



# CIGNA MEDICAL COVERAGE POLICY

The following Coverage Policy applies to all plans administered by CIGNA Companies including plans administered by Great-West Healthcare, which is now a part of CIGNA.

**Subject Sensory and Auditory  
Integration Therapy -  
Facilitated Communication**

**Effective Date ..... 2/15/2009  
Next Review Date ..... 2/15/2010  
Coverage Policy Number ..... 0283**

## Table of Contents

Coverage Policy .....	1
General Background .....	1
Coding/Billing Information .....	5
References .....	6
Policy History.....	8

## Hyperlink to Related Coverage Policies

Attention-Deficit/Hyperactivity Disorder:  
Assessment and Treatment  
Autism Spectrum Disorders/Pervasive  
Developmental Disorders: Assessment  
and Treatment  
Occupational Therapy  
Pediatric Intensive Feeding Programs  
Physical Therapy  
Speech/Language Therapy

## INSTRUCTIONS FOR USE

Coverage Policies are intended to provide guidance in interpreting certain **standard** CIGNA HealthCare benefit plans as well as benefit plans formerly administered by Great-West Healthcare. Please note, the terms of a participant's particular benefit plan document [Group Service Agreement (GSA), Evidence of Coverage, Certificate of Coverage, Summary Plan Description (SPD) or similar plan document] may differ significantly from the standard benefit plans upon which these Coverage Policies are based. For example, a participant's benefit plan document may contain a specific exclusion related to a topic addressed in a Coverage Policy. In the event of a conflict, a participant's benefit plan document **always supercedes** the information in the Coverage Policies. In the absence of a controlling federal or state coverage mandate, benefits are ultimately determined by the terms of the applicable benefit plan document. Coverage determinations in each specific instance require consideration of 1) the terms of the applicable group benefit plan document in effect on the date of service; 2) any applicable laws/regulations; 3) any relevant collateral source materials including Coverage Policies and; 4) the specific facts of the particular situation. Coverage Policies relate exclusively to the administration of health benefit plans. Coverage Policies are not recommendations for treatment and should never be used as treatment guidelines. Proprietary information of CIGNA. Copyright ©2009 CIGNA

## Coverage Policy

**CIGNA does not cover sensory integration therapy (SIT), auditory integration therapy (AIT) or facilitated communication (FC) therapy because they are considered experimental, investigational or unproven.**

**Note: This Coverage Policy does not address sensory desensitization therapy.**

## General Background

### Sensory Integration Therapy (SIT)

Sensory integration is the process where individuals resist, modulate and discriminate sensations received through the sensory system to produce purposeful, adaptive behaviors in response to the environment (American Occupational Therapy Association [AOTA], 2008a). Sensory integration dysfunction, or disorder, is a condition that includes an imbalance among the primary sensations of sight hearing, touch, taste, or smell; the sense of movement and/or the positional sense (Eide, 2003). Individuals with this disorder receive sensory information normally, but process the information abnormally. This condition can occur by itself, but can also accompany other conditions, such as vertigo, deafness, stroke, multiple sclerosis, and peripheral neuropathy. In children it has been noted to appear in various conditions including severely neurologically handicapped, prematurely born children, autism spectrum disorders, and pervasive developmental disorders.

Evaluation for sensory processing problems may include observation of the child in the natural setting, caregiver and teacher interviews, standardized testing may be used. In addition, if sensory integration deficits are suspected, testing may be performed that includes the Sensory Integration and Praxis Test to determine the specific areas of sensory integration that are problematic (AOTA, 2008a).

Sensory integration therapy (SIT) has been proposed as a method to improve the way the brain processes and organizes external stimuli, such as touch, movement, body awareness, sight and sound. SIT is usually performed by an occupational therapist. Sensory stimulation is provided in combination with muscle activities, theoretically in order to improve how the brain processes and organizes sensory information. The therapeutic techniques may include deep brushing, swings for vestibular input, textures, bounce pads, scooter boards, weighted vests and other clothing, ramps and generally increasing or decreasing sensory diet depending on the needs of the child (Shaw, 2002). SIT was originally developed as a treatment for learning disabilities and subsequently has been proposed as treatment for autism, mental retardation, Down syndrome, and developmental delays. Definitive patient selection criteria have not been established for SIT.

