

Occupational Therapy Guidelines

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1. What is Occupational Therapy?

FEDERAL DEFINITION

The federal definition of occupational therapy services within the context of special education.

34 CFR 300.34(a)(6) “Occupational Therapy” includes:

- (i) Improving, developing, or restoring functions impaired or lost through illness, injury, or deprivation;
- (ii) Improving ability to perform tasks for independent functioning if functions are impaired or lost; and
- (iii) Preventing, through early intervention, initial or further impairment or loss of function.

STATE DEFINITION

The Government Code, the Education Code, and Title 5 are all generally vague and/or silent with regard to a definition of occupational therapy.

EDUCATION CODE

For the children between the ages of 3 to 22:

56363(a) The term “related services” means transportation, and such developmental corrective, and other supportive services (including physical and occupational therapy...) as may be required to assist an individual with exceptional needs to benefit from special education, and includes the early identification and assessment of disabling conditions in children.

For children under 3 years of age:

56426.7 Medically necessary occupational therapy and physical therapy shall be provided to the infant when warranted by medical diagnosis and contained in the individualized family service plan, as specified under Chapter 26.5 (commencing with Section 7570) of Division 7 of Title 1 of the Government Code.

CALIFORNIA ADMINISTRATIVE CODE TITLE 5 (EDUCATION)

3051.6 Physical and occupational therapy

- (a) When the district, special education local plan area, or county office contracts for the services of a physical therapist or an occupational therapist, the following standards shall apply:
 - (1) Occupational or physical therapists shall provide services based upon the recommendation of the individual education program team. Physical therapy and occupational therapy services for infants are limited by Education Code 56426.6. Physical therapy services may not exceed services specified in the Business and Professions Code at Section 2620.

- (2) The district, special education services region, or county office shall assure that the therapist has available safe and appropriate equipment.

(b) Qualifications of therapist

- (1) The therapist shall have graduated from an accredited school.
- (2) A physical therapist shall be currently licensed by the Board of Medical Quality Assurance of the State of California and meet the educational standards of the Physical Therapy Examining Committee.
- (3) An occupational therapist shall be currently registered with the American Occupational Therapy Certification Board (AOTCB).(license?)

GOVERNMENT CODE (Applies to special education children only -- procedures for non-special education children may differ)

7572. (b) Occupational therapy and physical therapy assessment shall be conducted by qualified medical personnel as specified in regulations developed by the State Department of Health Services in consultation with the State Department of Education.

7575. (a) (1) Notwithstanding any other provisions of law, the State Department of Health Services, or any designated local agency administering the California Children's Services, shall be responsible for the provision of medically necessary occupational therapy and physical therapy, as specified by Article 5 (commencing with section 123800) of Chapter 3 of Part 2 of Division 106 of the Health and Safety Code, by reason of the medical diagnosis and when contained in the child's individualized education program.

(2) Related services or designated instruction and services not deemed to be medically necessary by the State Department of Health Services, that the individualized education program team determines are necessary in order to assist a child to benefit from special education, shall be provided by the Local Education Agency by qualified personnel whose employment standards are covered by the Education Code and implementing regulations..

2. Occupational Therapy in California Public Schools

Public schools are not required to provide a service to a disabled child just because the child will benefit from the service or even if the child requires the service for other than educational reasons. A key factor the IEP team must remember is that a related service such as OT is warranted only if it is necessary for the child to benefit from their educational instruction. Therefore, if the IEP team has exhausted the strategies, activities, or resources available (classroom teacher, SDC, RSP, APE teacher, etc.) and believes that OT is necessary for the child to benefit from his/her instructional program, a referral for such services should be made.

3. How do occupational therapists provide service in the school setting?

While physical therapists assist with muscle development, occupational therapists assist with the functional use of these muscles.

In the educational setting, OT services may include assessment, direct therapy, and several types of consultation. These intervention activities are not mutually exclusive and may occur at the same time.

