Practice Essentials

General Considerations

- Key documents and resources are essential for occupational therapy practice, everyday advocacy, and education.
- The essential components of occupational therapy's domain and process help to guide practice.

Key Resources
This outline presents key points from the documents governing practice, and students should be familiar with their general principles and content. Students should download and review the following AOTA documents.

- Guidelines for Documentation of Occupational Therapy (2018)
- AOTA 2020 Occupational Therapy Code of Ethics (2020)
- Guidelines for Supervision, Roles, and Responsibilities During the Delivery of Occupational Therapy Services (2020)
- Occupational Therapy Practice Framework: Domain and Process (4th ed.) (2020)
- Occupational Therapy Scope of Practice (2021)
- Standards for Continuing Competence (2021)
- Standards of Practice for Occupational Therapy (2021)

AOTA official documents are reviewed and/or updated every 5 years. The latest versions are published at the end of each year in the *American Journal of Occupational Therapy* (https://research.aota.org).

Key Documents and Concepts Governing Occupational Therapy Practice

I. Standards of Practice for Occupational Therapy

A. Purpose: The *Standards of Practice for Occupational Therapy* is an official document of AOTA that describes the requirements for occupational therapists and occupational therapy assistants for the delivery of occupational therapy services. The *Standards* "defines minimum standards for the practice of occupational therapy" (AOTA, 2021e, p. 1).

B. Occupational therapists and occupational therapy assistants are required to abide by federal and state laws. "State and other legislative or regulatory agencies may impose additional requirements to practice as occupational therapists and occupational therapy assistants in their area of jurisdiction" (AOTA, 2021e, p. 2).

C. The *Standards* provide education, examination, and licensure requirements. Students should be familiar with the document and understand the difference between practice standards and state regulations.

II. Occupational Therapy Scope of Practice

A. *Purpose:* The *Occupational Therapy Scope of Practice* (AOTA, 2021b) is an official document of AOTA that defines the scope of practice in occupational therapy and provides a model definition of occupational therapy to promote uniform standards and professional mobility across state occupational therapy statutes and regulations.

B. The *Scope of Practice* describes the domain and process of occupational therapy (based on the *Occupational Therapy Practice Framework: Domain and Process,* 4th ed.; *OTPF–4;* AOTA, 2020c) and the educational and certification requirements to become an OT or an OTA, outlined in the *Standards of Practice for Occupational Therapy* (AOTA, 2021e).

C. Students should understand how the scope of practice governs what occupational therapy practitioners are allowed to do during practice, both administratively and with clients.

D. Students should understand the difference between state and federal regulations and the AOTA *Scope of Practice* and other official documents (see AOTA's [2021c] "Scope of Practice Definitions" for a list of how different states define occupational therapy).

E. *Interprofessional practice:* In occupational therapy management or practice, collaboration with other health care professionals and agencies is crucial. Health care professionals with whom collaboration might be beneficial include physicians, nurses, physical therapists, speech-language pathologists, audiologists, recreational therapists, respiratory therapists, and social workers.

III. *Occupational Therapy Practice Framework: Domain and Process (4th ed.)*

A. The *Occupational Therapy Practice Framework: Domain and Process* (4th ed.; *OTPF–4*; AOTA, 2020c) is an official document of the American Occupational Therapy Association (AOTA). Intended for occupational therapy practitioners and students, other health care professionals, educators, researchers, payers, policymakers, and consumers, the *OTPF–4* presents a summary of interrelated constructs that describe occupational therapy practice. The domain and process are linked in a transactional relationship that is facilitated by the occupational therapy practitioner.

B. Students should be familiar with the following key concepts:

1. *Domain:* "The profession's purview and the areas in which its members have an established body of knowledge and expertise" (AOTA, 2020c, p. 4). Aspects of the occupational therapy domain are occupations, contexts, performance patterns, performance skills, and client factors.
2. *Process:* "The occupational therapy process is the client-centered delivery of occupational therapy services. The three-part process includes (1) evaluation and (2) intervention to achieve (3) targeted outcomes and occurs within the purview of the occupational therapy domain" (AOTA, 2020c, p. 17; see also OTPF–4 Exhibit 2).
   a. *Evaluation* includes developing an occupational profile and analyzing a client's performance of occupations.
   b. *Intervention* includes developing an intervention plan, implementing the intervention, and reevaluating and reviewing the intervention plan.
   c. *Outcomes* "emerge from the occupational therapy process and describe the results clients can achieve through occupational therapy intervention" (AOTA, 2020c, p. 26). Examples of outcomes are listed in the *OTPF–4*. Aspects of outcomes include outcome measurement and transition and discontinuation planning.
3. *Client:* "typically classified as persons (including those involved in care of a client), groups (collections of individuals having shared characteristics or a common or shared purpose, e.g., family members, workers, students, people with similar interests or occupational challenges),

