

OHCA Guideline

Medical Procedure Class:	Pediatric Occupational Therapy (OT)
Initial Implementation Date:	July 2017
Last Review Date:	September 2026
Effective Date:	October 01, 2026
Next Review/Revision Date:	October 2029
* This document is not a contract, and these guidelines do not reflect or represent every conceived situation. Although all items contained in these guidelines may be met, this does not reflect or imply any responsibility of this agency or department to change the plan provision to include the stated service as an eligible benefit.	
☐ New Criteria ☒ Revision of Existing Criteria	
Summary	
Purpose:	To provide guidelines to assure medical necessity and consistency in the prior authorization process.
Definitions	
Disability: According to the World Health Organization (WHO), “disability” is an umbrella term, covering impairments, activity limitations, and participation restrictions. An impairment is a problem in body function or structure; an activity limitation is a difficulty encountered by an individual in executing a task or action; while a participation restriction is a problem experienced by an individual in involvement in life situations. Licensed Qualified Clinician: May include an Occupational Therapist or Occupational Therapist Assistant that is board certified by and in good standing with the State’s Medical Board. Students in either profession are not “licensed” clinicians. Occupational Therapist (OT): A licensed professional health care provider who is a graduate of a program accredited by the Accreditation Council for Occupational Therapy (ACOTE) or predecessor organizations, has fulfilled state requirements for licensure, certification, or registration, and who provides occupational therapy services including evaluation, treatment program design/management/modification, and supervision of delegated portions of a treatment program. Occupational Therapist Assistant (OTA): A licensed and technically educated health care provider who is a graduate of a program accredited by the ACOTE or predecessor organizations, has fulfilled state requirements for licensure, certification, or registration, and who performs selected occupational therapy procedures and related tasks under the direction and supervision of an OT. Occupational Therapy Student: Any person fulfilling supervised field work experience leading to a degree or certificate in the profession of Occupational Therapy. Students must be in good standing with an educational program in Occupational Therapy accredited by the Accreditation Council for Occupational Therapy (ACOTE) in collaboration with the National Board for Certification in Occupational Therapy (NBCOT). Any note completed by the student should entail the signature of both the student and the supervising OT. Accepted Referring Providers: A Medical Doctor (MD), Doctor of Osteopathic Medicine (DO), Physician’s Assistant (PA), Doctor of Chiropractic (DC), Doctor of Podiatry (DPM), Doctor of Dentistry	

(DDS), Advanced Practice Registered Nurse (APRN), or Certified Nurse Practitioner (CNP) who is currently contracted with Sooner Care.

Description

The Purpose of Occupational Therapy is to provide necessary services for the diagnosis and treatment of impairments that impact a person's ability to participate in activities of daily living safely and effectively at the level of his/her peers. Thus, enhancing or enabling participation in roles, habits, or routines within the medical framework.

Occupational Therapy Practitioners are knowledgeable about and deliver services in accordance with AOTA standards, policies, guidelines, and state, federal, and other regulatory payer requirements relevant to practice and service delivery.

Occupational Therapy Services are expected to result in significant functional improvement in a reasonable amount of time. The complexity of the intervention and/or patient's condition must require the skilled level of judgment and knowledge of a licensed, qualified therapist. Services must be delivered according to currently accepted standards of practice (based on credible scientific evidence and cannot be considered experimental). Occupational Therapy practitioners are knowledgeable about evidence-based practice and apply it ethically and appropriately to provide services consistent with best practice approaches.

Occupational Therapist (OT): An OT has overall responsibility for the development, documentation, and implementation of the OT intervention plan based upon the evaluation, client goals, best available evidence, and professional and clinical reasoning. When delegating aspects of the OT intervention to an OTA the OT is responsible for providing appropriate supervision.

Occupational Therapist Assistant (OTA): An occupational therapist assistant selects, implements, and makes modifications to the therapeutic interventions that are consistent with the assistant's demonstrated competency and delegated responsibilities. An occupational therapy assistant contributes to the modification of the intervention plan by exchanging information with and providing documentation to the occupational therapist about the client's response to intervention and treatment.