### **Literature Review for Sensory Integration Therapy**

Miller et al. (2007) conducted a pilot, randomized controlled trial of the effectiveness of occupational therapy using a sensory integration approach (OT-SI) in children with sensory modulation disorders (SMDs). SMDs are impairments in regulating the degree, intensity and nature of responses to sensory input, resulting in considerable problems with daily roles and routines. The trial included 24 children who were randomly assigned to one of three treatment conditions: OT-SI (n=7), activity protocol (n=10) and no treatment (n=7). Pretest and post-test measurements of behavior, sensory and adaptive functioning, and physiology were performed at baseline and at 10 weeks. As compared to the other groups, the OT-SI group made significant gains on goal attainment scaling (GAS) ( $p < 0.001$  compared to no treatment and activity protocol) and on the Attention subtest ( $p = 0.03$  compared to no treatment;  $p = 0.07$  compared to activity protocol) and the Cognitive/Social composite of the Leiter International Performance Scale-Revised ( $p = 0.02$  compared to activity protocol). The OT-SI group showed improvement trends in the hypothesized direction on the Short Sensory Profile, Child Behavior Checklist and electrodermal reactivity. Larger randomized controlled studies are needed to determine whether OT-SI is an effective intervention, for which patients, and what conditions.

A review of SI outcomes research in relation to faithfulness of intervention to underlying therapeutic principles or fidelity was performed (Parham, et al., 2007). The review included 34 studies which were analyzed for consistency of intervention descriptions with the following elements: structural (e.g., equipment used, therapist training) and therapeutic process categories. The reviewers made the following findings:

- Most studies described structural elements related to therapeutic equipment and interveners' profession.
- Only one of the 10 process elements, presentation of sensory opportunities, was addressed in all studies. Most studies described fewer than half of the process elements.
- Intervention descriptions in 35% of the studies were inconsistent with one process element, therapist-child collaboration.

The authors note that the validity of SI outcomes studies is affected by weak fidelity in regard to the therapeutic process.

Watling and Dietz (2007) reported on a study of the effect of Ayres's sensory integration-based occupational therapy on the behavior and task engagement of four children with autism spectrum disorders (ASD). The single-subject study used an ABAB design to compare the immediate effect of SI and a play scenario on the undesired behavior and task engagement. The participants each received a different number of study sessions due to absences and different enrollment dates. The sessions ranged from 31 to 34. The results indicated that no clear patterns of change in undesired behavior or task management emerged through objective measurements. The subject data suggested that each child exhibited positive changes during and after intervention.

Smith et al. (2005) conducted a study for the purpose of comparing the effects of occupational therapy, using a sensory integration approach along with a control intervention of tabletop activities, on the frequency of self-stimulating behaviors. The study involved seven children, ranging in age from 8–19, diagnosed with pervasive developmental delay and mental retardation. The study took place over a four-week time period. During the

second and fourth weeks, a sensory integration treatment was provided for daily 30-minute sessions, five times a week. During the first and third weeks, a 30-minute controls session was provided, following the same schedule. The study found that the frequency of self-stimulating and self-injurious behaviors declined during the weeks when SIT was provided. Limitations with the study included the small sample size, use of a single clinical site, and the short-term follow-up. It was noted that continued research is needed to examine the long-term effects of more extensive intervention.

Dawson and Watling (2000) conducted a systematic review of the research regarding the effectiveness of interventions for sensory and motor abnormalities in autism. The interventions included SIT and auditory integration training (AIT). Four studies on the effectiveness of sensory integration therapy in autism that utilized objective measures of behavior to assess outcome were found. All but one had sample size of fewer than six subjects. None of the studies had a comparison group. One study that had a larger sample size and better design found no change in vocal behavior following brief participation in sensory activities. Five studies were found regarding the effectiveness of auditory integration training, three of which included a control condition. Two of the studies that included a control condition found improvement in both AIT and control conditions. The third study that included control conditions did find improvement in the AIT condition as compared to the control condition; however, it was noted that there were methodological difficulties with this study. The review concluded that although sensory and motor impairments are commonly found in autism, the interventions developed to address them have not been well validated. In the case of SIT, it was noted, "there exist so few studies that conclusions cannot be drawn" (Dawson and Watling, 2000). In the case of AIT, it is noted that "there is no, or at best equivocal support for this intervention approach based on the available controlled studies" (Dawson and Watling, 2000). There is little known regarding which ages or subgroups of individuals are most likely to benefit from therapies addressing sensory and motor difficulties, and further research is recommended.

