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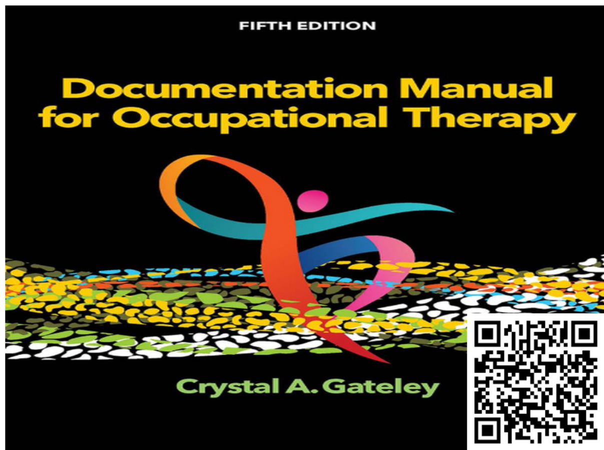

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FIFTH EDITION

Documentation Manual for Occupational Therapy

Crystal A. Gateley

SLACK Incorporated

FIFTH EDITION

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Documentation Manual for Occupational Therapy

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Dr. Crystal A. Gateley *reported no financial or proprietary interest in the materials presented herein.*

Sherry Borcherding authored the First and Second Editions and coauthored the Third and Fourth Editions.

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Dedication

This book is dedicated to all my past, current, and future occupational therapy students
who make teaching a wonderful and rewarding experience
and to my family who makes life worth living.

—Crystal A. Gateley, PhD, OTR/L

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—Crystal A. Gateley, PhD, OTR/L

About the Author

Crystal A. Gateley, PhD, OTR/L is Associate Chair and Teaching Professor at the University of Missouri, Department of Occupational Therapy, where she has been a full-time faculty member since 2009. She serves as Program Director for the Entry-Level Occupational Therapy Doctorate (OTD) program, providing oversight of curriculum revision and accreditation compliance. She also assists with new program development and the myriad of issues faced by a growing department. In addition to her administrative responsibilities, she teaches a variety of courses across the curriculum including Clinical Reasoning and Documentation, Foundations and Theory in Occupational Therapy, Conditions in Occupational Therapy, Psychosocial Aspects of Occupational Therapy, Emerging Trends in Occupational Therapy, Professional Seminar, Capstone Mentor Hour I and II, and Leadership, Management, and Policy. She also has taught interdisciplinary courses including Clinical Pathophysiology and Introduction to the Health Professions.

Crystal graduated Summa Cum Laude from the University of Missouri in 1995 with a Bachelor of Health Science in Occupational Therapy. She went on to complete a master's (2003) and doctorate (2015) in Educational Leadership and Policy Analysis with an Emphasis in Higher Education and Administration, also from the University of Missouri. Crystal has worked in a variety of occupational therapy practice settings throughout her career, including acute care, inpatient and outpatient rehabilitation, skilled nursing, home health, early intervention, outpatient pediatrics, public schools, and community programs for adults with developmental disabilities. She still provides occasional occupational therapy coverage at Boone Health in Columbia, Missouri, on weekends and holidays, and her experiences there with patients and interprofessional colleagues inform her teaching as she passes along insights from contemporary occupational therapy practice to her students.

Beyond her love for college teaching and occupational therapy practice, Crystal enjoys spending time with friends and family in outdoor activities including hiking, camping, fishing, canoeing, and rafting along various Missouri rivers. She is an avid football fan, and she is still basking in the glory of the Kansas City Chiefs' Super Bowl victories in 2020 and 2023! She currently lives in rural Holts Summit, Missouri, with her husband Curt, her parents, and her two cats, Cora and Loki. Crystal treasures the occasional phone calls and visits from her two daughters, Katrina and Lauren, who are pursuing their dreams in Connecticut and Tennessee.

Chapter 1

Documenting the Occupational Therapy Process

Welcome to a new style of writing. The first time you see an experienced occupational therapist make an entry in a health record, you may think you will never be able to do it with such ease. The technical language alone can be intimidating. Then there is the amazing attention to detail in the client observation, the insightful assessment, and the plan that just seems to roll off the therapist's fingertips while you are wondering how long it will take you to predict a course of treatment like that.

Professional documentation is a skill, and like any skill, you can learn it and eventually master it. Learning a new skill requires two things: instruction and practice. I have designed this book to provide you with both parts of the process. I introduce information about each part of the documentation process, and I present worksheets to let you practice each step as you learn it.

The material presented here emerged from a course on clinical documentation taught to occupational therapy students at the University of Missouri. With each new edition, I rely on my students for suggestions to ensure the information I present is understandable and effective in helping you learn both documentation and the professional reasoning skills underlying the documentation process.

Occupational therapy practitioners use different formats for documentation depending on their practice settings. This manual introduces specific formats for writing occupation-based problem statements and goals. In addition, the manual presents a systematic approach to one form of documentation: the SOAP note. SOAP is an acronym for the four parts of an entry into a health record. The letters stand for *Subjective, Objective, Assessment,* and *Plan*. Although not all practice settings use the SOAP note format, the professional reasoning skills underlying SOAP note documentation can be adapted to nearly any occupational therapy practice setting. Additionally, although narrative note writing has become much less common with the evolution of electronic health records, many documentation software products still use a SOAP structure to organize information into electronic flowsheets.

Our Evolving Profession

The American Occupational Therapy Association (AOTA) represents the interests and concerns of occupational therapy practitioners and students in all aspects of professional practice, including provision of quality services, improvement of consumer access to services, promotion of professional development, education of the public, and advancement of the profession (AOTA, 2021). AOTA publishes mission and vision statements that help guide the profession (see text box for details). AOTA updates these statements every few years to reflect contemporary practice.

Gateley, C. A. *Documentation Manual for Occupational Therapy, Fifth Edition* (pp. 1-6).
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Mission and Vision Statements of the American Occupational Therapy Association

Mission Statement: "To advance occupational therapy practice, education, and research through standard setting and advocacy on behalf of its members, the profession, and the public." (AOTA, 2021, para. 6)

Vision 2025: "As an inclusive profession, occupational therapy maximizes health, well-being, and quality of life for all people, populations, and communities through effective solutions that facilitate participation in everyday living." (AOTA, 2021, para. 7)

These statements serve as a roadmap for all aspects of professional practice, including documentation. Current occupational therapy practice is in many ways determined by which services are reimbursable, and documentation of client care is the vehicle through which we communicate those services. As the profession continues to move toward evidence-based practice in a context where payer sources are rewarding service quality over service quantity, occupational therapy is well poised to be a leader in the health care arena. "There is compelling evidence that occupational therapy provides cost-effective interventions that address many of the U.S. health care system's greatest needs" (Hart & Parsons, 2015, p. 1). In fact, one recent study found that occupational therapy services are associated with a significant reduction in hospital readmissions for particular diagnoses including heart failure, pneumonia, and myocardial infarction (Rogers et al., 2016). Researchers based that study in part on the occupational therapy documentation included in patients' Medicare claims, again highlighting the importance of what and how we communicate about the services we provide to our clients.

Occupational therapy practitioners must combine the ever-changing knowledge base of the profession with its historical foundations and this visionary roadmap for the future. Leaders in the profession have identified four principles to guide contemporary occupational therapy practice (Boyt Schell et al., 2019, p. 64):

1. Client-centered practice
2. Occupation-centered practice
3. Evidence-based practice
4. Culturally relevant practice

Our Evolving Professional Language

Although various health care professions share a common language in terms of diagnoses and procedures, each profession has its own specific language that explains its unique role in addressing a client's health care needs, typically found in some sort of official documents. This section will review the most important documents that guide occupational therapy documentation.

Occupational Therapy Practice Framework: Domain and Process, Fourth Edition

Several decades ago, leaders in our profession recognized the need for a system of uniform terminology. The original document, *Occupational Therapy Product Output Reporting System and Uniform Terminology for Reporting Occupational Therapy Services*, was developed in 1979 in response to a change in public laws targeted at reducing fraud and abuse of the Medicare and Medicaid systems (AOTA, 1989). That original document evolved into the *Occupational Therapy Practice Framework: Domain and Process* (AOTA, 2002). AOTA revises the *Occupational Therapy Practice Framework* approximately every 5 to 6 years.

At the time of this writing, the most recent version is the *Occupational Therapy Practice Framework: Domain and Process, Fourth Edition*, hereafter referred to as *OTPF-4* (AOTA, 2020). If you are reading this textbook in 2026 or beyond, I encourage you to explore the AOTA website to determine if an *OTPF-5* has been published and to familiarize yourself with minor changes. The *American Journal of Occupational Therapy* publishes each revision of the document, and this journal is readily available to AOTA members. You also may be able to access the journal online through your academic library. I am writing this section with the assumption that most readers will already be somewhat familiar with the *OTPF-4* before encountering this documentation textbook. Therefore, the summary that follows is very brief.

The *OTPF-4* "describes the central concepts that ground occupational therapy practice and provides a common understanding of the basic tenets and vision of the profession" (AOTA, 2020, p. 4). The authors emphasize that the document builds on values established by the profession's founders back in 1917. The *OTPF-4* is divided into two major sections, which "are linked inextricably in a transactional relationship" (AOTA, 2020, p. 6):

1. *Domain*: This section of the document outlines the purview of occupational therapy practice and identifies the areas in which occupational therapy practitioners have knowledge and expertise.
2. *Process*: This section focuses on the delivery of occupational therapy services, with an emphasis on occupation-based and client-centered practices.

Domain of Occupational Therapy

The aspects of occupational therapy's domain have a dynamic and transactional relationship. "All aspects are of equal value and together interact to affect occupational identity, health, well-being, and participation in life" (AOTA, 2020, p. 6).

- *Occupations*: In the *OTPF-4*, the term *occupation* refers to "personalized and meaningful engagement in daily life events by a specific client" (AOTA, 2020, p. 7). Activities are actions not related to a specific client or context but may be used as interventions to enhance occupational engagement. Occupations include:
  - Activities of daily living (ADLs)
  - Instrumental activities of daily living (IADLs)
  - Health management
  - Rest and sleep
  - Education
  - Work
  - Play
  - Leisure
  - Social participation
- *Contexts*: Context refers to the environmental factors and personal factors that influence occupational performance.
- *Performance Patterns*: "Performance patterns are the acquired habits, routines, roles, and rituals used in the process of engaging consistently in occupations and can support or hinder occupational performance" (AOTA, 2020, p. 12).
- *Performance Skills*: Performance skills include the motor skills, process skills, and social interaction skills that clients use to engage in activities and occupations.
- *Client Factors*: Client factors are the "specific capacities, characteristics, or beliefs that reside within the person, group, or population and influence performance in occupation" and include values, beliefs, and spirituality; body functions; and body structures (AOTA, 2020, p. 15).