and populations (aggregates of people with common attributes such as contexts, characteristics, or concerns, including health risks"; AOTA, 2020c).

4. *Occupational therapy practitioner:* refers to both occupational therapists and occupational therapy assistants (AOTA, 2019).
5. *Cornerstones:* "Occupational therapy practitioners have distinct knowledge, skills, and qualities that contribute to the success of the occupational therapy process, described [in the *OTPF–4*] as 'cornerstones'" (AOTA, 2020c, p. 6):
    - Core values and beliefs rooted in occupation
    - Knowledge of and expertise in the therapeutic use of occupation
    - Professional behaviors and dispositions
    - Therapeutic use of self

6. **"Occupational therapy services are provided for habilitation, rehabilitation, and promotion of health and wellness for clients with disability- and non–disability-related needs" (AOTA, 2020c, p. 1).**

Documentation of Occupational Therapy Practice

Key Resources

- American Occupational Therapy Association. *Guidelines for documentation of occupational therapy* (2018)
- American Occupational Therapy Association. *AOTA 2020 occupational therapy code of ethics* (2020)
- Gateley, C., & Borcherding, S. (2017). *Documentation manual for occupational therapy: Writing SOAP notes* (4th ed.). Slack.
- McGuire, M. J. (2019). Regulatory and payment issues. In K. Jacobs & G. L. McCormack (Eds.), *The occupational therapy manager* (6th ed., pp. 687–693). AOTA Press.
- Sames, K. M. (2019a). Documentation in practice. In B. A. B. Schell & G. Gillen (Eds.), *Willard & Spackman's occupational therapy* (13th ed., pp. 572–581). Wolters Kluwer.
- Sames, K. (2019b). Guidelines for effective documentation and quality reporting. In K. Jacobs & G. L. McCormack (Eds.), *The occupational therapy manager* (6th ed., pp. 269–275). AOTA Press.
- Smith, J. (2018). Documentation of occupational therapy services. In H. M. Pendleton & W. Schultz-Krohn (Eds.), *Pedretti's occupational therapy: Practice skills for physical dysfunction* (8th ed., pp. 120–140). Elsevier.
- U.S. Department of Health and Human Services. Privacy, security, and electronic health records. (n.d.).

I. The *Guidelines for Documentation of Occupational Therapy* (AOTA, 2018c) is an official AOTA document that describes the purpose, types, and content of professional documentation used in occupational therapy. Documentation of occupational therapy services is required whenever professional services are provided to a client.

A. Occupational therapy practitioners identify the types of documentation required and record all necessary components of services provided within their scope of practice.

B. Each occupational therapy practitioner documents the occupational therapy services provided "within the time frames, formats, and standards established by the practice settings, agencies, external accreditation programs, federal and state laws, other regulatory and payer requirements, and AOTA official documents" (AOTA, 2021e, p 5).

C. Depending on the facility or practice setting, documentation requirements apply to both electronic and written forms of documentation.

D. Payers for occupational therapy services, such as Medicare, require that the services received by the client must be "skilled" and "medically necessary" (CMS, 2021a).

1. *Medically necessary* means that "services must be under accepted standards of medical practice and considered to be specific and effective treatment for the patient's condition." (CMS, 2021a).
2. *Skilled* means that "the medical record must support that the expertise and knowledge of a qualified clinician was necessary and was provided" (CMS, 2021a).

E. Effective documentation practice should be timely, clear, free from jargon, and individualized; it should reflect the distinct value of occupational therapy.

II. Purpose and Importance of Documentation

A. To communicate information about the client's occupational history and experiences, interests, values, and needs

B. To articulate the rationale for provision of occupational therapy services and the relationship of those services to client outcomes

C. To provide a clear chronological record of client status, the nature of occupational therapy services provided, client response to occupational therapy intervention, and client outcomes

D. To provide an accurate justification for skilled occupational therapy service necessity and reimbursement (AOTA, 2018c, p. 1).