CPT Codes Covered Requiring Prior Authorization (PA)

97022 Whirlpool Therapy
97110 Therapeutic Exercise
97112 Neuromuscular Re-Education
97113 Aquatic Therapy
97124 Massage Therapy
97140 Manual Therapy
97150 Group Therapy
97168 OT Re-Evaluation
97530 Therapeutic Activity
97532 Development of Cognitive Skills
97533 Sensory Integrative Techniques
97535 Self-care/Home Management Training
92526 Swallowing Dysfunction and/or Oral Function for Feeding
97542 Wheelchair Management
97755 Assistive Technology Assessment
97760 Initial Orthotic Management and Training
97761 Initial Prosthetic Management and Training
97763 Subsequent Orthotic/Prosthetic Management and Training

Only those in **BOLD** are also eligible for coverage via telehealth. Appropriate modifiers should be used. See CPT Manual for full definition of codes.

Approval Criteria

I. GENERAL INFORMATION

- A. Medical Necessity must be met. The occupational therapy note submitted to request services or substantiate previously provided services must demonstrate, through adequate medical records, evidence sufficient to justify the member's need for the service in accordance with the OAC 317:30-3-1(f).
- B. Initial evaluations do not require prior authorization; However, re-evaluation requests require prior authorization, and the 97168 CPT code can be listed as a line-item on the HCA-61 prior authorization request form (see forms below). While an annual/initial evaluation can be reimbursed no earlier than one year from the date of the previously performed evaluation, a re-evaluation can be requested no earlier than six months from the date of the previous evaluation when criteria are met.
- C. Occupational Therapy services are covered with a prior authorization for the pediatric population from 0-20 years of age when medical necessity is met.
- D. Frequent changes of therapists within the same entity should be avoided as it impacts continuity of care and may negatively impact a child's ability to make progress. If the member is to receive services from more than one provider at a location, list the name of the entity as the rendering provider and the NPI of that entity on the HCA-61 therapy prior authorization request form. A change in service providers to another location (with the same entity) or a different entity should be reported via a new PA submission and inclusion of an HCA SC-16 Change of Provider Form, along with all other required documents (see below for additional information on this topic).
- E. Treatments are expected to be evidence-based and result in significant, functional improvement in a reasonable and generally predictable period of time or are necessary for the establishment of a safe and effective maintenance program.
- F. The complexity of the therapy and the patient's condition must require the judgment and knowledge of a licensed qualified OT as defined above practicing within the scope of practice for the service. Requests for services must show the skilled need of the qualified professional.
- G. Treatment goals that may be addressed in an academic setting and/or do not require skilled services of an OT do not meet medical necessity.

II. **REQUIRED DOCUMENTS (4) FOR ALL PRIOR AUTHORIZATION REQUESTS:**

- A. **First:** A signed/dated prescription requesting the specific service(s) from a contracted qualified health professional licensed as a physician or surgeon with unlimited license (MD/DO), the physician assistant of the person so licensed (PA), Doctor of Dentistry (DDS), Doctor of Chiropractic (DC), Doctor of Podiatry (DPM), Advanced Practice Registered Nurse (APRN), or Certified Nurse Practitioner (CNP) – referrals from the latter five being limited to their respective areas of training and practice.
 - 1. A referral to "evaluate and treat" is valid for 12 months from the date of signature,

unless specified otherwise with specific parameters (ex: 2x a week for 6 weeks). Request end-dates should be adjusted accordingly.