Process of Occupational Therapy Service Delivery

The occupational therapy process is "facilitated by the distinct perspective of occupational therapy practitioners engaging in professional reasoning, analyzing occupations and activities, and collaborating with clients" (AOTA, 2020, p. 17). Service delivery does not occur in a linear fashion. It is a dynamic and fluid process that allows occupational therapy practitioners to focus on identified outcomes while continually reflecting on and accommodating new developments and insights throughout the service delivery process. Accurate and effective documentation during all phases of service delivery is essential to communicate the necessity and benefit of occupational therapy to all involved parties. The process of occupational therapy service delivery involves (AOTA, 2020):

- **Evaluation**
  - *Occupational Profile*: The occupational therapist summarizes information related to the client's occupational history, experiences, daily living patterns, interests, values, needs, contexts, and reasons for seeking services.
  - *Analysis of Occupational Performance*: After obtaining a thorough occupational profile, the occupational therapist identifies the client's assets, limitations, and potential problems through observation and assessment of the client's performance.
  - *Synthesis of Evaluation Process*: The occupational therapist interprets the information gathered from the occupational profile and the analysis of occupational performance to determine priorities for intervention and outcomes, working collaboratively with the client to create goals.
- **Intervention**
  - *Intervention Plan*: "The occupational therapy practitioner integrates information from the evaluation with theory, practice models, frames of reference, and research evidence" to develop an action plan for addressing targeted goals and outcomes in collaboration with the client (AOTA, 2020, p. 24).
  - *Intervention Implementation*: The occupational therapy practitioner implements the action plan and continually monitors the client's response to interventions, which may include therapeutic use of occupations and activities, interventions to support occupations, education, training, advocacy, self-advocacy, group intervention, or virtual intervention.
  - *Intervention Review*: The occupational therapy practitioner reviews the effectiveness of the intervention plan and the client's progress toward targeted goals and outcomes.
- **Outcomes**
  - *Selecting Outcome Measures*: The occupational therapist selects valid, reliable methods to measure any of the following targeted outcomes: occupational performance, prevention, health and wellness, quality of life, participation, role competence, well-being, or occupational justice (AOTA, 2020).
  - *Measuring Progress and Adjusting Goals and Interventions*: Throughout the occupational therapy process, the practitioner uses the selected outcome measures to monitor progress, update goals, modify interventions, and plan for transition and/or discontinuation of occupational therapy services.

Other Publications of the American Occupational Therapy Association

The content of this book reflects the domain and process of contemporary occupational therapy practice as described in the *OTPF-4*. The *OTPF-4* is just one of many *Official Documents* published by AOTA that influence occupational therapy practice and therefore documentation. *Official Documents* are divided into the following types (AOTA, 2019):

- *Guidelines*: Guidelines provide descriptions, examples, or recommendations of procedures pertaining to occupational therapy practice or education.
- *Position Papers*: Position papers present AOTA's official stance on a particular issue or subject.
- *Standards*: Standards include a general description of a topic relevant to occupational therapy practice and define the minimum requirements for performance and quality.
- *Statements*: Statements describe and clarify an aspect or issue relevant to occupational therapy practice or education. Although they do not present an official stance like position papers, statements link to fundamental concepts of occupational therapy.
- *Societal Statements*: Societal statements are typically written as a public announcement that identifies a societal issue of concern to individuals, groups, or communities and may offer recommendations of action to be taken.

Each AOTA *Official Document* undergoes review approximately every 5 years (AOTA, 2019). This book incorporates information from the most recent documents available at the time of writing that are relevant to occupational therapy documentation. Practitioners should remain informed about revisions that affect practice and documentation. Updated documents are approved by AOTA's Representative Assembly and published in the *American Journal of Occupational Therapy*. All *Official Documents* are also available on the AOTA website (https://www.aota.org).

The Accreditation Council for Occupational Therapy Education (ACOTE) publishes accreditation standards for educational programs at the levels of associate and baccalaureate degrees for the occupational therapy assistant and master's and doctoral degrees for the occupational therapist. This book is a tool for becoming competent in the documentation skills specified in the accreditation standards. There are minor wording differences between standards for the different educational levels, particularly regarding role differences between occupational therapists and occupational therapy assistants. Like AOTA's routine revision of *Official Documents*, ACOTE updates its standards periodically, and students and educators should ensure they are working toward meeting the most current standards. This book addresses ACOTE standards related to documentation, reporting data, reimbursement, and electronic documentation systems.

In summary, numerous documents and publications affect the occupational therapy profession as a whole and professional documentation in particular. Each occupational therapy practitioner has a responsibility to be familiar with current literature, standards, and state and federal regulations that affect documentation. Leaders in the profession are continually researching and publishing both revised and novel works that affect occupational therapy practice. Staying current with all professional publications allows occupational therapy practitioners to engage in evidence-based practice, and this must be reflected in your documentation.

Overview

This book arranges information in the order most easily learned by students or new practitioners, with foundational concepts presented first. More complex concepts build on these foundational concepts as professional reasoning is developed. Below is a very brief description of each of the following chapters.

- Chapter 2 provides an overview of the health record including its function, uses, and history.
- Chapter 3 reviews reimbursement, coding, and billing guidelines that impact occupational therapy practice and documentation.
- Chapter 4 reviews legal, regulatory, and ethical considerations that influence occupational therapy practice and documentation.
- Chapter 5 presents the rules and mechanics that guide occupational therapy documentation.
- Chapter 6 discusses the process of developing functional problem statements that can be addressed through occupational therapy intervention.
- Chapter 7 introduces the COAST format for writing occupational therapy goals, a format that has been endorsed by AOTA (Amini, 2016; Sames, 2015).
- Chapter 8 explains the Subjective portion of the SOAP note format.
- Chapter 9 reviews the Objective portion of the SOAP note format.
- Chapter 10 covers the Assessment portion of the SOAP note format.
- Chapter 11 discusses the Plan portion of the SOAP note format.
- Chapter 12 introduces the intervention planning process.
- Chapter 13 discusses documentation requirements in different practice settings.
- Chapter 14 reviews how the professional reasoning underlying SOAP notes can translate into the use of electronic documentation software.
- Chapter 15 discusses requirements specific to various settings and funding sources and provides related examples from numerous practice settings and client populations. This chapter has its own Table of Contents for ease of locating each note.
- The Appendix provides suggestions for completing the worksheets found throughout this book. You will learn the most from attempting the worksheets on your own before comparing them with the suggested responses in the Appendix. Remember also that there are multiple "correct" ways to document, and the suggested responses are simply one example to help you learn.

New in This Edition

This edition of *Documentation Manual for Occupational Therapy* is based on the *OTPF-4* (AOTA, 2020) and on the *Guidelines for Documentation of Occupational Therapy* (AOTA, 2018). Information regarding reimbursement, coding, and billing has been expanded significantly in a separate chapter with an emphasis on recent Medicare changes, specifically the use of Section GG in post-acute practice settings. The use of symbols commonly used in written documentation has been eliminated to reflect the predominant use of electronic documentation in health care. Examples have been updated and added throughout the book to reflect contemporary practice across a variety of occupational therapy practice settings. Several tables have been added throughout the book to improve readability and highlight important concepts.

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Chapter 2

The Health Record

The health record, often called the *medical record*, is a compilation of data that includes the client's past and present health information. The purpose of the health record is to serve as the medical and legal document of a client's history, current condition and status, the intervention provided, and the client's response to intervention (Kettenbach & Schlomer, 2016; Quinn & Gordon, 2016; Sullivan, 2019; Sutton, 2015). Like many aspects of health care, the health record is continuously undergoing changes. Before moving on to the specific processes involved in documenting occupational therapy practice, it is important to understand the history of health records in general and the implications for occupational therapy documentation. This chapter provides a brief history of health records in general, a history and overview of SOAP notes, a very brief overview of other documentation formats, and a discussion of the many audiences and functions of the health record.

History of Health Records

The recording of patient information can be traced back through antiquity from the cave paintings and stone carvings of prehistoric times to Egyptian surgical case reports documented on papyrus (Gillum, 2013; Synapse Medical, 2019). As civilizations developed, people transitioned to pen and paper for recording events. In the 1700s, businesses in the United States, including banks, stores, and eventually hospitals, used ledgers to record information. Benjamin Franklin, secretary of one of the first incorporated hospitals in Pennsylvania in the mid-1700s, kept records of clients' names, addresses, disorders, and dates of admission and discharge (Gensel, 2005; University of Pennsylvania, 2015). With the establishment of major teaching hospitals across the United States, more formal medical records were developed (Gillum, 2013). As medicine has advanced, so has the complexity and detail of the record. An entire profession, now called *health information management*, emerged to oversee the collection, classification, storage, retrieval, and dissemination of health records (American Health Information Management Association [AHIMA], 2021).

The use of computers to support health records management began in the late 1960s (Gillum, 2013). Over the past several decades, the use of electronic health records (EHRs) or electronic medical records (EMRs) has transitioned from the exception to the rule in many health care settings (Kettenbach & Schlomer, 2016; Quinn & Gordon, 2016; Sullivan, 2019). Garrett and Seidman (2011) explained a critical difference between EMRs and EHRs. **EMRs contain medical and treatment information for a patient at a single location.** In contrast, "EHRs focus on the total health of the patient—going beyond standard clinical data collected in the provider's office and inclusive of a broader

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view on a patient's care" (Garrett & Seidman, 2011, para. 6). Rather than being restricted to a single practice, **EHRs are designed to share information across many providers and locations**, including laboratories and specialists, so that all clinicians involved in the patient's care have quick and easy access to the information about the individual's history and current condition. The use of EHRs has the potential to streamline and improve the overall quality of client care, increase efficiency of health practitioners, and reduce health care costs (Office of the National Coordinator for Health Information Technology, 2019).

"Whether paper-based or electronic, the health record is the link connecting all of health care" (Smith, 2016, p. 3). In addition to the clinical information documented by providers, health records also contain an administrative section including demographic information, payment source, account number, patient identification number, referral information, consent to release information, acknowledgment of patient rights and privacy notices, and advance directives (Kettenbach & Schlomer, 2016). Depending on the setting, occupational therapy practitioners may be responsible for gathering some of this information.

History of the SOAP Note

EHRs allow members of a client's health care team to access information with a few simple clicks of the mouse. While many health care organizations have moved fully or partially to EHRs, printed health records are still in use in many settings and are the default back-up plan when EHRs experience technological glitches. Printed health records typically are organized in one of the following methods (Clark, 2004):

- *Source-oriented*: Documents are grouped together by the source from which they came (e.g., laboratory results, radiology results, physician notes, nursing notes, therapy notes).
- *Integrated*: Documents from various sources are entered in chronological or reverse chronological order.
- *Problem-oriented*: Documents are organized according to the client's problem list.

Each of these formats has its advantages and disadvantages. However, the problem-oriented medical record (POMR) is the basis for the SOAP note format presented in this manual. Dr. Lawrence Weed introduced the POMR in the late 1960s to standardize physician and nursing documentation (Aronson, 2019; Weed, 1968). Weed believed that the POMR format offered a more client-centered approach by focusing on the client's problems and the progress made toward solving those problems. As part of the more client-centered approach to documentation, Weed recommended organizing the progress note into four sections, including the client's own perception of the situation, which previously had been considered irrelevant. He used the acronym SOAP to define the four sections (Podder et al., 2020; Weed, 1968):

- *S—Subjective*: This section includes the **client's report** of their problems, limitations, and needs as well as the client's perception of treatment and progress. Typically, the Subjective section of the progress note is brief. However, in an initial evaluation report, the "S" might be longer since it will include the information obtained in the initial interview for the client's occupational profile.
- *O—Objective*: This section contains the health professional's **observation** of the client's performance and the treatment provided. In an initial evaluation note, this section also includes all of the measurable, quantifiable, and observable data that were collected.
- *A—Assessment*: This section is the health professional's **analysis and interpretation** of the events reported in the Subjective and Objective sections. This section shows the practitioner's professional reasoning. An initial evaluation contains the functional problem list and the client's rehabilitation potential. Subsequent progress notes will focus on one or more problems from that list as well as the progress made and rehabilitation potential.
- *P—Plan*: This section is the health professional's plan of **what to do next**, and it includes the anticipated frequency and duration of services. An initial evaluation includes a detailed intervention plan. Subsequent progress notes specify the planned focus for future sessions with the client. This section may also include plans to refer the client to other disciplines when appropriate.

SOAP notes help standardize documentation among physicians as well as nurses, pharmacists, psychologists, therapists, and many other health care professionals (Hovey, 2019; Quinn & Gordon, 2016). In fact, SOAP notes have been described as "the most common method of documentation used by providers to input notes into patients' medical records" (CareCloud, 2021, para. 2). Many EHRs are built around the SOAP note concept and contain options for data entry in a SOAP note format. "A major advantage of the SOAP format is its widespread acceptance and the resulting familiarity with the format. … It emphasizes clear, complete, and well-organized reporting of findings with a natural progression from data collection to assessment to plan" (Quinn & Gordon, 2016, p. 11).