III. Documentation Basics

A. Use the following guidelines for documentation (AOTA, 2018c, p. 2):

1. Documentation practices and storage and disposal of documentation must meet all state and federal regulations and guidelines, payer and facility requirements, practice guidelines, and confidentiality requirements.
2. Client's full name, date of birth, gender, and case number, if applicable, are included on each page of the documentation.
3. Identification of the type of documentation and the date service is provided and documentation is completed are included in the documentation.
4. Acceptable terminology, acronyms, and abbreviations are defined and used within the boundaries of the setting.
5. Clear rationale for the purpose, value, and necessity of skilled occupational therapy services is provided. The client's diagnosis or prognosis is not the sole rationale for occupational therapy services.
6. Professional signature (first name or initial, last name) and credential; cosignature and credential when required for documentation of supervision; and, when necessary, signature of the recorder are included with each documentation entry.
7. All errors are noted and initialed or signed.

B. Types of documentation

1. *Order:* A physician or other designated professional may write an order or referral for occupational therapy services. A physician referral is not always necessary, depending on the state regulations. However, some payers and state licensure regulations may require a

physician referral before initiating occupational therapy services. A referral should include the date and source of referral, the services requested, and the reason for referral (AOTA, 2018c).

2. *Screening:* The purpose of screening is to identify whether a person may benefit from occupational therapy services and an occupational therapy evaluation is necessary. Screenings are usually conducted using chart review and client observations.
3. *Evaluation report:* An evaluation "documents the referral source and data gathered through the occupational therapy evaluation process" (AOTA, 2018c, p. 3).
4. *Intervention plan:* This document includes the goals and the interventions to be used along with the goals for the client. It may be included in the initial evaluation report or written as a separate document. Depending on the practice setting and the payer source, the intervention plan may be revised at certain intervals or as needed because of changes in a client's condition.

IV. Documentation Content

A. Goals

1. Generally written in collaboration with client, significant others, or both.
2. Short- versus long-term goals
   a. *Short-term goals or objectives:* Steps to reach the long-term or overarching goal of occupational therapy services. These goals are modified and changed as the client improves. The time frame for short-term goals varies depending on the client, practice setting, and payer source.
   b. *Long-term goals or discharge goals:* Goals the client is expected to achieve on discharge from occupational therapy services.

B. Contact and progress notes (names of this type of documentation may vary by setting):

1. Contact note
   a. Documents the occupational therapy practitioner's contact with a client; interventions used during the session; client's response to the intervention; instruction, training, and education given; and telephone calls or meetings that relate to the client.
   b. Nonattendance or missing an occupational therapy session is generally documented with a contact note.
2. Progress notes or reports
   a. Typical contents of a progress note or report
      i. Identifying data (e.g., client's name, date of birth, gender)
      ii. Intervention provided during session (e.g., environmental modifications, ADL retraining, orthotics fitting)
      iii. Length of session; where session occurred (e.g., home)
      iv. Precautions followed during intervention session
      v. Contraindications or reasons why particular interventions were not completed
      vi. New assessments completed or information obtained
      vii. Client's current functional level and progress made toward goals
      viii. Intervention plan modifications
      ix. Whether occupational therapy services should continue and rationale for continuing intervention or for discharging client
      x. Referrals to other services
      xi. Recommendations with rationale; plan for next session

b. Formats for progress notes or reports (see Gateley & Borcherding, 2017)
   i. SOAP
      - **S:** *Subjective* information from client, paraphrased or quoted (e.g., client reported he was able to undress himself before bed last night; "I didn't sleep well last night")
      - **O:** *Objective* information from intervention session, such as measurements, observable data, and any quantifiable data such as goniometric or strength measurements
      - **A:** *Assessment;* includes the occupational therapy clinician's interpretation or analysis of the information in the previous sections of the note, therapist's judgment
      - **P:** *Plan;* includes the estimated duration and frequency of occupational therapy services, anticipated intervention strategies to be used. Should relate to previous sections of the note.
   ii. DAP (*description, assessment,* and *plan*): Similar to SOAP except that the S and O sections of the note are collapsed together in the D section
   iii. Narrative: May include pertinent information in a logical order of the writer's choosing but not in a specific format as in SOAP or DAP notes.
   iv. BIRP, PIRP, SIRP: Formats are similar to each other; sometimes used in behavioral health settings
      - BIRP: *Behavior* of client, *intervention* provided, *response* of client to intervention, *plan* for continued intervention
      - PIRP: *Purpose* or reason for the intervention, *intervention* provided, *response* of client to intervention, *plan* for continued intervention
      - SIRP: *Situation, intervention* provided, *response* of client to intervention, *plan* for continued intervention.

