

1 **Clinical Practice Guideline: Sensory Integrative (SI) Therapy**

2

3 **Date of Implementation: April 19, 2012**

4

5 **Product: Specialty**

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7

8 **GUIDELINES**

9 **Medically Necessary**

10 Ayres Sensory Integration Therapy® is considered medically necessary for treatment of
11 individuals with autism spectrum disorder when **ALL of the following** have been met:

12

- 13 • The individual’s condition has the potential to improve or is improving in response
14 to therapy, maximum improvement is yet to be attained; and there is an expectation
15 that the anticipated improvement is attainable in a reasonable and generally
16 predictable period of time.
- 17 • The program is individualized, and there is documentation outlining quantifiable,
18 attainable treatment goals.
 - 19 ○ Progress toward short- and long-term goals is documented to support
20 continuation of treatment and goals are not yet met.
 - 21 ○ Improvement is evidenced by successive objective measurements.
 - 22 ○ Generalization and carryover of targeted skills into natural environment is
23 occurring.
- 24 • Individual is actively participating in treatment sessions.
- 25 • The services are delivered by a qualified provider of therapy services (i.e.,
26 appropriately trained and licensed by the state to perform therapy services).
- 27 • Therapy occurs when the judgment, knowledge, and skills of a qualified provider
28 of therapy services (as defined by the scope of practice for therapists in each state)
29 are necessary to safely and effectively furnish a recognized therapy service due to
30 the complexity and sophistication of the plan of care and the medical condition of
31 the individual, with the goal of improvement of an impairment or functional
32 limitation.

33

34 Ayres Sensory Integration Therapy is considered unproven for any other indication.

35

36 All other forms of sensory integration therapy (SIT) are each considered unproven for any
37 indication.

1 As stated, under most circumstances, most forms of SI therapy are not medically necessary
 2 and would be considered unproven. SI therapy has shown some promise in particular
 3 patient populations and would be reviewed on a case-by-case basis for medical necessity.

4
 5 **ALL of the following** criteria must be met for consideration of medical necessity on a
 6 case-by-case basis:

- 7 • The patient is a child or adolescent.
- 8 • Other supported therapies have been tried without success.
- 9 • SI therapy is provided as one of the components of a comprehensive treatment plan.
- 10 • The loss of sensory systems compromises patient safety.
- 11 • Therapy must provide adaptations to allow the patient to safely interact with their
 12 environment.
- 13 • The patient’s medical records should document the practitioner’s clinical rationale
 14 for the services provided and include:
 - 15 ○ Objective assessments of the patient’s sensory integration impairments and
 16 functional limitations; and
 - 17 ○ Description of the treatment techniques used that will improve sensory
 18 processing and promote adaptive responses to environmental demands, and
 19 the patient’s response to the intervention, to support that the practitioner’s
 20 skills were required.

22 CPT® Codes and Descriptions

CPT® Code	CPT® Code Description
97533	Sensory integrative techniques to enhance sensory processing and promote adaptive responses to environmental demands, direct (one-on-one) patient contact, each 15 minutes

24 BACKGROUND AND DESCRIPTION

25 Sensory integration (SI) therapy has been proposed as a treatment of developmental
 26 disorders in patients with established dysfunction of sensory processing, e.g., children with
 27 autism, attention deficit hyperactivity disorder (ADHD), brain injuries, fetal alcohol
 28 syndrome, and neurotransmitter disease. Sensory integration therapy may be offered by
 29 occupational and physical therapists. Sensory Integrative Techniques (SIT), also known as
 30 Sensory Integrative Therapy, are performed to enhance sensory processing and promote
 31 adaptive responses to environmental demands. These techniques are performed when a
 32 deficit in processing input from one of the sensory systems (e.g., vestibular, proprioceptive,
 33 tactile, visual, or auditory) decreases an individual’s ability to make adaptive sensory,
 34 motor and behavioral responses to environmental demands. Practitioners have used SIT for

1 years for patients who demonstrate a variety of problems, including sensory defensiveness,
2 over-reactivity to environmental stimuli, attention difficulties, and behavioral problems.
3 Sensory integration techniques are used to organize the sensory system by involvement of
4 full body movements that provide vestibular, proprioceptive, and tactile stimulation.
5 Brushes, swings, balls, and other specially designed therapeutic or recreational equipment
6 are used to provide these stimuli. Proponents believe the goal of SIT is to improve the way
7 the brain processes and organizes sensations, as opposed to teaching higher order skills
8 themselves. Therapy usually involves activities that provide vestibular, proprioceptive, and
9 tactile stimuli, which are selected to match specific sensory processing deficits of the child.
10 For example, swings may be used to incorporate vestibular input, while trapeze bars and
11 large foam pillows or mats may be used to stimulate somatosensory pathways of
12 proprioception and deep touch. Tactile reception may be addressed through a variety of
13 activities and surface textures involving light touch.