Table 2-1

Components of Different Note Formats

DART		FOCUS	
D	Data observed and reported	Focus of the concern	
A	Action taken	Data	
R	Response of the client	Action	
T	Teaching given	Response	
PIE		**SBAR**	
P	Problem observed and reported	S	Situation observed or reported
I	Interventions taken	B	Background information
E	Evaluation of the client's response	A	Assessment
		R	Recommendation
SOAPIE		**SOAPIER**	
S	Subjective	S	Subjective
O	Objective	O	Objective
A	Assessment	A	Assessment
P	Plan	P	Plan
I	Implementation of interventions	I	Implementation of interventions
E	Evaluation of outcomes	E	Evaluation of outcomes
		R	Revision

Data source: Rebar, 2009.

It is important to remember that SOAP is just a format—an outline for organizing information. Any note can be written in this format, although the SOAP format works better for some types of notes than others. An initial assessment can be quite lengthy when written in the SOAP format because it will contain an occupational profile, prior level of functioning, a summary of functional problems, and the detailed intervention plan including long- and short-term goals. For this reason, many practice settings do not use the SOAP format for the initial evaluation report, but the facility may use the SOAP format for treatment and progress notes.

The SOAP format is an alternative to narrative notes, which tend to be disorganized and subjective. It forces the writer to look at all four aspects of the therapy session and to present the information in an orderly fashion. Learning the SOAP format is an excellent way for students and practitioners to develop the professional reasoning process that underlies therapeutic intervention. Practitioners who learn to use the SOAP format will be able to adapt their documentation skills to nearly any practice setting as well as to EHRs. A more detailed explanation of each section of the SOAP note is provided in Chapters 8 through 11.

Other Formats for Notes

SOAP notes are only one method for writing notes. Although very common for occupational therapy practitioners, you may encounter other note formats, particularly in inpatient hospital settings. Rebar (2009) described several alternative formats for clinical documentation including DART, FOCUS, PIE, SBAR, SOAPIE, and SOAPIER. Although it is beyond the scope of this textbook to provide in-depth examples of each of these formats, it is important to understand how practitioners organize information in each format. Table 2-1 lists the components of each format.

Purposes of Client Care Documentation

The primary and obvious purpose of the health record is to document a client's health information for future reference. Documentation is the evidence that occupational therapy practitioners create to prove that a client or caregiver interaction occurred (Quinn & Gordon, 2016; Sames, 2015). It is important to consider the many potential audiences and functions of the health record whenever you make an entry into a client's record.

Client Care Management

The health record is one of the ways the treatment team communicates with each other about the day-to-day aspects of the client's care. Other occupational therapy practitioners and members of the interprofessional treatment team will read your notes to coordinate care (Quinn & Gordon, 2016; Sames, 2015). In your notes, you share the results of your evaluation, report the client's progress toward established goals, and advise other members of the team of your plan for continuing care, all of which are important to the treatment team. Good documentation is particularly important in ensuring continuity of care within and between settings as a single client may encounter multiple occupational therapy practitioners during the intervention process.

Reimbursement

The health record is the source for which services were provided and which services may be billed. Third-party payers such as Medicare, Medicaid, and private insurance companies may review documentation, not only for frequency and duration, but also to determine if the services provided to the client are worth paying for. Documentation in the health record is the primary means of justifying reimbursement for intervention (Combs, 2020; Quinn & Gordon, 2016; Sames, 2015). In all settings, but particularly outpatient settings where services typically are billed on a fee-for-service model, occupational therapy practitioners must ensure that their documentation about the treatment session justifies the billing codes that were used for the client's visit (Fusion Web Clinic, 2022). Documentation that is inaccurate or poorly written may be used by reimbursement sources to deny payment for occupational therapy services (Sames, 2015).

Utilization Review and Utilization Management

The health record may be used for determining whether services provided to a client are appropriate, medically necessary, and efficient according to the policies and procedures established by federal and state regulatory agencies. Duchinsky (2016) explained the distinction between *utilization review* and *utilization management*, two terms that often are used interchangeably but have different processes and meanings. Utilization review is a review of the health record that occurs **after** services have been provided to a client and "safeguards against unnecessary and inappropriate medical care" (Duchinsky, 2016, para. 2).

In contrast, utilization management involves the proactive processes that take place **before and during** a client's provision of health services. These processes may include discharge planning or precertification for an acute care or rehabilitation unit stay. For example, in acute care settings, physicians, social workers, and case managers rely heavily on the recommendations of occupational and physical therapy practitioners to determine whether a patient is safe to discharge home or needs continued therapy services via home health, inpatient rehabilitation, or skilled nursing facility. Utilization management "ensures healthcare systems continuously improve and deliver appropriate levels of care, reducing the risk of cases that need review for inappropriate or unnecessary care" (Duchinsky, 2016, para. 3).

The goals of both utilization review and utilization management are to ensure compliance of health care providers and organizations to regulatory standards and to use a client's funds for health care in the most cost-effective manner. In either situation, documentation of occupational therapy services may help determine whether a client's admission and continued treatment are necessary and appropriate.

The Legal System

The health record is a legal document that substantiates what occurred during a client's illness and treatment. Any entries made in the health record, whether in print or electronic format, become a part of that legal document and may be subpoenaed (Kettenbach & Schlomer, 2016; Quinn & Gordon, 2016; Sames, 2015). If you as an occupational therapy practitioner have to appear in court to testify, it will be helpful if your documentation is clear, accurate, and thorough. Court cases often occur years after the event or intervention that is being contested (Sames, 2015). You may not even remember the event or the client. What you have written in the health record will provide you with the information you need to testify. However, Scott (2013) explained that "despite its broad range of variegated uses as a legal instrument, healthcare recordkeeping … should not be carried out with a defensive legal focus. Rather, the creation of patient care records should be guided primarily by patient welfare-oriented healthcare principles" (p. 94).

Quality Improvement

Quality improvement, often referred to as QI, is a framework for improving the quality of health care delivery by measuring and analyzing various processes within a health care system, identifying areas for improvement, and implementing new strategies to address those issues (Agency for Healthcare Research and Quality [AHRQ], 2013). "In the United States there has been an evolution from quality assurance, where the emphasis was on inspection and punishment for medical errors (the 'bad apple' theory) to QI, where we ask, 'How did the system fail to support the worker involved in an error?'" (AHRQ, 2013, para. 2).

The health record is one of the primary sources of information used in the quality improvement process. An example of a quality improvement process is the review of occupational therapy documentation to determine whether practitioners were consistently documenting a client's pain level according to hospital policy, followed by the implementation of measures to increase the compliance with the hospital policy, such as a pop-up reminder in an EHR when a practitioner attempts to sign a note without documenting the patient's pain level. Another example of a quality improvement process is the review of client care records to determine whether specific standardized assessments were performed for particular populations according to departmental or facility policy and subsequent modifications to the electronic documentation flowsheet with more prominent cues as therapists document an evaluation.

Accreditation

Health care settings that bill Medicare and/or Medicaid for services must be accredited by a state survey agency or a national accreditation organization approved by the Centers for Medicare & Medicaid Services (CMS) to ensure compliance with applicable laws and regulations (CMS, 2021). Some health care facilities voluntarily seek accreditation from private entities to improve their professional reputation as a provider of quality health care. For example, The Joint Commission, the oldest and largest health care accreditation entity in the United States, accredits more than 22,000 health care organizations and programs (The Joint Commission, 2022a). The Joint Commission accredits hospitals, nursing care centers, home care agencies, ambulatory care clinics, laboratory services, and behavioral health care programs. The Joint Commission's mission is "to continuously improve health care for the public, in collaboration with other stakeholders, by evaluating health care organizations and inspiring them to excel in providing safe and effective care of the highest quality and value" (The Joint Commission, 2022b, para. 1). The Commission on Accreditation of Rehabilitation Facilities (CARF) is another accrediting agency that occupational therapy practitioners may encounter. Founded in 1966 in the United States, CARF International now accredits more than 62,000 programs and services worldwide in the areas of aging services, behavioral health, child and youth services, employment and community services, and medical rehabilitation (CARF International, 2022). Accreditation surveyors always rely heavily on the review of client health records during the accreditation survey of a facility.

Education and Research

The health record may be used as a teaching tool. Students in various health care professions use the health record to gain information about a client's medical history and current clinical condition. An occupational therapy or occupational therapy assistant student may review the health record to learn about quality occupational therapy interventions or to gain a better understanding of the roles and interventions of other members of the client's health care team.

The health record may also be used to provide data for research by a variety of individuals. Public health entities may use the health record to identify and document the incidence of certain medical conditions. In recent decades, there has been a demand for evidence-based practice in all health care professions, including occupational therapy, to improve client outcomes and reduce health care costs (Cullen, 2018). For example, researchers may collect and analyze data from the health record to improve methods of disease and injury prevention or to analyze client outcomes to determine efficacy of specific therapeutic interventions. Good documentation practices help ensure that credible and valid data are available to clinical researchers (Sames, 2015).

Business Development and Management

Management teams use the information contained in the health record to plan and market services provided by a facility. For example, are there enough referrals for outpatient occupational therapy driving evaluations to warrant the cost of purchasing expensive assessment equipment and providing specialized training for staff? Does the number of referrals for inpatient occupational therapy following total joint replacement justify the need for additional occupational therapy staffing on the orthopedic unit? Are there significant differences in discharge outcomes for clients who received daily occupational therapy sessions as opposed to a frequency of three to five times per week in the acute care setting? If so, a rehabilitation director may be able to justify a new occupational therapist or occupational therapy assistant position.

Health care records can also provide a productivity measure of occupational therapy practitioner workload and performance. Productivity is a measure of the amount of billable time in a practitioner's workday (Braveman, 2022). Although many practitioners cringe at the mention of productivity standards, "workload expectations and productivity measurement are legitimate management tools utilized to ensure appropriate staffing resources for service delivery as well as to maximize reimbursement, with the goal of achieving economic sustainability" (American Occupational Therapy Association [AOTA] Ethics Commission, 2019).

Client Access

Another significant user of the health record is the client. When you are documenting in the health record, always remember that the client owns the information and may choose to exercise the right to review or obtain a copy of the health record (U.S. Department of Health & Human Services [DHHS], 2020). As health care has evolved to a more client-centered, collaborative approach, encouraging and increasing client access to health records can improve clients' sense of control over their health and well-being. Clients who access their own health information "are better able to monitor chronic conditions, adhere to treatment plans, find and fix errors in their health records, track progress in wellness or disease management programs, and directly contribute their information to research" (U.S. DHHS, 2020, para. 1).

A recent trend in the United States is encouraging clients to use a personal health record (PHR), which is a way to organize and manage health information that may be scattered across various health care facilities and providers (Sarwal & Gupta, 2021). Unlike EHRs, PHRs are maintained and controlled by the client rather than the provider and may be kept in either written or electronic form. While providers still maintain a health record on each client, the PHR allows the individual to keep health information in an organized fashion for personal reference and for ease of communication with health care providers. A client may choose to include information in the PHR about occupational therapy services you have provided.