3. Reevaluation or reassessment report: "Formal reevaluation is conducted 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, or additional information is required for discharge or when required by practice guidelines and payer, facility, and state and federal guidelines and requirements" (AOTA, 2018c, p. 3).
   a. Frequency: May need to be written at required intervals, which may vary depending on payer source, intervention setting, or the amount of progress the client has made.
   b. Typical information included in a reevaluation report
      i. Client or facility identifying data (e.g., name of facility, discipline, client's name, date of birth, gender, diagnoses or medical issues affecting intervention, precautions, and contraindications)
      ii. Updated information related to client's occupational profile
      iii. Reevaluation results including the rationale for completing the reevaluation, assessments completed, assessment results, updated information on client's performance, and client's response to intervention
      iv. Summary and interpretation of reevaluation findings
      v. Recommendations.

C. Transition plan: This report "documents the formal transition plan to support the client's transition from one service setting to another within a service delivery system" (AOTA, 2018c, p. 6) and typically includes the following information:

1. Client- or facility-identifying data (e.g., name of facility, discipline, client's name, date of birth, gender, diagnoses or medical issues affecting intervention, precautions, and contraindications)
2. Client's current abilities

3. Information related to client's current intervention setting, where client will be transitioning to, when the transition is expected to occur, and preparation for transition
4. Recommendations for type and amount of occupational therapy services, special requirements at transition site, and reason for recommending these services or providing these suggestions.

D. Discharge or discontinuation report and summary: This report "documents the discharge plan to support the client's discharge from occupational therapy service" (AOTA, 2018c, p. 6) and typically includes the following information:

1. Client- or facility-identifying data (e.g., name of facility, discipline, client's name, date of birth, gender, diagnoses or medical issues affecting intervention, precautions, and contraindications)
2. Synopsis of occupational therapy services provided, including frequency of services, number of sessions completed, types of interventions used during the provision of services, progress since initial evaluation and toward goals, response to interventions, equipment or training provided, and recommendations for discharge (e.g., home programs).

E. Hints for correct documentation are as follows:

1. Acronym: RUMBA, for describing how information is presented. It should be *relevant, understandable, measurable,* and *behavioral* (i.e., it describes behaviors); outcomes should be *achievable* (Smith, 2018).
2. Acronym: SMART, for writing goals. Each goal should be *specific, measurable, achievable, related* to other goals and the client's needs, and *time* limited (i.e., has an end point; Smith, 2018).
3. Acronym: COAST, for writing goals (Gateley & Borcherding, 2017):
   - C**:** *Client*
   - O: *Occupation* (e.g., cut meat)
   - A: *Assistance* level (e.g., independently)
   - S: *Specific* conditions (e.g., using a rocker knife and an inner-lip plate)
   - T: *Timeline* (e.g., within 1 week).

   Example of goal written using the COAST method: *Client will be able to cut meat independently using a rocker knife and an inner-lip plate within 1 week.*
4. Strategies to document change in client's status over time
   a. How often or consistently the client performs the desired behavior (e.g., fed self 50% of the meal independently)
   b. The length of time or duration (e.g., attended to a task for 15 seconds)
   c. The amount of assistance the client needs (e.g., client required maximal assistance of one to transfer from the wheelchair to the bed)
   d. Performance quality (e.g., able to don shirt with one error when aligning buttons)
   e. Complexity of task or activity (e.g., number of steps; number and type of cues given during task performance)

V. Setting-specific documentation

A. Pediatric settings (see Cahill, 2020; Cahill & Bazyk, 2020; Myers & Cason, 2020; U.S. Department of Education, n.d.-a, n.d.-c)

1. School-based settings: Occupational therapy practitioners working in school-based settings must relate their documentation to the student's *individualized education program (IEP),* a

written document detailing the student's academic needs and functional goals in that setting. The occupational therapy intervention and goals in the school system setting should relate to the child's functional abilities to perform school-related tasks.