14

15 Sensory integration techniques are generally provided to pediatric populations. Advocates
16 have proposed SIT as a treatment for developmental disorders in patients with established
17 dysfunction of sensory processing, [e.g., children with autism, attention deficit
18 hyperactivity disorder (ADHD), brain injuries, fetal alcohol syndrome, and
19 neurotransmitter disease]. According to the American Academy of Pediatrics (AAP),
20 (2012) “Sensory-based therapies are increasingly used by occupational therapists and
21 sometimes by other types of therapists in treatment of children with developmental and
22 behavioral disorders. Occupational therapy with the use of sensory-based therapies may be
23 acceptable as one of the components of a comprehensive treatment plan. However, parents
24 should be informed that the amount of research regarding the effectiveness of sensory
25 integration therapy is limited and inconclusive.” Additionally, it is unclear whether
26 children who present with sensory-based problems have an actual "disorder" of the sensory
27 pathways of the brain or whether these deficits are characteristics associated with other
28 developmental and behavioral disorders. Because there is no universally accepted
29 framework for diagnosis, sensory processing disorder generally should not be diagnosed.
30 Other developmental and behavioral disorders must always be considered, and a thorough
31 evaluation should be completed. Difficulty tolerating or processing sensory information is
32 a characteristic that may be seen in many developmental behavioral disorders, including
33 autism spectrum disorders, attention-deficit/hyperactivity disorder, developmental
34 coordination disorders, and childhood anxiety disorders.

35

36 The therapeutic approach of sensory integration was originally developed by A. Jean
37 Ayres, PhD, OTR, and is known as Ayres Sensory Integration® (ASI®). Once the
38 evaluation is complete, the therapist will design an intervention plan aimed at enhancing

1 the child’s unique ability to utilize sensation. The fidelity principles of Ayres sensory
2 integration include (Parham, et al., 2011):

- 3 • Children integrate sensory information from their bodies and the environment.
- 4 • Include visual, auditory, tactile, proprioceptive, and vestibular input.
- 5 • Individually tailored activities that challenge sensory processing and motor
6 planning, encourage movement and organization of self in time and space, and
7 utilize “just right” challenges.
- 8 • Incorporate clinical equipment in purposeful and playful activities to improve
9 adaptive behavior.
- 10 • Implemented by trained therapy practitioners.
- 11 • Used only after an evaluation is completed and a need for such intervention is
12 identified.

13
14 The American Academy of Child and Adolescent Psychiatry (AACAP) practice parameter
15 for “The assessment and treatment of children and adolescents with autism spectrum
16 disorder” (Volkmar et al, 2014) states: “There is a lack of evidence for most other forms
17 of psychosocial intervention, although cognitive behavioral therapy has shown efficacy for
18 anxiety and anger management in high functioning youth with ASD. Studies of sensory
19 oriented interventions, such as auditory integration training, sensory integration therapy,
20 and touch therapy/massage, have contained methodologic flaws and have yet to show
21 replicable improvements.” A 2013 practice parameter for the assessment and treatment of
22 children and adolescents with autism spectrum disorder states: “Studies of sensory oriented
23 interventions, such as auditory integration training (AIT), sensory integration therapy (SIT)
24 and touch therapy/massage, have contained methodological flaws and have yet to show
25 replicable improvements.”

26
27 Lane and Schaaf (2010) sought to critically examine the basic science literature to
28 specifically identify evidence for the assumptions and tenets of Ayres' theory of SI. The
29 review focused on sensorimotor-based neuroplasticity; explored the data that addressed the
30 links among sensory input, brain function, and behavior; and evaluated its relevance in
31 terms of supporting or refuting the theoretical premise of occupational therapy using an SI
32 framework (OT/SI) to treatment. Although direct application from basic science to OT/SI
33 is not feasible, they concluded that there was a basis for the assumptions of Ayes' SI theory.
34 In 2011, AOTA published evidence-based occupational therapy practice guidelines for
35 children and adolescents with challenges in sensory processing and sensory integration
36 (SI). AOTA gave a level B recommendation for sensory integration for gross motor and
37 motor planning skills for children with learning disabilities, sensory integration to address
38 maladaptive behaviors in children with problems in sensory processing, and sensory
39 integration to address self-esteem in children with learning disabilities and sensory

1 integrative dysfunction. Level B means there is moderate evidence that occupational
2 therapy practitioners should routinely provide the intervention to eligible clients. At least
3 fair evidence was found that the intervention improves important outcomes and concludes
4 that benefits outweigh harm.