Assessment information is gathered by direct, personal contact with the child, standardized tests, structured informal assigned tasks, and classroom observation.

Direct therapy employs specific therapeutic techniques to remediate or prevent problems that are identified through the assessment process, adversely affect educational performance, are required to meet educational goals and are based on program objectives developed by the multidisciplinary team.

Motor planning, gross motor and fine motor skills, and visual perception skills, as well as self-help skills, are the primary areas of focus, but sometimes other areas are addressed as well (e.g., processing sensory input, coordination of skills, external adaptations, alternative ways of completing activities, etc.).

Consultation is the collaboration among therapists, educational staff, parents and/or child to plan and implement modifications and interventions, to meet the child's needs. It can also include monitoring or periodic rechecking of the child's progress. The nature of the consultation should be defined on the comments page of the IEP. All consultation should have a written report delineating what the consultation encompassed and the results.

4. Who may receive occupational therapy?

Simply having needs in the areas of gross or fine motor skills does not mean that a child needs occupational therapy. Special education teachers can assess and assist children who have special needs in fine or gross motor skills. Most special education children with needs in these areas can and should be served by their teachers.

There are a few children whose needs are so significant and unique that the child's special education teacher cannot serve them. These children may need the services of an occupational therapist. Neither state nor federal law sets aside distinct eligibility criteria for occupational therapy services.

In order to receive occupational therapy as a related service, a child must first be eligible for special education. This means that the child must be determined to be an "Individual with Exceptional Needs" as defined by the Education Code and local SELPA guidelines. All the requirements for eligibility must be met. Within this framework, both the American Occupational Therapy Association and federal legislation focus on "improvement of functioning" and not serving goals beyond the capacities of the individual.

The objective of occupational therapy is to have a child participate and function as independently as possible in the in the classroom setting.

Once a child has been found to be eligible for special education, a listing of all his needs which cannot be met by the regular education program must be made. These become his special education needs. Needs in the areas of gross and or fine motor, special physical adaptations or similar areas, which cannot be met by the regular or special education teacher, then raise the possibility of OT involvement (consult, monitor, direct service).

5. In California, who is responsible for providing OT services to school-age children?

FOR SERVICES THAT ARE MEDICALLY NECESSARY:

Childs who have medically necessary occupational or physical therapy needs are served by California Children Services (CCS) when they meet the criteria for medical eligibility for the CCS program. This applies from birth-21 years old whether or not they are also eligible for special education.

When a child is suspected of being in need of “medically necessary” therapy, please refer directly to CCS.

Medical eligibility for the CCS program is determined by the CCS Medical Consultant through a review of applicable medical reports from the child’s physician(s). Medical eligibility for the CCS medical therapy program is defined in the California Code of Regulations, Title 22, Division 2, Subdivision 7, Section 41832.

CCS medical therapy services are available to all eligible children who require them and are available at no cost to the parents of those children. The frequency of CCS therapy services (monitoring or direct service) is based on physician prescription and is determined by the physician, parent, and therapy team. Services may increase or decrease based on the child’s medical condition and progress towards therapy goals. If the parent or legal guardian is not in agreement with the frequency of prescribed occupational or physical therapy he/she may appeal this decision by contacting the CCS administrative office.

CCS therapists may share information and participate in a child’s IEP when it is requested and notification of the IEP is provided. The CCS program is required to inform the school whenever the frequency of a child’s occupational or physical therapy changes.

If a child does not meet CCS eligibility requirements and the IEP team determines after an evaluation that the service is required in order for the child to benefit from his/her program of specially designed instruction, special education is responsible for providing this service.

Children who may need occupational therapy for other reasons (e.g. temporary physical disability or where there is no significant/major educational impact) are not the responsibility of the schools.

FOR CHILDREN WHO ARE ALREADY ELIGIBLE FOR SPECIAL EDUCATION:

Even when a child is disabled and needs specifically designed instruction, the child does not automatically receive related services. These services become part of a child's IEP when the IEP team determines that they are needed in order for the child to benefit from special education and when the identified needs are so severe that they cannot be served by his/her regular or special education teacher.