Advocacy

You may be able to use your documentation to advocate for a client. For example, perhaps a client needs a customized power wheelchair to meet positioning and mobility needs. Your documentation helps the payer understand why each feature of the wheelchair is medically necessary. Or perhaps you can use your documentation to convince a local charitable organization to fund home modifications for a client who otherwise would not be able to remain at home. On a larger scale, occupational therapy documentation may serve as a tool for advocating for our profession:

> Good documentation can help educate others, including other healthcare professionals, third party payers, and patients themselves, about the services that physical or occupational therapy can provide. Although the services may seem obvious to us, they are not so obvious to people outside our profession. (Kettenbach & Schlomer, 2016, p. 22)

A team of researchers recently discovered that higher hospital spending on occupational therapy services was associated with lower readmission rates (Rogers et al., 2016), prompting a call by AOTA for occupational therapy services to be utilized more in hospital settings (AOTA, 2017). That research was based in part on documentation by occupational therapy practitioners.

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Chapter 3

Reimbursement, Coding, and Billing

The previous chapter provided an overview of the various purposes and uses of the health record and the potential impacts on the documentation of occupational therapy practitioners. Some of those issues warrant further explanation and discussion. Because documentation is the primary means of justifying reimbursement for services (Moninger, 2021), it is important for occupational therapy practitioners to understand various reimbursement systems as well as the coding and billing systems that affect reimbursement. Reimbursement, coding, and billing issues vary considerably between practice settings, and occupational therapy practitioners work in diverse health care settings. This chapter will provide a general foundation of information to guide documentation, but practitioners will need to stay up to date on policy changes that affect occupational therapy documentation and reimbursement.

Sources of Reimbursement

Medicare

Medicare is a federal health insurance program managed by the Centers for Medicare & Medicaid Services (CMS; 2022d). Medicare helps pay the health care costs of people over age 65 years, people under age 65 years with certain disabilities, and people with end-stage renal disease. See Table 3-1 for a brief explanation of the four parts of Medicare benefits.

Some Medicare beneficiaries have a supplemental insurance policy from a previous employer to help cover the portion of costs that Medicare does not. Others choose to purchase Medigap, which is a supplemental policy sold by private insurance companies. Medigap policies may help cover deductibles, copayments, and coinsurance, although "Medigap plans sold to people new to Medicare [since January 1, 2020] can no longer cover the Part B deductible" (CMS, 2022g, para. 2).

People who are eligible for Medicare have a variety of options to consider when selecting their Medicare coverage. Each client you treat will have different benefits, co-pays, and deductibles depending on the coverage options they have selected. In many situations, your clients may have little to no understanding of their Medicare benefits. Occupational therapy services may be billed through Medicare Parts A, B, and C. Occupational therapy services covered under Medicare must be medically necessary and skilled (Kroll & Richman, 2018). *Medically necessary* means that services are consistent with accepted standards of practice for the client's condition. *Skilled* means that

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Table 3-1

Benefits Under Different Parts of Medicare

MEDICARE PART A	Inpatient care in hospitals and critical access hospitals, skilled nursing facilities (SNFs), home health care, and hospice.
MEDICARE PART B	Physicians' services and outpatient care, including occupational therapy; services in long-term care facilities when the client does not qualify for coverage under Part A; durable medical equipment (DME) and preventive services such as vaccines, screening, and wellness visits.
MEDICARE PART C	Private insurance companies contract with Medicare to provide individuals with their Part A, B, and D benefits through Medicare Advantage Plans rather than through Original Medicare. These plans function like health maintenance organizations (HMOs) or preferred provider organizations (PPOs) in which beneficiaries typically may see providers only in a particular network to have services covered. These plans may also include coverage for vision, hearing, and dental services that are not covered under Original Medicare.
MEDICARE PART D	Covers a portion of prescription drug costs.
Data source: Centers for Medicare & Medicaid Services, 2022d.	

the services provided require the decision making, clinical judgment, and highly complex competencies of an occupational therapist or occupational therapy assistant with a knowledge base of human functioning and occupational performance. *Nonskilled* services are those that are routine or maintenance types of therapy that could be carried out by nonprofessional personnel or caregivers.

Furthermore, occupational therapy services should result in documentable improvements within a reasonable and predictable time period based on contemporary practice standards. Documentation should "make the correlation between intervention and outcomes as explicit as possible" (Kroll & Richman, 2018, Slide 101). However, in 2013, the *Jimmo v. Sebelius* settlement agreement clarified that Medicare also covers skilled interventions that are intended to maintain function by slowing or preventing decline, so long as these services require the skill of a licensed practitioner (CMS, 2021a). In other words, coverage cannot be denied simply because an individual does not have the potential for improvement.

"The *Jimmo* Settlement Agreement clarified that when a beneficiary needs skilled nursing or therapy services under Medicare's skilled nursing facility (SNF), home health (HH), and outpatient therapy (OPT) benefits in order to maintain the patient's current condition or to prevent or slow decline or deterioration (provided all other coverage criteria are met), the Medicare program covers such services and coverage cannot be denied based on the absence of potential for improvement or restoration. … It does not matter whether such care is expected to improve or maintain the patient's clinical condition. In addition, although such maintenance coverage standards do not apply to services furnished in an inpatient rehabilitation facility (IRF) or a comprehensive outpatient rehabilitation facility (CORF), the *Jimmo* Settlement Agreement clarified that for services performed in the IRF setting, coverage should never be denied because a patient cannot be expected to achieve complete independence in the domain of self-care or because a patient cannot be expected to return to his or her prior level of functioning" (CMS, 2021a, para. 1).

Because Medicare regulations and guidelines are constantly changing, it is important that you stay abreast of current issues related to Medicare reimbursement for occupational therapy services. Several online resources are available to help you understand Medicare reimbursement:

- CMS website: https://www.cms.gov/
- Medicare website: https://www.medicare.gov/
- American Occupational Therapy Association (AOTA) website: https://www.aota.org/

The following sections will provide more detail about Medicare Parts A, B, and C, the three parts of Medicare that may serve as a source of reimbursement for occupational therapy services.

Medicare Part A

Medicare Part A has multiple reimbursement systems for providers and health care facilities. Although you may not be directly involved in billing and reimbursement processes, your occupational therapy documentation provides information about an individual's condition and performance, and you should have a general understanding of the reimbursement systems at your fieldwork site or place of employment (Healthinsurance.org, LLC, 2022). Here is a very brief overview of some of the most common reimbursement systems for Medicare Part A:

- *Fee-for-Service*: In this reimbursement model, health care providers are paid separately for each service provided (CMS, 2021f).
- *Prospective Payment Systems*: Under a Prospective Payment Systems model of reimbursement, Medicare payments are based on a predetermined fixed amount according to a patient's diagnosis-related group (CMS, 2021g).
- *Value-Based Bundled Payments*: Under this payment system, multiple entities and providers work together to manage each episode of care. For example, a hospital may team up with one or more physician groups, and collectively they are paid for the client's overall episode of care based on the client's outcomes. This model shifts incentives away from volume (more services provided = more money) to value (accountable use of resources and better client outcomes = more money; CMS, 2022f).
- *Patient Driven Payment Model (PDPM)*: This payment model for SNFs went into effect in late 2019. Prior to the implementation of PDPM, Medicare SNF payments were based in large part on the number of therapy minutes that each resident received. Thus, there was an incentive to provide high volumes of therapy to maximize payment (Net Health, 2022). Under PDPM, reimbursement is based on resident classifications and anticipated resource needs. "SNFs who over-deliver therapy won't get paid for services provided beyond the reimbursement level for each resident classification. But under-delivering therapy will lead to poor patient outcomes and potential Medicare audits and take-backs" (Net Health, 2022, para. 3).
- *Patient Driven Groupings Model (PDGM)*: Like PDPM, the PDGM model for home health services emphasizes "value over volume, eliminating therapy services thresholds as a reimbursement factor" (CareCentrix, Inc., 2020). Under PDGM, patients are classified into one of more than 400 case-mix groups based on the following factors (CMS, 2021c; Vontran & Gehne, 2019):
    - **Source of admission**: This is determined by whether the referral came from an institution (e.g., hospital, SNF, long-term care hospital, inpatient rehabilitation, inpatient psychiatric facility) or from the community (e.g., primary care physician).
    - **Clinical groupings**: The client's primary diagnosis is assigned to one of 12 clinical groups as the main reason for needing home health services. A few examples are neurorehabilitation, surgical aftercare, behavioral health, infectious disease, wound care, and respiratory conditions.
    - **Timing of episode of care**: Each 30-day period is classified as early or late. The first 30-day period of home health services is considered early. All subsequent 30-day periods are classified as late.
    - **Functional impairment level**: This level is classified as low, medium, or high based on client ability to complete grooming, dressing, bathing, toileting, transfers, and ambulation/locomotion and the risk for hospitalization.
    - **Comorbidities**: The comorbidity adjustment level of none, low, or high is based on the presence of secondary diagnoses. Multiple comorbidities are tied to more complex medical needs, poorer health outcomes, and higher costs.

Table 3-2

Tools for Documenting Patient Status in Post-Acute Care Settings

INPATIENT REHABILITATION FACILITY—PATIENT ASSESSMENT INSTRUMENT (IRF-PAI)	The IRF-PAI collects "patient assessment data for quality measure calculation and payment determination in accordance with the IRF Quality Reporting Program (QRP)" (CMS, 2022a, para. 4). The IRF-PAI is required for all patients in an IRF who have Medicare Part A or Part C.
LONG-TERM CARE HOSPITAL (LTCH) CONTINUITY ASSESSMENT RECORD AND EVALUATION (CARE) DATA SET	For simplification, CMS refers to this document as the LCDS. The LCDS is the instrument used to collect patient assessment information in LTCHs (CMS, 2022b).
LONG-TERM CARE MINIMUM DATA SET (MDS)	The MDS is the electronic document used for "clinical assessment of all residents in Medicare and Medicaid certified nursing homes," regardless of individual payment source for each resident, and "provides a comprehensive assessment of each resident's functional capabilities" (CMS, 2021e, para. 1; CMS, 2022b).
OUTCOME AND ASSESSMENT INFORMATION SET (OASIS)	This tool is used to collect information about Medicare beneficiaries receiving home health services. Home health providers use the OASIS to collect information about a client's health conditions, living arrangements, and level of functional performance (CMS, 2022e).

By now you probably have realized that Medicare has a lot of acronyms to describe various aspects of health care delivery, documentation, and reimbursement. See Table 3-2 for a list of other terms and acronyms that you may encounter if you work with Medicare Part A beneficiaries in post-acute settings, in other words, after the individual is discharged from an acute care hospital. Each of the documentation tools listed in Table 3-2 has a Section GG that assigns a numerical score to the client's performance on several specific tasks related to self-care and mobility (Strunk, 2019). See Tables 3-3 and 3-4 for a brief overview of these scores and the self-care categories that occupational therapy practitioners most often score. Please note that occupational therapy practitioners may also be involved in scoring the mobility items on Section GG and/or the cognitive items in other portions of the post-acute care documentation tools. It is beyond the scope of this book to provide an extensive overview for all these items. If you work or have fieldwork in a post-acute setting, you likely will be required to complete training and an annual certification examination.