A meta-analysis was conducted for the purpose of determining whether existing studies of treatment using sensory integration approaches support the efficacy of this method (Vargas, et al., 1999). Sixteen studies were used to compare SIT with no treatment, and 16 studies were used to compare SIT with alternative treatments. The review noted that there was a significant difference between the average size of effect of the earlier studies compared to the more recent studies. The authors concluded that in the SIT and no treatment studies, the recent studies did not demonstrate an overall positive effect and that the sensory integration methods were found to be as effective as various alternative treatment methods.

The peer-reviewed literature fails to demonstrate that SIT, compared with other treatments or with no treatment, provides clinically relevant, long-term improvements in outcomes in children with learning disabilities, Down syndrome, developmental disorders or SI disorders. Studies of SIT in children with cerebral palsy or autism are also lacking, and therefore the evidence is insufficient to evaluate SIT for these indications as well.

### **Professional Societies/Organizations for Sensory Integration Therapy**

An assessment conducted by the National Academy of Sciences (NAS) concluded that there is insufficient evidence as to the effectiveness of SIT for autism. The NAS report states that there is a paucity of research concerning SIT in autism and that these interventions have not yet been supported by empirical studies (NAS, 2001).

The American Academy of Pediatrics (AAP) Committee on Children with Disabilities has stated that the scientific legitimacy of SIT has not been established for children with motor disabilities (Michaud, et al., 2004).

The Association for Science in Autism Treatment (ASAT) has noted in a viewpoint appearing on their website that the overwhelming scientific evidence indicates that SIT is ineffective and that practitioners of this therapy need to provide reliable evidence of its effectiveness instead of opinions and anecdotal reports (Fox, 2004).

### **Auditory Integration Therapy (AIT)**

Auditory integration therapy or training (AIT) refers to listening to music that has been computer modified to remove frequencies to which an individual demonstrates hypersensitivities and to reduce the predictability of auditory patterns. A special device is used to modify the music for the treatment sessions. The treatment program consists of 20 half-hour sessions during a 10- to 12-day period, with two sessions daily. Auditory thresholds are determined via audiograms. The audiogram is then reviewed for evidence of hyperacusis (i.e., an abnormal sensitivity to sound). A clinical history of sound sensitivities and behavior is also reviewed. Audiograms are repeated midway and at the end of the training session to document progress and to determine

whether further treatment sessions are necessary. AIT is usually provided by a speech-pathologist or audiologist. This treatment has been proposed for improving abnormal sound sensitivity in individuals with behavioral disorders, including autism spectrum disorders.

### **Literature Review for Auditory Integration Therapy**

Mudford et al. (2000) performed a crossover study for the purpose of evaluating the benefits of auditory integration training for children with autism. There were 16 children who had been diagnosed with autism involved in the study, with all children receiving both treatments. There were at least four months between treatments. The control treatment was conducted by the auditory integration training providers in an identical room with identical procedures, with the difference being that the headphones used were nonfunctional. The measures included parent and teacher ratings of behavior, direct observational recordings, IQ, language, and social/adaptive tests. It was noted that significant differences tended to show that the control condition was superior on parent-rated measures of hyperactivity and on direct observational measures of ear-occlusion, and no difference was detected on teacher-rated measures. The children's IQ and language comprehension did not increase; however, adaptive/social behavior scores and expressive language quotients decreased. The authors concluded that no children could be identified as benefiting from AIT clinically or educationally to any significant degree.

A Cochrane review was conducted with the objective of determining the effectiveness of AIT or other methods of sound therapy in individuals with autism spectrum disorders (Sinha, et al., 2004). Six randomized controlled trials of AIT were identified, including one crossover trial. Four trials had fewer than 20 patients involved in the study. Seventeen different outcome measures were used. It was noted in the review that due to the high heterogeneity or presentation of data in unusable forms, a meta-analysis was not possible. It was noted that three studies did not demonstrate the benefit of AIT over the control conditions. Three trials reported improvements at three months for the AIT group with the Aberrant Behavior Checklist (ABC), which is of questionable validity. The reviewers concluded, "Further research is needed to determine the effectiveness of sound therapies. In the absence of evidence, the treatment must be considered experimental and care must be taken not to risk hearing loss" (Sinha, et al., 2004). Sinha et al. published a systematic review in 2006. This review incorporated the same studies and findings that were included in the 2004 Cochrane review. There were no additional studies included. The authors concluded that at the present time there is not sufficient evidence to support the use of AIT (Sinha, et al., 2006).

A review of the scientific literature does not support the efficacy of AIT for the treatment of patients with learning disabilities, autism, and other behavioral disorders.

