the condition but not change the underlying neuromuscular problem. <sup>3 4</sup>

## Key Points

Evaluating the efficacy and effectiveness of therapy for motor disability is difficult, because treatment is not a standardized, readily quantifiable process that can be prescribed in discrete, consistent units. Individualized therapy programs vary in many parameters and incorporate subjective as well as objective elements. Clear documentation of efficacy related to the variable parameters of therapy continues to be elusive. <sup>3 4</sup>

### Evaluating the Evidence

- A recent review of the evidence to support the effectiveness of neurodevelopmental treatment for children with cerebral palsy indicates that this popular method of intervention does not confer an advantage over the alternatives with which it has been compared in altering abnormal motor responses, slowing or preventing contractures, or facilitating more normal motor development or functional motor activities, nor does more intensive neurodevelopmental treatment result in greater benefit. <sup>4</sup>
- Physical therapy alone was found in 1 well-designed study to be less effective in improving motor development after 1 year than the therapy incorporating developmentally appropriate play and learning skills for children younger than 3 years with motor impairment. <sup>4</sup>
- Improvement in motor function is more likely to occur when the goals of therapy are specific and measurable. <sup>4</sup>
- Intensive amounts of physical therapy may confer no advantage over routine amounts of therapy, and long-term therapy may confer no advantage over short-term therapy. <sup>4</sup>
- Provision of a home exercise program, with instruction of family members and caregivers in therapeutic exercises and age-appropriate activities to meet the child's goals, is generally indicated. This program can include recommendation of participation in sports to increase endurance, strength, and self-esteem in a natural setting with peers. <sup>4</sup>
- Some programs such as patterning have little effect on functional skills and are inappropriate for children with motor disabilities. <sup>4</sup>
- Scientific legitimacy has also not been established for sensory integration intervention for children with motor disabilities. <sup>4</sup>

### Service Delivery

- Therapies for a child with motor impairment are required to be provided by the school if the disability interferes with the educational process. <sup>4</sup>
- Therapy services at school for students who are eligible for Medicaid and whose disabilities are medically based can be reimbursed by Medicaid if the disability has an adverse effect on the child's ability to benefit from the educational program. <sup>4</sup>

### The Practitioners Role

Regular communication among parents and other caregivers, therapists, educators, and prescribing (practitioners) should be ongoing, with periodic reevaluations to assess the achievement of identified goals, to direct therapy toward new objectives, and to determine when therapy is no longer warranted. <sup>4</sup>

### Measurement of Efficacy of the Clinical Practice Guideline

This Clinical Practice Guideline does not have established performance measures. As noted in Key Points:

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The guidance in this Clinical Practice Guideline (CPG) does not indicate an exclusive course of treatment or serve as a standard of medical care. Variations, taking into account individual circumstances, may be appropriate.

Molina Healthcare of New Mexico is aware that the Utilization Review process for therapies for ISHCN may not reflect the complexity or chronicity of these members. To that end, exceptions to the Utilization Review process for therapies are considered on a case-by-case basis.

**References:**

- 1. Individuals with Disabilities Education Act MAD Regulation 8.305.9.13 Coordination of Services with Schools
- 2. D.E. Shalala (November 6, 2000). Report to Congress: Safeguards for Individuals with Special Health Care Needs Enrolled in Medicaid Managed Care.
- 3. National Guideline Clearinghouse at: [www.guideline.gov](http://www.guideline.gov) NGC: 003638 Prescribing therapy services for children with motor disabilities.
- 4. Michaud LJ. Prescribing therapy services for children with motor disabilities. Pediatrics 2004 Jun; 113(6):1836-8. [23 references] [PubMed](#)