Scores are collected at admission, a discharge goal is set, and then scores are collected again at the time of the client's discharge from the respective setting. At the time of this writing, all post-acute care settings are experiencing or anticipating payment reforms. Data from Section GG, which may be completed in whole or part by occupational therapy practitioners, may be used to determine reimbursement levels and incentives for quality care (Grote, 2022). Prior to the creation of Section GG, the various post-acute care settings

> … were collecting their own data with their own definitions and rating scales, which created a challenge in caring for patients when they were transferred from one setting to another. Section GG, which provides a universal language relative to functional ability, is expected to decrease variability, standardize communication and care across settings, and provide the basis for comparing patient types, outcomes, and costs. (Strunk, 2019, para. 5)

Table 3-3

Self-Care and Mobility Section GG Scores

ACTIVITY WAS PERFORMED, WITH OR WITHOUT ASSISTIVE DEVICES	
6—Independent	Activity is completed with **no assistance** from a helper, with or without adaptive equipment.
5—Set-Up or Clean-Up Assistance	Helper provides set-up **before** the activity and/or clean-up **after** the activity. The individual completes the activity without helper assistance **during** the activity. In other words, the helper can leave the room during the activity.
4—Supervision or Touching Assistance	Helper provides **verbal cues** and/or **touching/steadying** and/or **contact guard assist** as the individual completes the activity. Assistance may be intermittent or provided throughout the activity.
3—Partial/Moderate Assistance	Helper assists by lifting, holding, or supporting the trunk or limbs during the activity, but overall provides **less than half** of the total effort to complete the activity.
2—Substantial/Maximal Assistance	Helper assists by lifting, holding, or supporting the trunk or limbs during the activity, but overall provides **more than half** of the total effort to complete the activity.
1—Dependent	Helper performs **all** of the effort to complete the activity, and the individual exhibits **none** of the effort, or the assistance of **two or more helpers** is required for the individual to complete the activity.
ACTIVITY WAS NOT ATTEMPTED	
07—Individual Refused	Every effort should be made to encourage the individual to complete the activity during the assessment period, but if the **individual completely refuses**, this score would be entered for the activity.
09—Not Applicable	Activity is not something the client was able to complete before the current injury, illness, or exacerbation and is **not relevant for the client now**. Example: Client has bilateral lower extremity above the knee amputations and does not have prostheses, so putting on and taking off footwear would be not applicable. In another example, if a client did not eat or drink by mouth prior to this admission (i.e., received tube feedings or total parenteral nutrition), then eating by mouth would be not applicable.
10—Not Attempted Due to Environmental Limitations	Activity is something relevant for the client, but **contextual circumstances prevent assessment** of the client's performance. May include lack of equipment or weather conditions. Example: If a facility does not have a car simulator indoors, and it is too cold or icy to take the individual outdoors to assess performance of a car transfer, then the activity would not be attempted due to environmental limitations.

(continued)

Table 3-3 (continued)

Self-Care and Mobility Section GG Scores

ACTIVITY WAS PERFORMED, WITH OR WITHOUT ASSISTIVE DEVICES	
88—Not Attempted Due to Medical Condition or Safety Concerns	Activity is something relevant for the client, but assessing this activity is **not possible due to current medical status or would put the patient at risk**. Example: If the client currently does not eat or drink by mouth due to aspiration risk, but did eat and drink by mouth prior to the illness or event leading to this admission, then eating by mouth would be unsafe to attempt for this assessment.
Data source: American Occupational Therapy Association, 2022d.	

Table 3-4

Self-Care Section GG Items and Definitions

Eating	Bring food and/or liquid to the mouth using suitable utensils and swallowing, after meal is placed in front of person.
Oral Hygiene	Use of suitable utensils to clean teeth. If the individual has dentures, this item includes removal and insertion of dentures as well as the ability to manage materials required for soaking and rinsing.
Toilet Hygiene	Perineal hygiene and the adjustment of clothing before and after voiding or having a bowel movement. If the individual has an ostomy, this item includes wiping the opening, but **not** applying or removing the ostomy equipment.
Wash Upper Body	Wash, rinse, and dry the face, hands, chest, and arms while sitting in a chair or bed. (As of 2023, this item is reported only in LTCH setting.)
Shower/Bathe Self	Wash, rinse, and dry self. Does not include washing back or hair; also does not include tub or shower transfer. (As of 2023, this item is only reported in IRF, SNF, and home health settings.)
Upper Body Dressing	Dress and undress self above the waist, including applicable fasteners. May include bra, shirt, neck or back brace, abdominal binder, and any applicable upper extremity orthotic or prosthetic items.
Lower Body Dressing	Dress and undress self below the waist, including applicable fasteners. May include underwear, incontinence brief, shorts or pants, skirts, knee brace, stump shrinker or sock, and any applicable lower extremity prosthetic. This item does **not** include footwear.
Putting On/Taking Off Footwear	Put on and take off socks, shoes, or other footwear needed for safe mobility. This includes compression stockings, an ankle foot orthosis (AFO), orthopedic walking boot, or other foot orthotic.
Data sources: American Occupational Therapy Association, 2022d; Deutsch & Dass, 2019.	

Medicare Part B

Medicare Part B covers occupational therapy services in outpatient clinics and long-term care settings when an individual is not eligible for SNF level of care. "Medicare Part B (Medical Insurance) helps pay for medically necessary outpatient occupational therapy if your doctor or other health care provider certifies you need it" (CMS, 2022d, para. 1). Original Medicare beneficiaries typically have a monthly premium for this medical coverage and pay 20% of the Medicare-approved amount for occupational therapy services after meeting the Part B deductible. If the individual has an additional insurance supplement, that supplemental policy may cover the 20% that Medicare Part B does not cover. Medicare Advantage plans set their own rules regarding deductibles and coinsurance.

An important change since the last edition of this book is that Medicare no longer sets a "therapy cap" or monetary limit on the amount of outpatient occupational therapy services a patient can receive in one calendar year. However, if billed occupational therapy services exceed a particular threshold (e.g., $2230 for 2023), services must be billed with a particular code called a KX modifier (CMS, 2021d, 2023). Once a client's billed occupational therapy services exceed a targeted medical review threshold, currently set at $3000 through 2028, the claim may be selected for review (American Physical Therapy Association [APTA], 2022). "Factors used to select claims for review may include any of the following:

- The provider has had a high claims denial percentage for therapy services or is less compliant with applicable requirements.
- The provider has a pattern of billing for therapy services that is aberrant compared with peers, or otherwise has questionable billing practices for services, such as billing medically unlikely units of services within a single day.
- The provider is newly enrolled or has not previously furnished therapy services.
- The services are furnished to treat targeted types of medical conditions.
- The provider is part of a group that includes another provider identified by the above factors" (APTA, 2022, para. 9).

If future therapy services are not reasonable and necessary, or if the client is not expected to demonstrate significant functional improvement within a reasonable amount of time, the occupational therapist must provide the Medicare beneficiary with an Advanced Beneficiary Notice of Noncoverage (ABN). The ABN informs clients that services are not likely to be paid by Medicare so they can make decisions about whether they want to receive those services and pay for them out of pocket (AOTA, 2020a). Many clients think that just because a physician has ordered occupational therapy, Medicare will automatically cover those services. However, the responsibility lies with the occupational therapy practitioner to document the functional status and improvement of the client to prove medical necessity.

Medicare Part C

Medicare Part C plans, also known as *Medicare Advantage plans*, are offered by private Medicare-approved insurance companies, which administer the client's Parts A, B, and D benefits (CMS, 2022c). Although these private insurance companies must follow general rules set by Medicare, they establish their own rules about how clients access various health care services, including occupational therapy. For example, a Medicare Advantage plan can limit which facilities and providers are covered under the plan. In acute care settings, occupational therapy practitioners often are involved in making recommendations for a patient to go to a SNF or an inpatient rehabilitation facility (IRF). Under Original Medicare, patients can choose any SNF or IRF that will accept them. However, a Medicare Advantage plan may require additional preauthorization and may limit which facilities the patient goes to. People who enroll in Medicare Advantage plans "often give up the freedoms that come along with Original Medicare in exchange for the additional benefits" like dental and vision coverage (Elite Insurance Partners LLC, 2022, para. 9). Furthermore, insurance companies administering Medicare Advantage plans can set their own out-of-pocket costs such as deductibles and copayments.

Medicaid and Children's Health Insurance Plan

Medicaid is a health insurance program jointly funded by the federal government and each individual state (Benefits.gov, 2021). It covers individuals who have limited income and meet certain eligibility requirements. Medicaid is administered by each individual state. While all states must follow general federal guidelines, there is considerable variance between states in terms of which individuals are eligible for Medicaid and which services are covered. There may also be differences within a single state between services that are covered by Medicaid for adults versus children.

> While Medicaid serves both children and adults in low-income families, CHIP [Children's Health Insurance Plan] was created to help build upon Medicaid coverage for low-income children and does not provide additional coverage for adults. Medicaid programs are required to provide certain coverage by federal standards, while CHIP's coverage requirements are established by the individual states. (Benefits.gov, 2021, para. 3)

Occupational therapy practitioners must become familiar with Medicaid and CHIP documentation and reimbursement guidelines for the state in which they are practicing if these serve as sources for reimbursement in their practice settings.

Private Insurance

Private insurance coverage may be offered through an individual's employer or the employer of the individual's spouse, partner, or significant other. Individuals may also be covered through an insurance policy offered by a parent's employer, up through age 26 (U.S. Department of Health & Human Services, 2017). The cost of such plans often is subsidized by the employer. Individuals may also sign up for private health insurance coverage via the Health Insurance Marketplace at www.healthcare.gov. All insurance plans in the Marketplace must cover 10 essential health benefits (CMS, 2022h, para. 1):

1. Ambulatory patient services (outpatient care)
2. Emergency services
3. Hospitalization
4. Pregnancy, maternity, and newborn care
5. Mental health and substance use disorder services
6. Prescription drugs
7. Rehabilitative and habilitative services and devices
8. Laboratory services
9. Preventive and wellness services and chronic disease management
10. Pediatric services, including oral and vision care (however, adult dental and vision care are **not** classified as essential health benefits)

There are many different private insurance plans with varying coverage, and there may be specific requirements that must be followed for the insurance company to pay for health care services, including occupational therapy. These requirements may include seeking health care from only particular providers considered in-network, getting preauthorization or prior approval before seeing a health care provider, and limiting the number of visits per year to a particular type of provider. Many health care settings have individuals whose primary role is to deal with these insurance issues, but occupational therapy practitioners may have more direct involvement in the process in some settings. Documentation must meet the requirements of the individual practice setting, and there may be additional documentation required for a client's specific insurance plan. AOTA (2022a, para. 2) explained:

> For practitioners in the private practice/outpatient setting, private insurance reimbursement can be a significant portion of their practice revenue. Any change in benefit, coverage, or reimbursement policy for occupational therapy services by a commercial insurance company can have a profound impact on private practitioners and their clients.

Workers' Compensation

Workers' Compensation is a type of business insurance that covers "loss of income, medical expenses, and other related expenses when an employee is injured or develops a health condition related to their work environment" (AOTA, 2022c, para. 1). Each state has different requirements for its Workers' Compensation program. Occupational therapy may be a service covered under the medical expenses of the program. When a client has Workers' Compensation as the funding source, therapeutic interventions and documentation should focus on improving the individual's capacity to return to work. In some cases, occupational therapists may be called upon to conduct an Ergonomic Worksite Analysis to determine if a client's injury, disease, or condition is work related (Heller-Ono, 2021). The U.S. Department of Labor (2022) has a webpage that provides contact information for state Workers' Compensation officials and links to each state's website.

Schools

Reauthorized in 2004, and later amended in 2015 through the Every Student Succeeds Act, "the Individuals with Disabilities Education Act (IDEA) is a law that makes available a free appropriate public education [FAPE] to eligible children with disabilities throughout the nation and ensures special education and related services to those children" (U.S. Department of Education, 2022, para. 1). Part B of IDEA requires schools to provide students with disabilities a FAPE in the least restrictive environment (LRE). The law applies to students ages 3 through 21 years. Children who qualify for special education services under Part B may be eligible for occupational therapy services if those services are necessary to benefit from education.

Section 504 of the Rehabilitation Act of 1973 and Title II of the Americans with Disabilities Act (ADA) of 1990 prohibit schools from excluding a student with a disability from participating in educational activities (U.S. Department of Education, 2020). In other words, Section 504 ensures that children receive necessary accommodations and modifications for equal access to education:

> A student on a 504 plan may require related services such as occupational therapy. This may take the form of an OT helping develop accommodations, consultative services, and in rare cases, direct services. … It's important to note that IDEA is a function of **special** education and Section 504 is a facet of **general** education. (Breithart, 2021, para. 12-13)

Schools use an Individualized Education Program to document the student's educational needs, goals, and services (Hanft & Shepherd, 2016). Documentation requirements vary from school to school, but the services provided must be relevant to the educational setting. In some cases, school-based services may be covered by Medicaid. In such cases, services must meet requirements of both educational relevance and medical necessity (Laverdure & LeCompte, 2021).