### **Professional Societies/Organizations for Auditory Integration Therapy**

The American Speech-Language-Hearing Association (ASHA) prepared an evidenced-based technical report regarding AIT (ASHA, 2004). They noted that, despite approximately one decade of practice, this method has not met scientific standards for efficacy and safety that would justify its inclusion as a mainstream treatment for a variety of communication, behavioral, emotional and learning disorders.

An assessment conducted by the National Academy of Sciences (NAS) concluded that there is insufficient evidence of the effectiveness of AIT for autism. The NAS report states that there is a paucity of research concerning AIT in autism and that these interventions have not yet been supported by empirical studies (NAS, 2001).

The American Academy of Audiology (AAA) has published a position statement regarding AIT (AAA, 1993). The statement notes that "that there are no published results of peer-reviewed studies using controlled populations and using scientific methods that demonstrated whether this auditory training program provides significant improvement in any dimension for any population." It is also noted that the organization believes this training to be entirely investigational, and further research is needed to demonstrate the efficacy.

The Educational Audiology Association (EAA) issued a position statement regarding AIT (EAA, 1997). They stated that "Auditory integration therapy has not been proven to be a viable treatment for any disability. Only inconsistent, uncontrolled, anecdotal evidence has been provided to support claims of changes in auditory performance." In addition, the position statement noted that without controls to protect against excessively loud auditory stimuli, AIT may cause harm to the auditory system.

The AAP has published a statement regarding two treatments proposed for autism (i.e., AIT and facilitated communication) (AAP, 1998). They have noted that, as yet, there are no good controlled studies to support the use of AIT for children with autism. It is also noted that, until further information is available, the use of these treatments does not appear warranted at this time, except within research protocols.

### **Facilitated Communication (FC)**

Facilitated Communication (FC) is a method of providing assistance to a nonverbal person by typing out words using a typewriter, computer keyboard, or other communication device. FC involves supporting the individual's hand to make it easier for him or her to indicate the letters that are chosen sequentially to develop the communicative statement. Proponents claim that this manual prompting by a trained facilitator provides expressive language abilities to a wide range of individuals, including those with severe intellectual disabilities or autism. FC has been at the center of a growing controversy, because several scientific studies have suggested that facilitators may unintentionally influence the communication, perhaps to the extent of actually selecting the words themselves. A review of the scientific literature has shown many controlled studies with consistently negative findings, indicating that the technique is neither reliably replicable nor valid. Methods used have included single- and double-blind procedures, repeated measures and self-controls, and passing messages about which the facilitator had no prior information.

### **Professional Societies/Organizations for Facilitated Communication**

The AAP has published a statement regarding two treatments proposed for autism: AIT and facilitated communication. According to the AAP, there is good scientific data showing FC to be ineffective; therefore, its use does not appear warranted at this time (AAP, 1998).

The American Academy of Child & Adolescent Psychiatry (AACAP) published a policy statement regarding facilitated communication that states, "Studies have repeatedly demonstrated that FC is not a scientifically valid technique for individuals with autism or mental retardation. In particular, information obtained via FC should not be used to confirm or deny allegations of abuse or to make diagnostic or treatment decisions" (AACAP, 1993).

The American Psychological Association (APA) has adopted the position that facilitated communication is a controversial and unproven communicative procedure with no scientifically demonstrated support for its efficacy (APA, 1994).

### **Summary**

Evidence in the published, peer-reviewed scientific literature does not support the efficacy of sensory integration therapy (SIT), auditory integration therapy (AIT) or facilitated communication (FC) for autism, mental retardation, developmental delays, behavioral disorders, or other medical conditions. In addition, these treatments are not accepted by the professional organizations that are involved in the care of these conditions. The role of these interventions in the management of these conditions is not known at this time.

## **Coding/Billing Information**

**Note:** This list of codes may not be all-inclusive.

### **Experimental/Investigational/Unproven/Not Covered:**

<b>CPT* Codes</b>	<b>Description</b>
97533	Sensory integrative techniques to enhance sensory processing and promote adaptive responses to environmental demands, direct (one-on-one) patient contact by the provider, each 15 minutes

<b>ICD-9-CM Diagnosis Codes</b>	<b>Description</b>
	All codes

\*Current Procedural Terminology (CPT®) © 2008 American Medical Association: Chicago, IL.