5
6 AOTA gave a level C recommendation for SI therapy for sensory integration, sensory diets,
7 and therapeutic riding to address performance on functional, parent-centered goals in
8 children with problems with sensory processing, individual functional goals for children,
9 for parent-centered goals, for participation in active play in children with sensory
10 processing disorder, to address play skills and engagement in children with autism, for
11 visual perception in children with Developmental Coordination Disorder (DCD), for
12 sensory integration combined with perceptual–motor curriculum for visual, auditory, and
13 tactile perception for children with suspected neurological problems, for occupational
14 therapy using a sensory integration approach for decreasing externalizing and internalizing
15 behaviors in children with problems in sensory processing, for engagement and reduced
16 aggression in children with sensory modulation disorder, for improved social interaction
17 and reduced disruptive behaviors in children with autism, for attention in children with
18 autism, and to address tactile discrimination for children with suspected neurological
19 problems. A level C recommendation is based on weak evidence that the intervention can
20 improve outcomes, and the balance of the benefits and harms may result in a
21 recommendation that occupational therapy practitioners routinely provide the intervention
22 to eligible clients or in no recommendation because the balance of the benefits and harm is
23 too close to justify a general recommendation. Specific performance skills evaluated were
24 motor and praxis skills, sensory-perceptual skills, emotional regulation, and
25 communication and social skills. There was insufficient evidence to provide a
26 recommendation on sensory integration for academic and psychoeducational performance
27 (e.g., math, reading, written performance).

28
29 Case-Smith et al. (2015) completed a systematic review of sensory processing
30 interventions for children with autism spectrum disorders. Children with autism spectrum
31 disorders often exhibit sensory processing problems and receive interventions that target
32 self-regulation. This systematic review examined the research evidence (2000-2012) of
33 two forms of sensory interventions, sensory integration therapy and sensory-based
34 intervention, for children with autism spectrum disorders and concurrent sensory
35 processing problems. A total of 19 studies were reviewed: 5 examined the effects of
36 sensory integration therapy, and 14 sensory-based interventions. The studies defined
37 sensory integration therapies as clinic-based interventions that use sensory-rich, child-
38 directed activities to improve a child's adaptive responses to sensory experiences. Sensory-
39 based interventions are characterized as classroom-based interventions that use single-
40 sensory strategies such as weighted vests or therapy balls to influence a child's state of

1 arousal. Few positive effects were found in sensory-based intervention studies. Studies of
2 sensory-based interventions suggest that they may not be effective; however, these studies
3 did not follow recommended protocols or target sensory processing problems. Although
4 small randomized controlled trials resulted in positive effects for sensory integration
5 therapies, additional rigorous trials using consistent protocols for sensory integration
6 therapy are needed to evaluate effects for children with autism spectrum disorders and
7 sensory processing problems. Barton et al. (2015) conducted a comprehensive and
8 methodologically sound evaluation of the efficacy of sensory-based treatments for children
9 with disabilities. Thirty studies involving 856 participants met their inclusion criteria and
10 were included in this review. Considerable heterogeneity was noted across studies in
11 implementation, measurement, and study rigor. The research on sensory-based treatments
12 is limited due to insubstantial treatment outcomes, weak experimental designs, or high risk
13 of bias. Authors conclude that although many people use and advocate for the use of
14 sensory-based treatments and there is substantial empirical literature on sensory-based
15 treatments for children with disabilities, insufficient evidence exists to support their use.
16 Watling and Hauer (2015) completed a systematic review on the effectiveness of Ayres
17 Sensory Integration® and Sensory-Based Interventions for People with Autism Spectrum
18 Disorder. Of the 368 abstracts screened, only 23 met the inclusion criteria and were
19 reviewed. Moderate evidence was found to support the use of ASI. The results for sensory-
20 based methods were mixed.