Early Intervention Programs

The Early Intervention Program for Infants and Toddlers with Disabilities (Part C of IDEA) is a federal grant program that assists states in operating a program of early intervention services for infants and toddlers from birth through a child's third birthday, along with their families (U.S. Department of Education, 2022). The program targets children who have a diagnosis associated with developmental delay and children who are deemed at risk for developmental delay. A major provision of Part C is that services are to be provided in a child's *natural environment*. These include the child's home and community settings that are typical for children without disabilities, such as preschools, day care centers, and other community settings. Eligibility requirements vary among states based on each state's definition of developmental delay, the degree to which a child must exhibit such a delay, and the physical or mental diagnoses that are identified as placing a child at risk for developmental delay (Early Childhood Technical Assistance Center, 2021).

Just as some school-based services are covered by Medicaid, occupational therapy services provided through early intervention programs may also be covered by Medicaid (Stuart, 2022). Each child served in an early intervention program will have an Individualized Family Service Plan (IFSP) that includes (U.S. Department of Education, 2017):

- The child's present physical, cognitive, communication, adaptive, and social or emotional developmental level
- The family's resources, concerns, and priorities for the child
- Expected results or outcomes of intervention
- Early intervention services needed to meet the identified needs of the child and family
- Medical or other services provided through other sources
- Projected dates and duration of services
- Identification of a service coordinator
- A transition plan out of Part C services

Occupational therapy is one of the many services that may be provided as part of the IFSP, and specific documentation requirements vary across states.

Billing Codes

Occupational therapy practitioners will encounter multiple coding systems as part of their documentation and billing processes. These coding systems are intended to provide a standard language between health care providers and reimbursement sources for describing a client's diagnosis and the services provided (American Medical Association [AMA], 2022a; Centers for Disease Control and Prevention [CDC], 2022). It should be noted that the coding systems described in this section are updated frequently, and practitioners must keep track of changes that may affect their documentation.

ICD-10 Codes

Originally designed in the 1800s by the International Statistical Institute to track causes of death (mortality), the *International Classification of Diseases* (ICD) currently is maintained by the World Health Organization (WHO) and now includes codes for illness and disease while a person is still alive (morbidity; American Association of Professional Coders [AAPC], 2021). Countries use variations of the ICD coding system, "each modified to align with their unique healthcare infrastructure. The US version of ICD-10, created by the Centers for Medicare & Medicaid Services (CMS) and the National Center for Health Statistics (NCHS)," consists of two sets of codes (AAPC, 2021, para. 2):

1. *ICD-10-CM (Clinical Modification)*: These are alphanumeric **diagnosis codes used in all health care settings**. These codes allow a high degree of specificity about a client's condition. "ICD-10-CM is a standardized classification system of diagnosis codes that represent conditions and diseases, related health problems, abnormal findings, signs and symptoms, injuries, external causes of injuries and diseases, and social circumstances" (AAPC, 2021, para. 5).
    - Example: I69.351—Hemiplegia and hemiparesis following cerebral infarction affecting right dominant side
2. *ICD-10-PCS (Procedure Classification System)*: These are the codes used to classify and bill for the **procedures in inpatient hospital settings only**. Like the diagnosis codes, the procedure codes allow for a high degree of specificity.
    - Example: F0FZ1FZ—Caregiver training in dressing using assistive, adaptive, supportive, or protective equipment

In most hospital and clinic settings, there are individuals or entire departments whose responsibility it is to review documentation and ensure that applicable codes were included in a client's health record and related billing documentation. However, those individuals rely on the detailed documentation of health professionals, including occupational therapy practitioners, to assign the appropriate codes. As mentioned previously, coding systems are updated frequently. At the time of this writing, WHO had already published ICD-11 (2022), but it is unclear when the U.S. health care system will transition from the current ICD-10 coding system.

Current Procedural Terminology Codes

Current Procedural Terminology (CPT) codes are owned and copyrighted by the AMA (2022a, 2022b). The codes are a standardized listing of descriptive and identifying terms for reporting medical services and procedures. CMS adopted the use of CPT codes in 1983 as the mandatory system of coding for **outpatient services** under Medicare Part B. CPT codes, also known as *HCPCS Level I codes*, comprise one of the subsystems of the Healthcare Common Procedure Coding System used by Medicare and other health insurance programs to process health care claims. Most managed care and private insurance companies also base their reimbursements on the CPT relative value units (RVUs) established by CMS. The RVU of each code is based on three factors (Jordan et al., 2022):

1. *Work*: The technical skill and physical effort, mental effort and judgment, time to perform the service, and the psychological stress incurred by the provider.
2. *Practice expense*: The clinical staff, medical equipment, and medical supplies needed to perform the service or procedure.
3. *Professional liability*: The insurance premiums for specialists that perform a service based on risk of performing the service.

CPT codes are continuously reviewed, and new and revised CPT codes are published yearly. Some codes are deleted, and new codes are added. This annual review process "ensures clinically valid codes are issued, updated, and maintained on a regular basis to accurately reflect current clinical practice and innovation in medicine" (AMA, 2022a, para. 4). Furthermore, the AMA collaborates with AOTA and other organizations to modify existing codes and create new codes when needed. For example, following years of advocacy by AOTA and other professional organizations, the AMA established new CPT codes in 2017 to distinguish different levels of occupational therapy evaluation (Table 3-5). Occupational therapy evaluations are categorized as Low Complexity, Moderate Complexity, or High Complexity based on the complexity of three primary factors:

1. **Occupational profile and client history**, including both medical and therapy history
2. **Assessment of occupational performance** with identification of performance deficits that result in activity or participation restrictions
3. **Clinical decision making** in analyzing the occupational profile, the assessment data, and the number of treatment options

To bill for a High Complexity evaluation, the complexity of each of the three factors **must meet** the High Complexity criteria in Table 3-5. To bill for a Moderate Complexity evaluation, the complexity of each of the three criteria must be **no lower than** the Moderate Complexity criteria. In other words, you must bill an evaluation at the lowest complexity of any of the three individual factors. For example, if two factors meet Moderate Complexity criteria but one factor only meets Low Complexity criteria, you must bill the entire evaluation as Low Complexity. AOTA has a training video to better understand the use of these evaluation codes (AOTA, 2019).

It is the responsibility of each occupational therapy practitioner and employer to understand the current codes that may be assigned for services provided. Each year, AOTA provides members with a list of CPT codes from the AMA of the most frequently used codes by occupational therapy practitioners to classify and bill for services. The following are just a few of those common codes. Please note that this list is not all-inclusive (AOTA, 2022f):

- 97165 Occupational therapy evaluation, low complexity
- 97166 Occupational therapy evaluation, moderate complexity
- 97167 Occupational therapy evaluation, high complexity
- 97168 Occupational therapy re-evaluation
- 97110 Therapeutic procedure (exercises for strength, endurance, ROM)
- 97112 Neuromuscular reeducation
- 97129 Therapeutic interventions focused on cognitive function (first 15 minutes)
- 97130 Each additional 15 minutes of cognitive therapeutic interventions
- 97140 Manual therapy (mobilization, lymphatic drainage, traction)
- 97530 Therapeutic activities (dynamic activities to improve function)
- 97533 Sensory integrative techniques
- 97535 Self-care/home management training
- 97537 Community/work reintegration training
- 97545 Work hardening/conditioning (initial 2 hours)

Table 3-5

Occupational Therapy Evaluation Codes

CPT CODE AND EVALUATION CATEGORY	OCCUPATIONAL PROFILE AND CLIENT HISTORY	ASSESSMENT OF OCCUPATIONAL PERFORMANCE	CLINICAL DECISION MAKING IN THE COLLECTION AND ANALYSIS OF DATA
97165 OT Evaluation: Low Complexity	Occupational profile and history with **brief** review of medical/therapy records related to presenting problem and functional performance	**1 to 3 performance deficits** relating to physical, cognitive, or psychosocial skills limiting activity or participation	Data collection and analysis from **problem-focused** assessment/s
97166 OT Evaluation: Moderate Complexity	Occupational profile and history with **expanded** review of medical/therapy records related to presenting problem and functional performance	**3 to 5 performance deficits** relating to physical, cognitive, or psychosocial skills limiting activity or participation	Data collection and analysis from **detailed** assessment/s
97167 OT Evaluation: High Complexity	Occupational profile and history with **extensive** review of medical/therapy records related to presenting problem and functional performance	**5 or more performance deficits** relating to physical, cognitive, or psychosocial skills limiting activity or participation	Data collection and analysis from **comprehensive** assessment/s
Data source: American Occupational Therapy Association, 2016.			

- 97546 Each additional hour of work hardening/conditioning
- 97755 Assistive technology assessment
- 97760 Orthotic management and training—Initial encounter
- 97761 Prosthetic training—Initial encounter
- 97763 Orthotic or prosthetic management and training, subsequent encounters
- 92526 Treatment of swallowing dysfunction and/or oral function for feeding
- 96110 Developmental screening
- 96112 Developmental test administration
- 98977 Remote therapeutic monitoring

Each of the codes above has specific guidelines for use. Each year the AMA publishes a new CPT code book with thorough descriptions and details of how to use each code correctly (AMA, 2022b). Some CPT codes are billed as a single unit regardless of time spent on the activity described by the code. For example, the three codes for occupational therapy evaluation are billed as a single unit, regardless of time spent on the evaluation. Other codes are billed in 15-minute units and follow the 8-minute rule, which differs by payment source.

Table 3-6

Billing Current Procedural Terminology Codes Using the Centers for Medicare & Medicaid Services 8-Minute Rule

NUMBER OF 15-MINUTE UNITS THAT CAN BE BILLED	TOTAL BILLABLE INTERVENTION TIME IN MINUTES
0	1 to 7
1	8 to 22
2	23 to 37
3	38 to 52
4	53 to 67
5	68 to 82
6	83 to 97
Data source: American Occupational Therapy Association, 2021.	

Centers for Medicare & Medicaid Services 8-Minute Rule

The CMS 8-minute rule stipulates that a service must have been provided for at least 8 minutes to bill one 15-minute CPT code. A second billable unit cannot be billed "until you have at least 8 minutes past the 15-minute mark. If more than one timed CPT code is billed during a calendar day, then the total treatment time determines the number of units billed" (AOTA, 2021, para. 2). See Table 3-6 for a quick reference of how many units you can bill based on the number of intervention minutes when you are working with a Medicare beneficiary or another payer source that follows CMS guidelines. **Under the CMS 8-minute rule, you cannot bill more than 4 units in an hour.**

Substantial Portion Methodology or the American Medical Association 8-Minute Rule

Some private insurance companies do not follow the CMS 8-minute rule. Instead, they follow the Substantial Portion Methodology or the AMA 8-minute rule (AOTA, 2021). This method follows CPT coding conventions. **If you have performed a substantial portion of the timed service, you can bill the code, even if the total number of 15-minute codes exceeds 1 hour.** For example, suppose that in a single 1-hour session, you perform 10 minutes each of 97110—Therapeutic procedure, 97112—Neuromuscular reeducation, 97140—Manual therapy, 97530—Therapeutic activities, and 97535—Self-care/home management training. In this case, you could bill one 15-minute unit for each of the five codes. The total number of timed codes is 75 minutes, although you only saw the patient for 60 minutes. You must be certain that you are using the correct method of billing for your client's payer source. Check with your fieldwork educator or employer for further guidance.