2. If parameters are specified, any subsequent prior authorization request needs to provide either a new referral, or a progress note with the referring provider's dated signature on it.
 3. The SC-10 OHCA Referral Form can always be used to meet this requirement. In this form, the 'reason for referral' section must specify the discipline/s to which the referral is being sent, along with the diagnosis.
- B. **Second:** A signed/dated parental consent form that is completed in its entirety. Submission of an HCA SC-15 Parental Consent Form is needed to meet this requirement (use Spanish version when necessary) when member is <18 years old.
1. Another version of a parental consent form can be accepted if all information from the SC-15 Form is included.
 2. Parental consent forms are valid for 12 months from the date of parent/caregiver signature. Request end-dates should be adjusted accordingly.
- C. **Third:** An entirely completed HCA-61 Therapy Prior Authorization Request form; Another version of this form must include all applicable information. This form needs to be filled in accurately in all applicable fields with line-item (CPT code) units requested equating the usable total amount for all timed sessions. For example, a request for 12 sessions to be held at 60 minutes each cannot exceed 48 units.
- D. **Fourth:** An OT **initial/annual evaluation, re-evaluation, or progress note** supporting the need for requested services.
1. Either of the above three note types provided for review must be tied to a visit and include the sections listed in the note requirements (see below) ensuring all the necessary information to make a determination.
 2. This document must be signed/dated by the supervising OT. If an OTA performs a progress note and the supervising OT signature is not presented, then a statement should be included by the OTA confirming that the visit was supervised by an OT and include the OT's name, credentials, and license number.
 3. Reports must be legible, and performed within 30 days of the anticipated prior authorization request start date. Timely PA submission should be prioritized for appropriate continuity of care.
 4. If 30 days are exceeded between the OT visit performed and the anticipated prior authorization request start date, then another up-to-date progress note will be required.
 5. Per the AOTA Guidelines for Documentation in Occupational Therapy and the Code of Ethics, timely reassessment following the start of care is a necessary component of ongoing care. The benefits of using the timeline above for documentation provision include: effective tracking of goals achieved, recognizing changes secondary to gaps in service, establishing support for demonstrating medical necessity, and accounting for care handoff when necessary.
 6. To ensure legibility, hand-written OT notes should be limited.

III. **NOTE REQUIREMENTS FOR ALL REQUESTS FOR OCCUPATIONAL THERAPY:**

- A. Subjective section for an evaluation or re-evaluation should be detailed and include:
1. Member/caregiver self-reported history of current presentation.
 2. Member/caregiver reason for seeking services (evaluation) or perceived benefit with services to date (if re-evaluation).
 3. A narrative of the member and/or caregiver priorities or desired outcomes.

4. If providing a progress note: above is not necessary; however, current subjective measures should be elaborated for relevant goals within the goals section.
 5. Regardless of note type, mention of additional services the member is currently receiving should be included in this section, including school services and/or early Intervention.
- B. Objective section for an evaluation or re-evaluation should have a detailed report of tools, tests, or measures administered (when applicable) to include:
1. Description of the tool, test or measure used.
 2. Reason for choosing the tool, test, or measure.
 3. Detail of the degree of delay and/or variation from “norms” if applicable.
 4. A detailed narrative of the measure of change over time.
 5. Interpretation and results of the testing.
 6. If providing a progress note: above is not necessary; however, current objective measures should be elaborated for relevant goals within the goals section.
- C. Goals section should list functional and measurable goals tied to subjective and objective measurements using the following format:
1. Name the member and the activity they will complete.
 2. Specify the exact timeframe in which you expect the activity to be completed (can be applicable for all goals).
 3. Describe the conditions under which the activity is expected to be completed.
 4. Provide the clinical rationale for the goal (can be applicable for all goals).
 5. Predict the prognosis, provide comments describing current level of progress, and state if the goal is baseline/abandoned/modified/continued.
 6. Example STG (Initial visit): Member will engage in activities wearing seasonally appropriate clothing with min assist for 10 minutes during 4 repetitive sessions within 3 months suggesting improved neurosensory processing and increased time-to-occurrence of aggressive behaviors in the home and community settings. (*Current Progress: baseline, engages 5 min with mod assist before onset of aggressive behavior; Prognosis: excellent*)
 7. Example LTG (Initial Visit): Member will dress self for school using assistive equipment PRN within 15 min with min assist from caregiver during 5 repetitive sessions within 12 months suggesting increased neurosensory processing, sequencing, and attention to task for performance of routine ADL tasks with decreased caregiver reliance. (*Current Progress: baseline, requires 20 min with mod to max assist; Prognosis: excellent*)
 8. Example STG for Progress Note, Re-Evaluation, or Annual Evaluation (during a continuation request): Member will engage in activities wearing seasonally appropriate clothing with min assist for 10 minutes during 4 repetitive sessions within 3 months suggesting improved neurosensory processing and increased time-to-occurrence of aggressive behaviors in the home and community settings. (*Current Progress: continue, engages up to 8 min with min assist during 4 repetitive sessions before onset of aggressive behavior eliciting continued need for sensory integrative techniques; Prognosis: excellent with continued coverage over the next auth period*)
 9. Example LTG for Progress Note, Re-Evaluation, or Annual Evaluation (during a continuation request): Member will dress self for school using assistive equipment PRN within 15 min with min assist from caregiver during 5 repetitive sessions within 12 months suggesting increased neurosensory processing, sequencing, and attention to task for performance of routine ADL tasks with decreased caregiver reliance. (*Current Progress: continue, still requires 20 min but is now at min assist for 3 repetitive sessions suggesting continued need to facilitate performance of this activity with progressive decrease in assist; Prognosis: excellent with continued coverage over the next auth*)