2. Early intervention settings
   a. *Individualized family services plan (IFSP):* Occupational therapy practitioners working in early intervention services that are federally mandated will also need to be familiar with the IFSPs of children they are treating.
   b. Documentation is generally written in lay terms to increase a parent's ability to understand it.
3. Refer to the Pediatrics lesson for additional information to guide documentation in pediatric settings.

B. Mental health settings: Documentation may be multidisciplinary, and intervention may be provided in groups. Refer to the adult and pediatric mental health lessons for additional information to guide documentation in mental health settings.

C. Skilled nursing facility, inpatient rehabilitation, and long-term-care settings

1. Occupational therapy practitioners working in these settings should familiarize themselves with Medicare requirements because Medicare is a primary payer for occupational therapy services in these settings.
2. Section GG outcome measures are used in all postacute care (PAC) settings for Medicare beneficiaries to track progress across the continuum of care. The following Medicare PAC Assessments use Section GG for function and mobility-related outcome measures:
   - The Inpatient Rehabilitation Facility Patient Assessment Instrument (IRF-PAI; CMS, 2022, 2023)
   - The Long Term Care Hospital Continuity Assessment Record Evaluation (LTCH; CMS, n.d.-b)
   - The Minimum Data Set (MDS) in skilled nursing facilities (CMS, n.d.-c)
   - The Outcome and Assessment Information Set (OASIS) in home health agencies (CMS, 2017).
3. See also AOTA's Section GG—Medicare Self-Care Measures (n.d.-b).

D. Outpatient practice settings: The type and amount of documentation will vary in these settings depending on the client's age, payer source and requirements, facility requirements, and any outside accrediting bodies (Gateley & Borcherding, 2017).

E. Home health settings (CMS, 2017)

1. Home health clients who have Medicare or Medicaid must have the Outcome and Assessment Information Set (OASIS) completed. This assessment helps provide guidance for the services the client requires and helps determine the client's eligibility to receive home health.
2. In certain instances, occupational therapy clinicians may complete the OASIS.
3. Occupational therapy home health documentation generally focuses on the client's ability to perform functional tasks as well as safety or environmental concerns.

VI. Legal and ethical issues related to documentation

A. Privacy and confidentiality

1. Health Insurance Portability and Accountability Act (HIPAA) of 1996 (Pub. L. 104-191): Part of this legislation gives clients certain rights regarding the privacy and release of their medical information (U.S. Department of Health and Human Services [HHS], 2017).
   a. Occupational therapy practitioners should familiarize themselves with HIPAA regulations and their facility's specific policies for meeting these requirements. Examples of strategies for meeting HIPAA's privacy requirements when completing documentation:
      - Ensure that a client's record remains private by positioning computer screens or hard charts out of others' view when completing documentation or reading others' documentation.
      - Do not leave hard charts or electronic charts open for others to read if you need to step away from your desk.
      - Do not discuss clients in public areas where others may hear what you are saying.
      - Keep hard-copy records locked in a secure area.
      - Password-protect electronic client records.
   b. HIPAA codified patient privacy and confidentiality rights. HIPAA's regulations have changed from time to time as technology and other circumstances change. Occupational therapy practitioners should make sure they maintain current knowledge and practice of HIPAA requirements.
   c. The HIPAA Privacy Rule defines and limits the use and disclosure of individuals' *protected health information* (PHI; see Kornblau, 2019). The law sets forth 18 identifiers that, if associated with medical information or billing, render that information PHI (e.g., a client's name, medical record number, or Social Security number). Failure to eliminate any of the 18 identifiers would allow someone to locate or identify the patient and thus violate HIPAA. Occupational therapy practitioners and other health care providers can de-identify the PHI by removing the 18 identifiers.
   d. Under the rules, a covered entity cannot use or disclose PHI unless the Privacy Rule allows or requires the disclosure or the individual or his or her personal representative authorizes the release in writing. The University of California, Berkeley, Human Research Protection Program provides a list of the 18 identifiers and definition of PHI at https://cphs.berkeley.edu/hipaa/hipaa18.html.
2. Family Educational Rights and Privacy Act of 1974 (20 U.S.C. § 1232g): This act protects the confidentiality of student information, including a student's educational record (Estes & Bennett, 2019), including occupational therapy documentation completed on students.
3. Individuals With Disabilities Education Improvement Act of 2004 (Pub. L. 108-446): This legislation also discusses privacy of information for children with disabilities (ages 0–21).
4. AOTA 2020 Code of Ethics:
   a. The *Code of Ethics* stresses the principle of autonomy and states that "occupational therapy personnel shall respect the right of the individual to self-determination, privacy, confidentiality, and consent." (AOTA, 2020a, p. 3).
   b. The *Code of Ethics* lists several Standards of Conduct for Occupational Therapy Personnel that apply to documentation:
      i. Standard 3 (Documentation, Reimbursement, and Financial Matters): "Occupational therapy personnel maintain complete, accurate, and timely records of all client encounters" (p. 6).
      ii. Standard 6 (Communication): "Whether in written, verbal, electronic, or virtual communication, occupational therapy personnel uphold the highest standards of