21
22 Weitlauf et al. (2017) evaluated the effectiveness and safety of interventions targeting
23 sensory challenges in ASD. Twenty-four studies, including 20 randomized controlled trials
24 (RCTs), were included. Limited, short-term studies reported potential positive effects of
25 several approaches in discrete skill domains. Specifically, sensory integration-based
26 approaches improved sensory and motor skills-related measures (low strength of
27 evidence). Schaaf et al. (2018) addressed the question "What is the efficacy of occupational
28 therapy using Ayres Sensory Integration® (ASI) to support functioning and participation
29 as defined by the International Classification of Functioning, Disability and Health for
30 persons with challenges in processing and integrating sensory information that interfere
31 with everyday life participation?" Three randomized controlled trials, one (1) retroactive
32 analysis, and one (1) single-subject ABA design published from 2007 to 2015, all of which
33 happened to study children with autism, met inclusion criteria. The evidence is strong that
34 ASI intervention demonstrates positive outcomes for improving individually generated
35 goals of functioning and participation as measured by Goal Attainment Scaling for children
36 with autism. Moderate evidence supported improvements in impairment-level outcomes of
37 improvement in autistic behaviors and skills-based outcomes of reduction in caregiver
38 assistance with self-care activities. Child outcomes in play, sensory-motor, and language
39 skills and reduced caregiver assistance with social skills had emerging but insufficient
40 evidence. Pfeiffer et al. (2017) examined the evidence for the effectiveness of cognitive

1 and occupation-based interventions to improve self-regulation in children and youth who
2 have challenges in processing and integrating sensory information in a systematic review.
3 Five studies were identified through a comprehensive database search and met the
4 inclusion criteria and were separated into categories of cognitive and occupation-based
5 interventions. Synthesis of the articles suggests that self-regulation (e.g., sensory
6 processing, emotional regulation, executive functioning, social function) improved with
7 cognitive and occupation-based interventions. Because the number of studies that
8 measured sensory processing or SI challenges was limited, authors suggest that researchers
9 should include these measures in future research to understand the impact of a broader
10 range of cognitive and occupation-based interventions.

11
12 Kashefimehr et al. (2018) examined the effect of sensory integration therapy (SIT) on
13 different aspects of occupational performance in children with ASD. The Short Child
14 Occupational Profile (SCOPE) and the Sensory Profile (SP) were used to assess outcomes.
15 The intervention group showed significantly greater improvement in all the SCOPE
16 domains, as well as in all the SP domains, except for the "emotional reactions" and
17 "emotional/social responses" domains, ($p < .05$). The authors concluded that the
18 effectiveness of SIT in improving occupational performance in children with ASD as a
19 health-related factor is supported by their findings. Schoen et al. (2019) evaluated the
20 effectiveness research from 2006 to 2017 on Ayres Sensory Integration (ASI) intervention
21 for children with autism using Council for Exceptional Children (CEC) Standards for
22 Evidence-Based Practices in Special Education. The results of this systematic review
23 indicate that SIT meets the criteria for an evidence-based practice according to the CEC
24 Standards for Evidence-Based Practices in Special Education. It also appears to meet the
25 criteria for an evidence-based practice as defined by the United States Preventative
26 Services Task Force and the FPG Child Development Institute Guidelines. Authors
27 concluded that consumers, third-party payers, and professionals concerned with the well-
28 being of children with autism spectrum disorders can feel confident that ASI is an effective
29 intervention for this population, particularly for those with IQs above 65 and who are 4–
30 12 years of age. However, authors caveat this conclusion by stating it is critical that
31 therapists providing ASI intervention adhere to the essential elements of this intervention,
32 to ensure that the intervention delivered is in keeping with an evidence-based practice.

33
34 For adult patients, sensory integration techniques have been used for acquired sensory
35 problems resulting from head trauma, illness, or acute neurologic events including
36 cerebrovascular accidents. They are not appropriate for patients with progressive
37 neurological conditions without potential for functional adaptation. Therapy is not
38 considered a cure for sensory integrative impairments but is used to facilitate the
39 development of the patient's ability to process sensory input differently. Research studies
40 are lacking for the adult population and SI therapy.

1 Due to the individual nature of sensory integration therapy and the large variation in
2 individual therapists and patients, large multicenter randomized controlled trials are needed
3 to evaluate the efficacy of this intervention. The most direct evidence related to outcomes
4 from SI therapy comes from small, randomized trials. Although some of the studies
5 demonstrated some improvements on subsets of the outcomes measured, the studies are
6 limited by small sizes, heterogeneous patient populations, and variable outcome measures.
7 As a result, the evidence is insufficient to draw conclusions about the effects of and the
8 most appropriate patient populations for SI therapy.