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## References

1. American Academy of Audiology. Position Statement: Auditory Integration Training. May 25, 1993. Accessed December 15, 2008. Available at URL address: <http://www.audiology.org/resources/documentlibrary/Pages/AuditoryIntegrationTraining.aspx>
2. American Academy of Child and Adolescent Psychiatry (AACAP). Practice Parameters for the Assessment and Treatment of Children, Adolescents, and Adults with Autism and other Pervasive Developmental Disorders. 1999. Accessed December 15, 2008. Available at URL address: <http://www.aacap.org/galleries/PracticeParameters/Autism.pdf>
3. American Academy of Child & Adolescent Psychiatry (AACAP). Policy statement facilitated communication. Approved by Council, October 20. 1993. Accessed December 15, 2008. Available at URL address: <http://www.aacap.org/page.wv?section=Policy+Statements&name=Facilitated+Communication>
4. American Academy of Pediatrics (AAP). Auditory integration training and facilitated communications for autism. *Pediatrics*. 1998 Aug;102(2 Pt 1):431-3.
5. American Occupational Therapy Association (AOTA). Frequently Asked Questions About Ayres Sensory Integration®. 2008a. Accessed December 19, 2008. Available at URL address: <http://www.aota.org/Practitioners/PracticeAreas/Pediatrics/Browse/Sl/Ayres-SI.aspx>
6. American Occupational Therapy Association (AOTA). AOTA Fact Sheet. Addressing Sensory Integration Across the Lifespan Through Occupational Therapy. 2008b. Accessed December 19, 2008. Available at URL address: <http://www.aota.org/Practitioners/SIS/SISs/SISIS/Fact-Sheet>
7. American Psychological Association (APA). Resolution on Facilitated Communication. Adopted in Council, August 14, 1994. Accessed December 15, 2008. Available at URL address: <http://www.apa.org/about/division/cpmscientific.html>
8. American Speech-Language-Hearing Association (ASHA). Auditory integration therapy. Position statement. 2004. Accessed December 15, 2008. Available at URL address: [http://www.asha.org/NR/rdonlyres/EC6C8637-57F3-4AD2-AEBB-66F6BE3DEE72/0/18943\\_3.pdf](http://www.asha.org/NR/rdonlyres/EC6C8637-57F3-4AD2-AEBB-66F6BE3DEE72/0/18943_3.pdf)
9. Case-Smith J, Bryan T. The effects of occupational therapy with sensory integration emphasis on preschool-age children with autism. *Am J Occup Ther*. 1999 Sep-Oct;53(5):489-97.
10. Committee on Children With Disabilities. American Academy of Pediatrics: The pediatrician's role in the diagnosis and management of autistic spectrum disorder in children. *Pediatrics*. 2001 May;107(5):1221-6.
11. Dawson G, Watling R. Interventions to facilitate auditory, visual, and motor integration in autism: a review of the evidence. *J Autism Dev Disord*. 2000 Oct;30(5):415-21.
12. ECRI Institute. Hotline Response [database online]. Plymouth Meeting (PA): ECRI Institute; 2008 May 28. Sensory Integration Therapy for Sensory Integration Dysfunction. 2008 May 28. Available at URL address: <http://www.ecri.org>.
13. ECRI Institute. Hotline Response [database online]. Plymouth Meeting (PA): ECRI Institute; 2008 Feb 13. Auditory Integration Training for Behavioral, Emotional and Hearing Disorders. 2008 Feb 13. Available at URL address: <http://www.ecri.org>.