6. Where does sensory integration therapy fit into all this?

The term “sensory integration” is used in California by different people to refer to different types of treatment strategies. Other terms, such as “sensory motor training,” “sensory integrative therapy,” and “sensory processing,” are often used as synonyms. For our purposes, sensory integration is a methodology used by the therapists at their discretion. A teacher (regular class, special education, art, music, dance, etc.) may include perceptual motor or sensory motor activities or instruction in his/her curriculum. Specific techniques individualized to a child, which are identified by the OT, can be utilized by the teaching staff with direct supervision and training by the OT.

In general, sensory integration therapy attempts to elicit appropriate behavioral responses to sensory input. It attempts to enhance the brain's ability to process and integrate sensory and motor information. Sensory integration therapy may result in improvement in the child's ability to organize sensory information and adapt responses so that they are appropriate to the environment. This technique focuses on ameliorating the underlying problem, rather than on teaching specific skills or utilizing accommodations.

CAN AN IEP TEAM INDICATE SENSORY INTEGRATION THERAPY TREATMENT AS A RELATED SERVICE ON THE IEP OR INDICATE THAT A THERAPIST USE THIS METHODOLOGY?

No, it is not a related service under IDEA 2004; but, rather, a technique or instructional method which may be used in providing special education or related services. The decision to use, or not use, sensory integration therapy as a method should be made by the person responsible for the service or instruction specified in the IEP, based on the professional judgment of the service provider and the needs of the child. This decision should be made only after the child is identified through assessment as an individual with exceptional needs.

The local school district is under no obligation to include sensory integration therapy in the IEP since it is a method, not a related service. After the IEP team has identified the child as an individual with exceptional needs and included, for example, therapy in the IEP, the therapist may decide to use whatever method(s) is most effective for carrying out the goals and objectives for that child.

7. Where does neurodevelopmental treatment (NDT) fit into all this?

NDT is a treatment approach that can be used by occupational or physical therapists, speech/language therapists, and teachers trained in its use. The aim of NDT is to provide a sense of normal movement, to assist the individual to use movement patterns to improve function. This is done by using techniques to inhibit abnormal patterns and facilitate normal movement. There are many different ways of inhibiting abnormal muscle tone and facilitating normal movement reactions.

The goals of NDT are:

- To carefully analyze problems of posture and movement in all possible positions;
- To normalize tone using techniques of inhibition and facilitation in order to allow the child to move more functionally;
- To teach parents and teachers the necessary procedures to ensure consistent management of motor deficits;
- To use equipment to aide in enabling more normal patterns of movement and to help in functional skills; and
- To prevent a cycle of abnormal sensory-motor development including secondary changes such as contractures and deformities from occurring.

Can an IEP team indicate NDT as a related service on the IEP or indicate that a therapist use this methodology?

No, it is not a related service; it is a technique to be used or not as determined by the current therapist. Typically, an evaluation that determines the need for NDT will result in a referral to a medically based service provider.¹

8. What is the difference between “medically necessary” OT and “educationally necessary” OT?

Medically necessary therapy conducted in the school is not the same as therapy conducted in the clinic. Therapy differs in these two settings in terms of its intent, the role of the therapist, and the type of support available to the therapist.

Medically necessary therapy is usually undertaken as an adjunct to medical treatment for acute and chronic conditions to ameliorate an underlying disability. The goal of medically necessary therapy is to improve global functioning through the use of a variety of modalities. Educationally necessary therapy is provided in the school to help the child access educational services and benefit from his educational program. In the school, educational goals hold a primary position, while occupational therapy goals are undertaken to support the educational goals.

The school therapist delivers a wide range of services. These services cover individual therapy, as well as therapy within small groups, and consultation with school staff, and with the child’s

family. Thus, the school therapist is expected to share his/her knowledge and skills with others by demonstrating and monitoring activities that are educationally appropriate.