9
10 Camarata et al. (2020) Reviewed sensory integration/processing treatments (SI/SP) and the
11 objective analysis challenges for children with autism spectrum disorders (ASD), ADHD
12 and disruptive behavioral dysfunction secondary to impaired sensory modulation and
13 integration of sensory stimuli. The treatment modalities reviewed focused on tactile,
14 proprioceptive, and vestibular systems, utilizing equipment, devices, and activities of daily
15 living. Treatments were based on the theories of Ayres (1975) which suggest the previously
16 mentioned modalities may facilitate the organization and use of sensory stimulation in
17 conjunction with motor activities to enhance sensory integration and processing skills. The
18 review included discussions of emerging evidenced based treatments such as NDBI
19 (Naturalistic Behavioral Intervention) treatment, Multisensory Integration, and Auditory-
20 visual integration as approaches to control confounds to objectively test the sensory
21 integration and processing theory and outcome changes. The review included case
22 presentations which identified factors that may have influenced the outcomes rather than
23 the sensory integration treatment approach effect. Consideration is needed to systemically
24 control the factors that account for the behavior changes. Based on this review, the research
25 supporting the effectiveness of SI/SP is not conclusive. There are few larger-scale,
26 randomized control trials that directly test the intervention with control for confounds and
27 include objective measurements to support evidence of the SI/SP approaches as the
28 treatment which impacted functional change. Standardized outcome measurements and
29 data collection are needed that reflect daily functional changes. Therefore, insufficient
30 evidence was found to determine that the effects of sensory integration training on
31 communication and daily activities impacted outcomes for children with ASD, ADHA and
32 disruptive behavioral dysfunction.

33
34 Lane (2020) reviewed the current best evidence regarding measurement of and
35 interventions for sensory symptoms. She notes there is ample evidence to support the
36 association of sensory symptoms with childhood function including social engagement,
37 repetitive behaviors, anxiety, and participation in self-care routines. The evidence for
38 interventions for sensory symptoms is emerging but still limited by low quantity and
39 methodological concerns. This author concluded that effective management of sensory
40 symptoms may mitigate the burden of neurodevelopmental disability and mental illness in
41 young people. Identification of sensory symptoms should be conducted by a skilled
42 practitioner utilizing multiple measurement methods. Intervention protocols for sensory

1 symptoms should be informed by current best evidence which is strongest for Ayres
2 Sensory Integration®, Qigong massage, the Alert Program®, and Social Stories.

3
4 Mailloux et al. (2021) reported on reliability and validity of six tests of vestibular and
5 proprioceptive functions of the Evaluation in Ayres Sensory Integration (EASI). The
6 sample contained typically developing children ($n = 150$) and children with sensory
7 integration concerns ($n = 84$); all participated voluntarily. Outcomes and Measures: The
8 EASI is used to measure sensory and motor functions in children ages 3 to 12 yr. The six
9 tests of vestibular and proprioceptive functions were analyzed in this study. Data from
10 >96% of items conformed to the expectations of the model. Authors found statistically
11 significant group differences with the typically developing children group scoring
12 significantly higher on all but one test, and moderate to strong evidence of internal
13 consistency for five of six tests. Authors concluded that the EASI vestibular and
14 proprioceptive tests have strong construct validity and internal reliability, indicating that
15 they are psychometrically sound clinical measures. Authors also state that the development
16 of occupational therapy assessments with strong psychometric properties, such as the EASI
17 tests of vestibular and proprioceptive functions, enhances clinical practice and research by
18 elucidating the factors affecting participation in accurate and dependable ways so that
19 occupational therapy interventions can be focused and effective.