Modifiers for Current Procedural Terminology Codes

"A modifier is an addition to a CPT code that provides additional information that can be used for payment or tracking purposes" (AOTA, 2020c, Slide 2). Use of modifiers depends on the requirements of each payment source. Here are some of the most common modifiers used for occupational therapy services:

- *Modifier 59*: Indicates that two codes that typically would not be billed during the same therapy session were in fact distinct and different procedures with no overlap.
- *Modifier GO*: Indicates that the service was performed under an occupational therapy plan of care; required by Medicare and some private insurance companies.

- *Modifier CO*: Indicates that an occupational therapy assistant performed at least 10% of the service independently. As of 2022, services coded with the CO modifier will be reimbursed at a 15% reduced rate by Medicare and other private insurances that follow this reimbursement policy. At the time of this writing, this controversial change was the focus of considerable advocacy by AOTA to reverse the policy (AOTA, 2022b).
- *Modifier KX*: Indicates that the service is still considered medically necessary despite having exceeded a particular annual monetary threshold established each year by Medicare. For example, in 2023, the annual threshold amount for outpatient occupational therapy services was $2230 (CMS, 2023).
- *Modifiers 96 and 97*: Modifier 96 indicates habilitative services to help clients develop skills or function they did not previously have. Modifier 97 indicates rehabilitative services to help clients regain previous function or skills that have been lost.
- *Modifier 95*: Indicates that services were provided via telehealth.
- *Modifier GA*: Indicates that an ABN is on file because the occupational therapy practitioner believes that the service will not be covered by Medicare.

Healthcare Common Procedure Coding System Level II Codes

Whereas CPT codes identify **services and procedures** provided by health care professionals, including occupational therapists, HCPCS Level II codes identify **products and supplies** such as durable medical equipment, orthotics, and prosthetics (CMS, 2021b). Like the use of CPT codes, occupational therapy practitioners may encounter certain limitations from payer sources and state regulatory agencies for specific HCPCS Level II codes. Furthermore, you should be aware that not all codes are accepted by Medicare and other payers.

Providing a product and bill does not guarantee that the client's funding source will pay for that product, particularly if a same or similar product has been billed to that patient in the past 5 years (AOTA, 2020b). Each year, AOTA provides members with a list of selected HCPCS Level II codes that are frequently used codes by occupational therapy practitioners to report fabrication and fitting of upper extremity orthoses.

> Not all codes are accepted by all payers, including Medicare. State regulations and/or payer policies may establish limitations on the use of one or more of these codes. Always review state rules and the official HCPCS book, and request information from specific insurers concerning the use of codes and payment policy. (AOTA, 2022e, para. 1)

Here are examples of HCPCS Level II codes that occupational therapy practitioners may use in various settings:

- L3764—Elbow Wrist Hand Orthosis, includes one or more nontorsion joints, elastic bands, turnbuckles; may include soft interface, straps, custom fabricated; includes fitting and adjustment
- L3923—Hand Finger Orthosis, without joints, may include soft interface, straps, prefabricated item that has been trimmed, bent, molded, assembled, or otherwise customized to fit a specific patient by an individual with expertise

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Chapter 4

Legal, Regulatory, and Ethical Considerations

Practitioners must be aware of federal and state laws and regulations that affect reimbursement and documentation. It is also necessary to understand the impact of *Official Documents* of the American Occupational Therapy Association (AOTA) on documentation. In addition, it is important to consider the ethical implications that practitioners may encounter regarding the documentation of occupational therapy services. This chapter will provide a general overview of the legal, regulatory, and ethical considerations that guide documentation. However, policies, statutes, and guidelines change frequently and vary greatly among occupational therapy practice settings. Occupational therapy practitioners must remain current with legal, regulatory, and ethical issues that affect their current practice setting.

Health Care Policy and Legislation

Health care policy and legislation have a direct impact on how occupational therapy services are provided, documented, billed, and reimbursed. In recent years, new legislation and policies have improved the ability of occupational therapy practitioners to be reimbursed for mental health services, to open home health cases, and to provide telehealth services (AOTA, 2022). Unfortunately, some policies and legislation have led to cuts for services provided by occupational therapy assistants and pressure by some post-acute facilities to provide group and concurrent therapy sessions to cut labor costs under new payment models. As our health care system is continually evolving, you should stay abreast of current issues that may impact your practice. AOTA's website has a section dedicated to advocacy issues.

Health Insurance Portability and Accountability Act

If you have been to any health care provider in the past 2 decades, you or your legal guardian likely had to sign a form indicating you have been made aware of your patient rights and the privacy guidelines of the facility. Originally passed by Congress in 1996 to ensure that employees could maintain health benefits when changing jobs, the Health Insurance Portability and Accountability Act (HIPAA) also established federal standards for the security, use, and disclosure of a client's protected health information (PHI; U.S. Department of Health & Human Services [DHHS],

Gateley, C. A. *Documentation Manual for Occupational Therapy, Fifth Edition* (pp. 31-41).
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2022a). A major goal of the HIPAA Privacy Rule "is to assure that individuals' health information is properly protected while allowing the flow of health information needed to provide and promote high quality health care and to protect the public's health and well being" (U.S. DHHS, 2022b, para. 3). Clients are also accorded several rights under HIPAA:

- The right to view and obtain a copy of the health record
- The right to request revision or omission of information in the health record that is incorrect
- The right to know how health information is used and shared with others
- The right to decide if PHI can be used for purposes of marketing and research
- The right to authorize the release of health information to selected individuals
- The right to file a complaint if it is believed that health information has been used in a way that violates the law

"The Privacy Rule protects all individually identifiable health information held or transmitted by a covered entity or its business associate, in any form of media, whether electronic, paper, or oral. … Individually identifiable health information is information, including demographic data, that relates to:

- the individual's past, present, or future physical or mental health condition,
- the provision of health care to the individual, or
- the past, present, or future payment for the provision of health care to the individual,

and that identifies the individual or for which there is a reasonable basis to believe it can be used to identify the individual. Individually identifiable health information includes many common identifiers (e.g., name, address, birth date, Social Security Number)" (U.S. DHHS, 2022a, para. 14).

HIPAA has several implications for occupational therapy practitioners, particularly as many health care settings have transitioned to electronic health records (EHRs). In 2013, the HIPAA Security Rule implemented new requirements to address technological advances (Collmer, 2015). The new rule "not only strengthened privacy and security safeguards for PHI, but it also created steeper civil and criminal penalties for violation" (Collmer, 2015, p. 13). In recent years, numerous health care providers, from individual practitioners to entire health care systems, have incurred penalties ranging from a few thousand dollars to several million dollars for HIPAA violations (Alder, 2022). Some of the most common compliance issues involve (Jannenga, 2019, para. 5):

- Impermissible uses and disclosures of PHI
- Lack of safeguards of hard copy and electronic PHI
- Inability for patients to access their PHI
- Use or disclosure of more than the minimum necessary PHI

In any fieldwork or practice setting, you should have a clear understanding of the site's strategies for HIPAA compliance and your role in maintaining client confidentiality. Although not all-inclusive, the following is a list of strategies that will help maintain compliance with HIPAA guidelines (Alder, 2021; CareCloud, 2022; Collmer, 2015):

- Do not discuss client PHI with anyone who does not have a need to know the information, including coworkers or personal acquaintances.
- Do not discuss client PHI in an area where it may be overheard by others.
- Do not leave paper charts out on a desk for easy access by unauthorized users.
- Do not leave client records open on a computer screen or other electronic device.
- Do not access a health record unless needed for work.
- Do not share your password with other staff.
- Always log off from electronic devices containing health records.
- When working on electronic devices, position yourself and the device in a manner to prevent others from viewing the screen.
- Make sure electronic devices containing PHI are locked up to prevent physical access by unauthorized users.
- Make sure that you are using encrypted emails or encrypted cloud-based software programs to share electronic PHI with other authorized users.

- Complete required HIPAA training offered by the site.
- Avoid documenting in public areas with unsecured wireless access.
- Never share any client information on social media.

I want to draw particular attention to three of the points above, particularly for students and new practitioners. First is the issue of not accessing health records unless needed for work purposes. This includes your own health record, those of family or friends, and those of well-known individuals. It can be very tempting when you see a name you recognize on the patient census for your facility to want to do a little exploring about the patient's situation. It is human nature to think, "Hmm … I wonder what's going on with that person?" **Your curiosity can get you fired and sued if you access the health record of someone who is not your client.** You leave an electronic "fingerprint" on every record that you access, and your facility can determine every individual that has accessed any given EHR.

Another important issue for further discussion is to **make sure that others cannot see your screen when you are documenting outside of designated staff areas.** For example, the hospital where I do some weekend work has a computer in every patient room, so it is common for me to document while I am with the patient, particularly as I gather information about the client's occupational profile, prior level of function, and home environment. It is not concerning for the client to see you documenting the information that they are reporting to you. However, clients and families are curious too, and they might ask you to check on other aspects of the health record. Be very careful with the information that you share. A patient may have just had a test that revealed a serious new medical condition, such as cancer, and it is not your role to be the first one to deliver that information. In that situation, you can simply say, "Your doctor or provider will be reviewing all your test results the next time they make rounds" or "I'll let your nurse know that you have questions about your tests." You should also be cautious about documenting on a patient while in a different patient's room. The patient, or more likely a visitor, may unexpectedly walk by your screen and see the PHI of another individual before you can close out of the chart.

A final issue that warrants further discussion is social media and HIPAA. Many of us use social media on a frequent basis to share moments of our day with others in our social network, but what you consider to be an innocent post may result in criminal charges and disciplinary action, including termination of your job. **No matter how tempted you are to share information about one of your clients, just don't do it!** Alder (2021, para. 12) listed the following common social media HIPAA violations:

- Posting of images and videos of patients without written consent
- Posting of gossip about patients
- Posting of any information that could allow an individual to be identified
- Sharing of photographs or images taken inside a health care facility in which patients or PHI are visible
- Sharing of photos, videos, or text on social media platforms within a private group

> "HIPAA was enacted several years before social media networks such as Facebook and Instagram were launched, so there are no specific HIPAA social media rules. However, as with all healthcare-related communications, the HIPAA Privacy Rule still applies whenever covered entities or business associates—or employees of either—use social media networks" (Alder, 2021, para. 1).

"Compliance with the HIPAA Security Rule means more than following the law. Occupational therapy practitioners who comply with the requirements protect their organization and themselves from hefty penalties and reputational damage" (Collmer, 2015, p. 16). Furthermore, occupational therapy practitioners must follow the AOTA *Code of Ethics* (2020). Principle 3 of the *Code of Ethics* states "occupational therapy personnel shall respect the right of the person to self-determination, privacy, confidentiality, and consent" (AOTA, 2020a, p. 3). The related standard of conduct specifies that occupational therapy personnel shall maintain high standards of confidentiality in all written, verbal, electronic, or virtual communication.

In summary, you should have a clear understanding of the privacy safeguards that exist at your place of fieldwork or employment and your role in ensuring compliance with HIPAA laws. For example, which procedure should you follow if a client asks for a copy of the health record? Which form must be signed to allow you to discuss health information with a client's relative or friend? What should your response be if another client innocently asks, "What's wrong with that person over there?"

Family Educational Rights and Privacy Act

The Family Educational Rights and Privacy Act (FERPA) is a federal law enacted in 1974 that protects the privacy of educational records (U.S. Department of Education, 2021). FERPA applies to educational institutions that receive government funding through the U.S. Department of Education. School occupational therapy practitioners have access to student educational records and must comply with FERPA regulations. In some instances, school practitioners may also be subject to HIPAA guidelines. For example, if a practitioner is providing occupational therapy services as outlined in the child's Individualized Education Program (IEP) but Medicaid is billed for the services, the billing procedures must comply with HIPAA guidelines, while the documentation for the services becomes part of the educational record and therefore falls under FERPA guidelines (Barboza et al., 2008). When in doubt about whether you can share information about school-based occupational therapy services, you should consult with school administrators and your employer if you are providing contract services and are employed by another entity.