The significant ways in which clinical therapy and school therapy differ from one another are summarized below.

MEDICALLY NECESSARY THERAPY	EDUCATIONALLY NECESSARY THERAPY
Therapy goals are primary.	Educational goals are primary
Intervention is directed toward alleviation of a specific medical problem.	Intervention is directed toward facilitating educational progress.
Services tend to be delivered individually in a clinic or hospital setting	Services are collaborative. Much time must be given to communicating with other service providers
Focus is based on developmental milestones and components of movement. The focus is on functional outcomes.	Focus is on functional skills and adaptations that promote the attainment of educational objectives
Few responsibilities are delegated except to parents	More responsibilities are delegated to parents and other educational professionals
Clients generally come to the clinics to see the therapist	The therapist works in the school setting

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9. What are the “educationally necessary” OT services that are provided by therapists in schools?

Intervention, as applied in the school, is typically divided into nine functional areas. The services provided in the school setting may differ somewhat from those provided in the clinical setting.

FUNCTIONAL AREA	SERVICES PROVIDED	RELATIONSHIP TO EDUCATION
Self-help	Mobility and transfer skills, feeding, toileting, adaptive equipment	To permit the child to manage personal needs in the classroom and school
Functional Mobility	Equilibrium and balance reactions, transfer skills	To permit the child freedom of movement within the educational setting

FUNCTIONAL AREA	SERVICES PROVIDED	RELATIONSHIP TO EDUCATION
Environmental	Recommend modifications of school's or child's equipment	To help the child access the educational environment
Positioning	Positioning with wheelchairs and/or adaptive equipment & handling methods	To maintain the child in the best position for learning and functional use of hands
Neuromuscular and Musculoskeletal Systems	Activities which promote muscle endurance, strength, motor coordination and planning, and integration of developmental reflexes	To enable the child to participate maximally in school activities. To increase speed, accuracy, and strength in manipulative skills in pre-academic and academic tasks.
Sensory Processing	Activities which promote muscle tone and integration of tactile, visual, auditory, proprioceptive, and vestibular input	To process information that will enhance the child's ability to perform learning and motor tasks in school
Adaptive Equipment	Recommend and fabricate devices to facilitate fine motor and self help tasks	Provide the child with alternative means to accomplish functional activities
Fine Motor/Visual Motor	Evaluate and improve functions such as reach, grasp, object manipulation, and dexterity	To facilitate the child's ability to manipulate classroom tools (such as writing implements, puzzles, and art materials)
Communication	In coordination with speech therapists & augmentative communication professionals, evaluate and recommend adaptive equipment, and communication devices necessary for functional communication	To enable the child to communicate in school, at home and in the community

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10. What do Special Education Teachers and Occupational Therapists do differently?

In general, OT's concentrate on postural background mechanisms, sensory impairments or motor impairments effecting function. There is, however, some overlap between the things teachers and Occupational Therapists do in the course of helping children learn and become independent. The following chart may help show who does what.