20
21 Randell et al. (2022) aimed to determine the clinical effectiveness and cost-effectiveness
22 of sensory integration therapy for children with autism and sensory difficulties across
23 behavioral, functional, and quality-of-life outcomes. Inclusion criteria were having an
24 autism diagnosis, being in mainstream primary education and having definite/probable
25 sensory processing difficulties. Exclusion criteria were having current/previous sensory
26 integration therapy and current applied behavior analysis therapy. The intervention was
27 manualized sensory integration therapy delivered over 26 weeks and the comparator was
28 usual care. The primary outcome was problem behaviors (determined using the Aberrant
29 Behavior Checklist), including irritability/agitation, at 6 months. Secondary outcomes were
30 adaptive behavior, functioning and socialization (using the Vineland Adaptive Behavior
31 Scales); carer stress (measured using the Autism Parenting Stress Index); quality of life
32 (measured using the EuroQol-5 Dimensions and Carer Quality of Life); functional change
33 (according to the Canadian Occupational Performance Measure); sensory processing
34 (determined using the Sensory Processing Measure™ at screening and at 6 months to
35 examine mediation effects); and cost-effectiveness (assessed using the Client Service
36 Receipt Inventory). Every effort was made to ensure that outcome assessors were blind to
37 allocation. A total of 138 participants were randomized ($n = 69$ per group). Usual care was
38 significantly different from the intervention, which was delivered with good fidelity and
39 adherence and minimal contamination and was associated with no adverse effects. Trial
40 procedures and outcome measures were acceptable. Carers and therapists reported
41 improvement in daily functioning. The primary analysis included 106 participants. There
42 were no significant main effects of the intervention at 6 or 12 months. Health economic

1 evaluation suggests that sensory integration therapy is not cost-effective compared with
 2 usual care alone. Authors concluded that the intervention did not demonstrate clinical
 3 benefit above standard care.

4
 5 Omairi et al. (2022) evaluated the outcomes of occupational therapy using Ayres Sensory
 6 Integration in a sample of Brazilian children with ASD. Seventeen children with ASD ages
 7 5-8 yr ($n = 9$ in the intervention group, $n = 8$ in the usual-care control group) participated
 8 in this study. The intervention group received occupational therapy using Ayres Sensory
 9 Integration, and the control group received usual therapeutic and educational services only.
 10 Participants in the intervention group scored significantly higher on outcome measures of
 11 self-care, social function, and parent-identified goal attainment compared with the control
 12 group. Authors recognize the small sample size but conclude that occupational therapy
 13 using Ayres Sensory Integration was effective in enhancing self-care, socialization, and
 14 goal attainment for children with ASD in a Brazilian cohort. This study contributes further
 15 support from outside the United States that occupational therapy using Ayres Sensory
 16 Integration is an effective evidence-based intervention to improve self-care, socialization,
 17 and parent-identified goal attainment in children with ASD.

18
 19 Raditha et al. (2023) evaluated the effect of Sensory integration occupational therapy (SI-
 20 OT) in improving positive behaviors of ASD children aged 2-5 years. A total of 72 subjects
 21 were studied. Following SI-OT, communication skills (expressive, receptive), socialization
 22 (coping skills), and daily living skills (personal, community) were improved significantly.
 23 Authors concluded that SI-OT with Ayres theory in 60 min, twice a week for 12 weeks
 24 improved positive behaviors.

25 26 **PRACTITIONER SCOPE AND TRAINING**

27 Practitioners should practice only in the areas in which they are competent based on their
 28 education training and experience. Levels of education, experience, and proficiency may
 29 vary among individual practitioners. It is ethically and legally incumbent on a practitioner
 30 to determine where they have the knowledge and skills necessary to perform such services
 31 and whether the services are within their scope of practice.

32
 33 It is best practice for the practitioner to appropriately render services to a patient only if
 34 they are trained to competency, equally skilled, and adequately competent to deliver a
 35 service compared to others trained to perform the same procedure. If the service would be
 36 most competently delivered by another health care practitioner who has more skill and
 37 training, it would be best practice to refer the patient to the more expert practitioner.

38
 39 Best practice can be defined as a clinical, scientific, or professional technique, method, or
 40 process that is typically evidence-based and consensus driven and is recognized by a
 41 majority of professionals in a particular field as more effective at delivering a particular

1 outcome than any other practice (Joint Commission International Accreditation Standards
2 for Hospitals, 2020).

3
4 Depending on the practitioner’s scope of practice, training, and experience, a patient’s
5 condition and/or symptoms during examination or the course of treatment may indicate the
6 need for referral to another practitioner or even emergency care. In such cases it is essential
7 for the practitioner to refer the patient for appropriate co-management (e.g., to their primary
8 care physician) or if immediate emergency care is warranted, to contact 911 as appropriate.
9 See the *Managing Medical Emergencies in a Health Care Facility (CPG 159 – S)* clinical
10 practice guideline for information.

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