14. Educational Audiology Association. Position statement: auditory intergration therapy. sept 18, 1997. Accessed December 15, 2008. Available at URL address:  
<http://eaa.affiniscape.com/associations/4846/files/AIT%20Position%20Statement.pdf>
15. Eide, F. Sensory integration - current concepts and practical implications. American Occupational Therapy Association. Sensory Integration Special Interest Section Quarterly. 2003;26(3).
16. Fox AM. Viewpoint: sensory integration therapy in autism. Association for Science in Autism Treatment (ASAT) [Web site].2004. Accessed December 15, 2008. Available at URL address:  
<http://www.asatonline.org/pdf/Fall99v2.pdf>
17. Hender K. Effectiveness of sensory integration therapy for attention deficit hyperactivity disorder (ADHD). Series 2001: intervention. Clayton, Victoria, Australia: Centre for Clinical Effectiveness (Evidence Centre Critical Appraisal); 2001 Mar. Accessed December 15, 2008. Available at URL address: <http://www.mihsr.monash.org/cce/res/pdf/b/597.pdf>
18. Hoehn TP, Baumeister AA. A critique of the application of sensory integration therapy to children with learning disabilities. J Learn Disabil. 1994 Jun-Jul;27(6):338-50.
19. Leemrijse C, Meijer OG, Vermeer A, Ader HJ, Diemel S. The efficacy of Le Bon Depart and Sensory Integration treatment for children with developmental coordination disorder: a randomized study with six single cases. Clin Rehabil. 2000 Jun;14(3):247-59.
20. Lilienfeld SO. Scientifically unsupported and supported interventions for childhood psychopathology: a summary. Pediatrics. 2005 Mar;115(3):761-4.
21. Michaud LJ; Committee on Children With Disabilities. Prescribing therapy services for children with motor disabilities. Pediatrics [serial online]. 2004 Jun;113(6):1836-8. American Academy of Pediatrics (AAP) Policy. Accessed: December 15, 2008. Available at URL address:  
<http://aappolicy.aappublications.org/cgi/content/full/pediatrics;113/6/1836>
22. Miller LJ, Coll JR, Schoen SA. A randomized controlled pilot study of the effectiveness of occupational therapy for children with sensory modulation disorder. Am J Occup Ther. 2007 Mar-Apr;61(2):228-38.
23. Mudford OC, Cross BA, Breen S, Cullen C, Reeves D, Gould J, et al. Auditory integration training for children with autism: no behavioral benefits detected. Am J Ment Retard. 2000 Mar;105(2):118-29.
24. National Academy of Sciences (NAS). National Research Council, Division of Behavioral and Social Sciences and Education. Committee on Educational Interventions for Children with Autism. Educating children with autism. 2001. Accessed December 15, 2008. Available at URL address:  
<http://newton.nap.edu/catalog/10017.html#toc>
25. Parham LD, Cohn ES, Spitzer S, Koomar JA, Miller LJ, Burke JP, et al. Fidelity in sensory integration intervention research. Am J Occup Ther. 2007 Mar-Apr;61(2):216-27.
26. Schaaf RC, Miller LJ. Occupational therapy using a sensory integrative approach for children with developmental disabilities. Ment Retard Dev Disabil Res Rev. 2005;11(2):143-8.
27. Shaw, SR. National Association of School Psychologists (NASP). NASP Communiqué, Vol. 31, #2. A School Psychologist Investigates Sensory Integration Therapies: Promise, Possibility and the Art of Placebo. October, 2002.
28. Sinha Y, Silove N, Wheeler D, Williams K. Auditory integration training and other sound therapies for autism spectrum disorders. Cochrane Database Syst Rev. 2004;(1):CD003681.
29. Sinha Y, Silove N, Wheeler D, Williams K. Auditory integration training and other sound therapies for autism spectrum disorders: a systematic review. Arch Dis Child. 2006 Dec;91(12):1018-22.

30. Smith SA, Press B, Koenig KP, Kinnealey M. Effects of sensory integration intervention on self-stimulating and self-injurious behaviors. *Am J Occup Ther.* 2005 Jul-Aug;59(4):418-25.
31. Tochel C. Sensory or auditory integration therapy for children with autistic spectrum disorders. In Bazian Ltd (Ed) STEER: Succinct and Timely Evaluated Evidence Reviews 2003; 3(17). Wessex Institute for Health Research & Development, University of Southampton and Bazian Ltd. Accessed January 8, 2009. Available at URL address: <http://www.signpoststeer.org/>
32. Vargas S, Camilli G. A meta-analysis of research on sensory integration treatment. *Am J Occup Ther.* 1999 Mar-Apr;53(2):189-98.
33. Watling RL, Dietz J. Immediate effect of Ayres's sensory integration-based occupational therapy intervention on children with autism spectrum disorders. *Am J Occup Ther.* 2007 Sep-Oct;61(5):574-83.
34. Weber W, Newmark S. Complementary and alternative medical therapies for attention-deficit/hyperactivity disorder and autism. *Pediatr Clin North Am.* 2007 Dec;54(6):983-1006; xii.

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## Policy History

<b>Pre-Merger Organizations</b>	<b>Last Review Date</b>	<b>Policy Number</b>	<b>Title</b>
CIGNA HealthCare	2/15/2008	0283	Sensory and Auditory Integration Therapy – Facilitated Communication
Great-West Healthcare	6/21/2007	07.352.01	Sensory Integration Therapy

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Connecticut General Life Insurance Company has acquired the business of Great-West Healthcare from Great-West Life & Annuity Insurance Company (GWLA). Certain products continue to be provided by GWLA (Life, Accident and Disability, and Excess Loss). GWLA is not licensed to do business in New York. In New York, these products are sold by GWLA’s subsidiary, First Great-West Life & Annuity Insurance Company, White Plains, N.Y.