AREAS OF NEED	WHAT THE TEACHER DOES	WHAT THE OCCUPATIONAL THERAPIST DOES
Fine Motor Function	Teaches, monitors and reinforces normal pencil grasp. Teaches and provides practice opportunities in form reproduction (lines, circles, squares etc.). Teaches letter reproduction, use of lines and spaces. Offers drill and practice opportunities in visual motor and visual perceptual activities. Offers opportunities and assistance to work with motor materials such as puzzles, peg boards, beads, and scissors. Monitors student progress.	Evaluates accommodations and assistive devices necessary for improved grip, grip strengthening activities, postural supports, fatigue minimization, kinesthetic cues. Provides activities which promote muscle endurance, motor planning and integration of developmental reflexes. Monitors student progress.
Self-Help Skills	Encourages independent attitude. Teaches organizational systems for dealing with instructional materials. Teaches and monitors organizational systems for dealing with class work completion. Teaches dressing, toileting, self-feeding specific to individual developmental level, using known adaptations. Develops structure and processes necessary for independence in the cafeteria, restroom, and moving between classes. Defines necessary mobility and transfer skills, and minimizes obstacles in the classroom.	Assists with management of instructional materials by providing exercises to improve visual tracking-scanning, vestibular or tactile issues. Provides adaptations for dressing. Provides postural support/adaptations for toileting. Provides support for utensil usage in feeding, and helps resolve sensory based food resistance. Promotes independence in cafeteria and other school locations by developing adaptations and training the student and staff in their use.
Behavior/ Attention	Addresses issues of oppositional behavior, immature social skills, different learning styles, decreased attention, impulsiveness and self-stimulatory behavior using behavioral/instructional strategies. These strategies include: posted schedules, transition supports, adapted curriculum, social skills training, self-monitoring programs, and systematic reinforcement of functionally equivalent replacement behaviors.	Addresses issues of increased or decreased arousal level based upon vestibular responsiveness, tactile irregularity, or kinesthetic sensation seeking. Addresses issues related to activity shift through work on vestibular/somatosensory regulation and modulation systems. Addresses self-stimulation behavior by assisting to design sensory activities that can be used in the classroom.

AREAS OF NEED	WHAT THE TEACHER DOES	WHAT THE OCCUPATIONAL THERAPIST DOES
Keyboarding	Teaches keyboarding skills.	Provides adaptations, positioning assistance.

11. How does an IEP team determine if Occupational Therapy is “Educationally Necessary?”

According to the CA Ed Code and IDEA 2004, the IEP team is addressing the question, “Is OT necessary for the child to benefit from his/her special educational instruction?”

While “educationally necessary” is difficult to define precisely, determining the need for educationally necessary OT may best be approached by the IEP team addressing a series of questions about the developmental issues involved in the student’s progress toward goals.

Answers to the questions below will help the team arrive at the answer to their ultimate question:

Is Occupational Therapy necessary for the student to benefit from his or her special educational program?

- Does the student have educational goals that involve motor skills or sensory functioning?
- Can these goals be addressed by adaptations or modifications to the classroom environment or curriculum?
- Can these goals be addressed by classroom instructional staff using typical educational strategies with reasonable expectation of success?
- Can these goals be addressed by classroom instructional staff with consultation and guidance or monitoring by an Occupational Therapist?
- Can classroom instructional staff conduct a program of activities designed by an Occupational Therapist specifically for this student, with reasonable expectation of success?
- Can activities designed to address educational goals be delivered to the student only by a professional Occupational Therapist?

As special education instruction frequently can overlap Occupational Therapy activities in many skill areas, the IEP team needs to thoroughly consider the level of professional expertise needed to address educational goals, to assure that special education resources have been explored before determining that Occupational Therapy services are required for a student to benefit from their special education program. **Public schools are not required to provide a related service to a student with disabilities simply because the student will benefit from the service. The IEP team must determine that a related service is warranted only if it is necessary for the student to benefit from the special education instruction. When the team has explored the strategies, activities and resources available within the instructional program, and has determined that the student is not likely to benefit from this program’s opportunities without additional professional services from an Occupational Therapist, then the related service should become part of the IEP.**

12. What is the IEP team’s response when a parent provides a medical doctor’s prescription or recommendation for OT?

An IEP team is the only legal body that determines special education services for a child. Any relevant input from a medical practitioner would be considered by an IEP team along with other health information but there is no educational requirement or authority to fill a physician’s prescription for OT.

13. What should I do if I think a child may need assessment/services in fine or gross motor skill which are not “medically necessary?”

If the child is not in special education, a Child Study Team (SST) should be convened, according to district procedures, to discuss the case. An outcome to this meeting may be classroom accommodation or a special education referral, or in some cases, Occupational Therapy may be explored as a general education service.