period)

D. Assessment section should include:

1. Continuation requests need to elaborate the member's ability to tolerate treatment to date and reasons if an intervention was unsuccessful i.e., unable to train family/caregiver.
2. Continuation requests should also include a statement regarding any new skills if they were developed within the previous authorization period.
3. All requests should entail a summary of the member's current status regarding their presentation, associated activity limitations and participation restrictions, and therapist's clinical commentary on member's progress and/or potential for continued progress with services (confirming medical necessity).

E. Plan section for any note type should include:

1. Specific frequency and duration of the visits requested and the anticipated timeline for which services will be rendered (matching the total visits, timeline, and units requested on the HCA-61 form).
2. Efforts to include the member and/or family/caregiver in the management and carry-over of the intervention into the home setting.
3. A titration plan for services towards eventual discharge.

IV. REQUIRED DOCUMENTS FOR CONTINUATION REQUESTS:

A. A **progress note, re-evaluation, or annual evaluation** performed within 30 days of the anticipated prior authorization request start date including all necessary note sections (see L to P) **AND**

- The goals section must include a narrative on the current level of progress for continued goals, and newly added baseline measurements should be included if new goals are added.

B. A fully completed **HCA SC-15 parental consent form** **AND**

C. A fully completed **HCA-61 Therapy Prior Authorization Request form** **AND**

- To avoid any overlap in requests, there needs to be at least 24 hours between the previous authorization's end date and the requested new authorization's start date.

D. A fully completed **prescription for services** or an HCA SC-10 referral form **AND**

- A dated signature of the referring provider on the OT progress or re-evaluation note that is being submitted within the year of the evaluation is acceptable. If an initial/annual evaluation is submitted, a new prescription will always be necessary along with it.

E. A fully completed HCA SC-16 change of provider form **if**: services are going to be provided by a new entity or a different location of the same entity (Provider ID change). It is the previous location's responsibility to perform a progress note meeting criteria when informed by member/caregiver about desire/need to change provider. It is the previous location's responsibility to share this progress note and related prescription for services with the new location of service. Failure to perform this task can be a detriment to a member's continuity of care.

- When a change of provider form is being submitted by the new location, the new therapist of record can submit the progress note being received from the previous location if the clinic aims to continue treatment with focus on the established goals.

All other required forms must be submitted along with this progress note.

- If the provided progress note visit is dated greater than 30 days from the new location's anticipated start date or if the previous location did not send a progress note, a new progress note visit will need to be performed at the new location.
 - The new clinic can perform an initial evaluation and submit a PA with provision of all required paperwork; however, it is important to note that evaluations are reimbursed once per member per year.

F. For additional information on required documentation on a per PA scenario basis, review the January 2026 provider newsletter's Therapy FAQ.