Regulatory and Ethical Guidelines

Occupational therapy practitioners must be aware of legal, regulatory, and ethical standards that affect documentation. The AOTA publishes several *Official Documents* that guide occupational therapy practice and have direct implications on documentation. In addition, each state has a practice act that further regulates occupational therapy practice. This section will highlight the key points of several documents that affect the documentation of occupational therapy practitioners. Keep in mind that AOTA *Official Documents* are revised approximately every 5 years, and state practice acts may be updated annually. Occupational therapy practitioners must be familiar with the most current documents available. The most recent *Official Documents* described below are located on the AOTA website, and state practice acts can be located on the website of the occupational therapy regulatory board for each state.

Scope of Practice

This document delineates the domain and process of occupational therapy practice and describes the educational and certification requirements for occupational therapy practitioners. The *Scope of Practice* document is based on the *Occupational Therapy Practice Framework: Domain and Process, Fourth Edition* (*OTPF-4*; AOTA, 2020c). Occupational therapy is defined as "the therapeutic use of everyday life occupations with person, groups, or populations (i.e., clients) for the purpose of enhancing or enabling participation" (AOTA, 2021b, p. 2). Documentation should demonstrate that the services provided to a client fall within the scope of practice for the occupational therapy profession. Furthermore, practitioners must abide by state laws for licensure, continuing education, and supervision. Such laws may affect the credentials included in a practitioner's signature on documentation and the type of documentation required to reflect that appropriate supervision has been provided to occupational therapy assistants during the delivery of services.

Standards of Practice for Occupational Therapy

This document defines the standards that must be met to practice as an occupational therapist or occupational therapy assistant (AOTA, 2021d). It outlines the education, examination, and licensure requirements for occupational therapy practitioners. The document goes on to outline specific expectations of occupational therapy practitioners related to the following standards:

- Standard I—Professional Standing and Responsibility
- Standard II—Service Delivery
- Standard III—Screening, Evaluation, and Reevaluation
- Standard IV—Intervention Process
- Standard V—Outcomes, Transition, and Discontinuation

The *Standards of Practice* document explains that occupational therapy documentation must abide "by the time frames, formats, and standards established by practice settings, federal and state laws, other regulatory and payer requirements, external accreditation programs, and AOTA *Official Documents*" (AOTA, 2021d, p. 4).

Guidelines for Supervision, Roles, and Responsibilities During the Delivery of Occupational Therapy Services

This document outlines the roles, responsibilities, and supervision requirements of occupational therapists, occupational therapy assistants, and occupational therapy aides in the provision of occupational therapy services, including documentation practice (AOTA, 2020b). The document explains that "supervision is based on mutual understanding between the supervisor and supervisee about each other's education, experience, credentials, and competence" (AOTA, 2020b, p. 1).

Occupational Therapists

Occupational therapists are considered autonomous practitioners, meaning they are independent in all aspects of service delivery, including documentation of the evaluation, intervention plan, intervention implementation, and outcomes (AOTA, 2020b). Occupational therapists initiate and direct the evaluation, interpret the data, develop and direct the intervention plan, modify or discontinue the intervention plan when appropriate, and interpret outcomes of a client's occupational performance. They collaborate with occupational therapy assistants by delegating selected assessments and interventions and exchanging information throughout the evaluation and intervention process. Documentation should reflect an occupational therapist's involvement throughout the delivery of occupational therapy services.

Occupational Therapy Assistants

Occupational therapy assistants must deliver occupational therapy services under the supervision of an occupational therapist (AOTA, 2020b). The amount of supervision that must be provided will vary depending on the state of practice and funding source. Occupational therapy assistants may contribute to the evaluation process by implementing assessments that have been delegated by the occupational therapist and providing verbal and written reports of the client's performance to the occupational therapist. They may collaborate with the occupational therapist during the development of the intervention plan.

Occupational therapy assistants are responsible for knowing the client's occupational therapy goals and targeted outcomes, and they provide written documentation and verbal reports to the occupational therapist about the client's progress toward those goals and outcomes. Finally, in collaboration with the supervising occupational therapist, occupational therapy assistants select, implement, and modify "occupational therapy interventions consistent with demonstrated competence levels, client goals, and the requirements of the practice setting, including payment source requirements" (AOTA, 2020b, p. 4). Their accompanying documentation should reflect that all guidelines have been followed throughout the delivery of occupational therapy services.

In some situations, occupational therapy practitioners may use their education and expertise to work in settings that are not related to the delivery of occupational therapy. "In these other arenas, supervision of the occupational therapy assistant may be provided by non–occupational therapy professionals, or supervisory relationships may not be applicable when the occupational therapy assistant is a sole proprietor" (AOTA, 2020b, p. 4).

Occupational Therapy Aides

Occupational therapy aides provide supportive nonskilled services specifically delegated by the occupational therapist or occupational therapy assistant (AOTA, 2020b). Ultimately, the occupational therapist is responsible for the use and actions of the aide, but aides may be supervised by the occupational therapy assistant. Aides may provide non–client-related tasks such as clerical, maintenance, and work area or equipment preparation. They may also perform routine client-related tasks under stable, predictable circumstances if they have previously demonstrated competence in the task. Occupational therapy practitioners must adhere to state and payer regulations when using aides and documenting the services provided by an aide.

Occupational Therapy Students and Occupational Therapy Assistant Students

Although not addressed in an *Official Document*, AOTA issues periodic updates to clarify supervision requirements for students when occupational therapy services are billed under Medicare. AOTA works "with a coalition of organizations to advocate for additional government support for educating allied health providers and to develop long-term solutions to the problems caused by Medicare's limitations on reimbursement when students participate in service delivery" (AOTA, 2021c, para. 17). Other payer sources may have different guidelines, and state laws and facility guidelines may be even more restrictive. The Medicare supervision requirements summarized by AOTA (2021c) are as follows:

- *Medicare Part A—Hospital and Inpatient Rehabilitation*: State and local laws and practice standards should be considered when determining supervision of students in these settings. "Services provided by therapy students may count toward the IRF three-hour rule/intensity of therapy services requirement" (AOTA, 2021c, para. 4).
- *Medicare Part A—SNF*: Services of an occupational therapy student or occupational therapy assistant student may be recorded on the MDS as minutes of therapy received by the client if the supervising occupational therapy practitioner provides skilled direction to the student. CMS does not require that services be provided within the line-of-sight of an occupational therapy practitioner. "Within individual facilities, supervising therapists/assistants must make the determination as to whether or not a student is ready to treat patients without line-of-sight supervision. Additionally, all state and professional practice guidelines for student supervision must be followed" (AOTA, 2021c, para. 6). Supervising occupational therapy practitioners should be physically present in the facility and immediately available for guidance as needed by the student.
- *Medicare Part A—Hospice*: CMS has not issued specific rules regarding student supervision in hospice. AOTA recommends that the approach for Part A inpatient settings be followed and that practitioners consult state practice acts for additional guidance (AOTA, 2021c).
- *Medicare Part A—Home Health*: CMS regulations define "qualified personnel" who may provide and bill for home health services. Students are not included in the definition of qualified personnel. AOTA offers the following clarification:

  > CMS has not issued specific restrictions regarding students providing services in conjunction with a qualified OT or OTA. Services by students can be provided (as allowed by state law) as part of a home health visit, when the student is supervised by an OT or OTA in the home. (AOTA, 2021c, para. 9)

  AOTA recommends that the approach for Part A inpatient settings be followed and that practitioners consult state practice acts for additional guidance.
- *Medicare Part B—Outpatient/SNF/Home Health/Private Practice*: There are very specific rules regarding the use of occupational therapy students in the provision of services under Part B reimbursement. "Only the services of the therapist can be billed and paid under Medicare Part B. The services performed by a student are not reimbursed, even if provided under 'line of sight' supervision of the therapist" (AOTA, 2021c, para. 13). However, the presence of an occupational therapy or occupational therapy assistant student in the room does not make the services unbillable. AOTA further explains that students can assist a qualified practitioner in the provision of occupational therapy services:

  > Students can participate in the delivery of services when the qualified practitioner (OT) is directing the service, making the skilled judgment, responsible for the assessment and treatment in the same room as the student, and not simultaneously treating another patient. The qualified practitioner is solely responsible and must sign all documentation. (AOTA, 2021c, para. 11)

Guidelines for Documentation of Occupational Therapy

This document articulates the purposes of documentation, explains different types of documentation, and lists the fundamental elements that should be present in all occupational therapy documentation (AOTA, 2018). There should be documentation any time occupational therapy services are provided to a client. The term *client* may be used to describe a person, group, or population as defined in the *OTPF-4* (AOTA, 2020c). According to the *Guidelines for Documentation of Occupational Therapy*, "the purpose of documentation is to:

- Communicate information about the client's occupational history and experiences, interests, values, and needs
- Articulate the rationale for provision of occupational therapy services and the relationship of those services to client outcomes
- Provide a clear, chronological record of client status, the nature of the occupational therapy services provided, client response to occupational therapy intervention, and client outcomes
- Provide an accurate justification for skilled occupational therapy necessity and reimbursement" (AOTA, 2018, p. 1)

Different types of documentation may be required throughout the occupational therapy process. Types of documentation include:

- *Screening report*: Documents need, or lack thereof, for occupational therapy evaluation
- *Evaluation report*: Includes thorough occupational profile, types of assessments used and results, analysis of occupational performance, summary and analysis, and recommendations
- *Re-evaluation report*: Completed "when, in the professional judgment of the occupational therapist, new clinical findings emerge, a significant change in the patient's condition requiring further tests and measures is observed, the client demonstrates a lack of response as expected in the plan of care, additional information is required for discharge, or when required by practice guidelines and payer, facility, and state and federal guidelines and requirements" (AOTA, 2018, pp. 2-3)
- *Intervention plan/plan of care*: Based on evaluation or re-evaluation results; may include goals, intervention approaches, types of approaches, service delivery mechanisms (e.g., location, frequency, duration), plan for discharge, and outcome measures
- *Contact report*: Daily treatment notes to document any contact or missed visit; includes client report, interventions and responses, devices used or fabricated, education or consultation provided, and present level of performance
- *Progress report*: Includes summary of client sessions/contacts, services provided, current client performance, and recommendations about changes or continuation of services
- *Transition plan*: Documents plan for a formal transition between service settings including expected time frame, outline of transition activities, and recommendations for occupational therapy services, accommodations, assistive technology, and/or environmental modifications
- *Discharge or discontinuation report*: Summarizes the intervention process, progress toward goals, outcomes, and recommendations for follow-up and/or referral to other professionals or agencies

Each type of documentation listed above will be discussed in more detail in Chapter 15 with examples provided. There are several fundamental elements that are essential to all documentation types (AOTA, 2018):

- Name, date of birth, gender, and case or health record number (if applicable)
- Date and type of occupational therapy contact
- Terminology, acronyms, and abbreviations acceptable to the setting
- Clear rationale for provision of skilled occupational therapy services
- Professional signature including name and credentials
- Co-signature and credentials if required by supervision guidelines, payer policy, state or federal laws, or facility standards
- Errors noted and initialed or signed
- Adherence to state and federal regulations, payer and facility requirements, practice guidelines, and confidentiality requirements for documentation storage and disposal

Occupational Therapy Code of Ethics

This document outlines the principles to promote and maintain ethical standards of conduct and is based on the core values of the occupational therapy profession: altruism, equality, freedom, justice, dignity, truth, and prudence (AOTA, 2020a). It is intended to guide decision making when ethical issues arise. In simple terms, practitioners must always consider the implications of their decisions and actions on occupational therapy clients. The six ethical principles and standards of conduct are summarized as follows (AOTA, 1993, 2020a):