14. When is a child ready to be discharged from OT services?

When a child has accomplished IEP goals and/or occupational therapy can no longer have an impact on the child’s function in special education, or the child no longer shows potential for progress or change after a variety of intervention strategies and levels of service and delivery have been used.

- Deficits are not interfering with child’s ability to function adequately within the school environment.
- Therapy is no longer affecting change in child’s level of function.
- Formal reassessment indicates the child no longer requires the previous level of service and IEP team concurs.
- The child has learned appropriate strategies to compensate for deficits.
- Strategies can be effectively implemented by current educational team and do not require the training and expertise of an OT.
- Equipment and environmental modifications are in place and are effective.

Occupational Therapy Child Needs Survey

CHILD: _____ DOB: _____ SCHOOL: _____

PREVIOUS OT: Yes No If Yes: CCS PRIVATE

Please indicate where there is a problem that influences the child's school performance and describe how the child's ability to gain from his educational program is affected. Your information will help determine an appropriate course of occupational therapy service.

- 1 Balance and motor coordination appear delayed relative to cognitive level, adversely affecting ability to participate in the educational program (frequent falls, significant clumsiness, bumps into things). Describe on back.
- 2 Classroom positions are difficult to assume, maintain or tolerate (independent sitting or standing, moving to or from the floor). Describe on back.
- 3 Fine Motor skills appear delayed relative to cognitive level, limiting ability to reach for, grasp, manipulate or release objects or to use both hands together (difficulty with clothing fasteners, poor scissors use, poor pencil/crayon grasp, hand does not assist with stabilization). Describe on back.
- 4 Visual-perceptual-motor abilities are delayed not due to vision impairment, developmental readiness or behavior/ emotional disorders (difficulty tracing or coloring within lines, copying from the board, forming and spacing letters). Describe on back.
- 5 Oral motor dysfunction or problems in self-feeding interfere with intake at meals or present a safety hazard (scoops poorly, loses food/liquids from mouth, gags, takes excessive time to feed or be fed). Describe on back.
- 6 Self-dressing skills related to managing outerwear and clothing at the toilet are delayed (difficulty taking off/putting on jacket, difficulty pulling pants up/down). Describe on back.
- 7 Adaptive or assistive equipment to perform educational activities needs to be acquired, fabricated, or adjusted (pencil grips, desk or chair modifications, positioners, built-up spoons). Describe on back.
- 8 Sensorimotor processing deficits may affect attention to task and performance (over-reaction to movement or accidental touch, difficulty with changes in routine, impulsive grabbing). Describe on back.
- 9 Functional living skills require task analysis and modifications to accomplish successful job performance (decreased strength, coordination, and endurance). Describe on back.
- 10 Motor planning abilities make it difficult to negotiate the school environment and learn new tasks (difficulty moving within the room or school areas, difficulty imitating movements, understands directions but cannot do task). Describe on back.

SIGNATURE _____

DATE _____

Service Recommended by OT: Screening Informal Consultation Assessment

End Notes

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- ¹ Adapted from: Neurodevelopmental Treatment (NDT): Therapeutic Intervention and its Efficacy, by Francine Martin Stern, BS, RPT, and Delia Gorga, Ph.D., OTR, in Infants and Young Children, Aspen Publishers, Inc., 1988.
- ² Adapted from: “The Role of the Physical Therapist and the Occupational Therapist in the School Setting,” by Judith Hylton, Penny Reed, Sandra Hall, and Nancy Cicirello. TIES: Therapy in Educational Settings. A collaborative project conducted by Crippled Children’s Division--University Affiliated Program, the Oregon Health Sciences University and the Oregon Department of Education, Regional Services for Childs with Orthopedic Impairment. Funded by the U.S. Department of Education, Office of Special Education and Rehabilitation Services, grant number G008630055.
- ³ Adapted from: “School Administrator’s Guide to Physical Therapy and Occupational Therapy in California Public Schools,” California Alliance of Pediatric Physical and Occupational Therapists, 40571 Ives Court, Fremont CA 94538.