G. The following applies for submission of an **amendment** to an active PA with an HCA-60 Prior Authorization Amendment Form:

1. If removing servicing provider – The presence of a service provider ID often results in issues with filing claims and removal should be prioritized. An amendment submission with an HCA-60 form is required for this. Note that this is different from a change of provider, where the entity or location of service is being changed.
2. If there is a provider number change – The information listed in U should be followed for a true change of provider situation. In rare cases, such as a clinic buyout, when the location remains the same, but the Provider ID is set to change, an amendment with the HCA-60 form can be submitted with this box checked.
3. If there is a member RID number change – An HCA-60 form amendment submission will be necessary.
4. If requesting a date change – To extend the end date, the request should be submitted within the active authorization period with the HCA-60 form along with an evaluation/progress note/re-evaluation performed within the past 30 days. Service start date will only be backdated when TEFRA or Transfer-Back PA requirements are met. It is important to note the signed date on the parental consent form and the signed date on the referral form when extending the end date or backdating the start date.
5. If requesting a unit change – The addition of units or the subtraction and transfer of units from one CPT code to another should occur within the active authorization period with the HCA-60 form along with an evaluation/progress note/re-evaluation performed within the past 30 days.
6. If requesting a code change – If a change of a CPT code is needed, this should occur within the active authorization period with the HCA-60 form along with an evaluation/progress note/re-evaluation performed within the past 30 days. Additionally, this code change amendment is only possible when there are no existing claims for the original CPT code, if claims exist, see additional line-item request below.
7. If requesting a change in modifier – 'GO' is the primary modifier used for approval of any of the applicable OT CPT codes listed in this guideline. An 'SC' modifier can be added as a secondary modifier on the PA request in urgent situations involving initial post-operative surgeries (no greater than three months from date of initial surgical procedure) or acute injuries (no greater than two weeks from initial injury date). The 'GT' modifier should be listed as a secondary modifier on claims submitted when services are delivered via telehealth (this modifier should not be listed as a secondary modifier on PAs, only on telehealth claims).
8. If requesting an additional line-item (CPT code) – If additional line-item(s) are needed, this should occur within the active authorization period with the HCA-60 form along with an evaluation/progress note/re-evaluation performed within the past 30 days. When approved, the addition of a new line-item shall go into effect on the date of the amendment submission.

- H. The following applies to submissions for Prior Authorization requests for equipment needs:
1. If a member is being seen solely to meet equipment-related needs – An OT note is not necessary but the other three of four forms for prior authorization request are needed.
 2. If a member presents an equipment-related need mid-treatment for another issue – An amendment request using the HCA-60 Form with addition of the appropriate line-item(s) will be necessary (see above).
- I. In special circumstances, additional information may be requested to further validate a prior authorization request. Subscribe to the provider newsletter for updates related to Therapies PA request submissions.

Denial Criteria: Request is outside the guidelines and/or fails to prove medical necessity.

Approval Period: Up to 12 months depending on the signed/dated parental consent, prescription, and medical necessity.

References

1. American Occupational Therapy Association (2018). [Guidelines for Documentation of Occupational Therapy](#). *American Journal of Occupational Therapy*, 72(Suppl. 2).
2. American Occupational Therapy Association (2020). [AOTA 2020 Occupational Therapy Code of Ethics](#). *American Journal of Occupational Therapy*, 74(Suppl. 3).
3. American Occupational Therapy Association (2020). [Guidelines for supervision, roles, and responsibilities during the delivery of occupational therapy services](#). *American Journal of Occupational Therapy*, 74(Suppl.3).
4. American Occupational Therapy Association. (2019). [Enforcement Procedures for the AOTA Occupational Therapy Code of Ethics](#). *American Journal of Occupational Therapy*, 73(Suppl. 2).
5. American Occupational Therapy Association. (2021). [Standards of practice for occupational therapy](#). *American Journal of Occupational Therapy*, 75(Suppl. 3).
6. American Occupational Therapy Association. (2022). [Model Occupational Therapy practice act](#).
7. Centers for Medicare & Medicaid Services. [Billing and Coding: Outpatient Physical and Occupational Therapy Services](#). (Updated 2023).
8. [OCCUPATIONAL THERAPY PRACTICE ACT](#) Title 59 O.S., Sections 888.1 - 888.16 (Amended 2019)
9. OKLAHOMA ADMINISTRATIVE CODE TITLE 435. [STATE BOARD OF MEDICAL LICENSURE AND SUPERVISION CHAPTER 30. OCCUPATIONAL THERAPISTS AND ASSISTANTS](#) (Updated 2020).
10. Oklahoma Health Care Authority; Policies & Rules, [OAC 317](#): 30-3-1; 317:30-3-65.5; 317:30-5, Part 17.