confidentiality, informed consent, autonomy, accuracy, timeliness, and record management" (p. 8).

B. Payer guidelines

1. Third-party payers (e.g., Medicare, Medicaid, private insurance companies) may request, review, and audit occupational therapy practitioners' documentation to determine whether it meets their specific guidelines for reimbursement and whether the occupational therapy services should be paid for by the payer (see the "Payment for Occupational Therapy Services" section of this lesson).
2. Occupational therapy clinicians should familiarize themselves with each payer's guidelines for reimbursement of occupational therapy services.
3. Therapists should also familiarize themselves with each payer's appeals process and consider appealing any inappropriate occupational therapy service denials by payer sources.
4. Documentation must be accurate and truthful to avoid misrepresenting the client's status, the occupational therapy services provided, or both.

Payment for Occupational Therapy Services

Key Resources

Note: The Centers for Medicare and Medicaid Services (CMS) is the largest third-party payer in the United States. Many payers of occupational therapy services follow Medicare's guidelines, making it essential for occupational therapy practitioners to understand these regulations. *Students do not need to memorize regulations for the NBCOT exam*, but they should know generally the basic requirements for reimbursement and how CMS determines eligibility. As practitioners, OTs and OTAs will need to know where to find information on CMS regulations; the links below may be helpful.

- Centers for Medicare and Medicaid Services. *Coding Section GG self-care and mobility activities included on the post-acute care item sets: Key questions to consider when coding*. (n.d.)
- Centers for Medicare and Medicaid Services. *Long-Term Care Hospital (LTCH) Continuity Assessment Record and Evaluation (CARE) Data Set (LCDS) & LCDS manual*. (n.d.)
- Centers for Medicare and Medicaid Services. *National Coverage Determination (NCD): Mobility assistive equipment (MAE)*. (2005)
- Centers for Medicare and Medicaid Services. *Medicare fee-for-service compliance programs: PMD documentation requirements (nationwide)*. (2019)
- Centers for Medicare and Medicaid Services. *Medicare and home health care*. (2020)
- Centers for Medicare and Medicaid Services. *Practitioner & DMEPOS Supplier Information on Power Mobility Devices*. (2021)
- Centers for Medicare and Medicaid Services. *HCPCS General information: HCPCS quarterly update*. (2022)
- Centers for Medicare and Medicaid Services. *Inpatient Rehabilitation Facility Patient Assessment Instrument (IRF-PAI) and IRF-PAI manual*. (2022)
- Haskins, A. M., & Hanson, D. J. (2019). Evolution and future of occupational therapy service delivery. In K. Jacobs & G. L. McCormack (Eds.), *The occupational therapy manager* (6th ed., pp. 35–48). AOTA Press.
- Jordan, K., & Sandhu, S. (2019). Private health insurance. In K. Jacobs & G. L. McCormack (Eds.), *The* occupational *therapy manager* (6th ed., pp. 285–296). AOTA Press.
- McGuire, M. J. (2019). Regulatory and payment issues. In K. Jacobs & G. L. McCormack (Eds.), *The occupational therapy manager* (6th ed., pp. 687–693). AOTA Press.

I. General information about payment and reimbursement

A. In all settings, occupational therapy practitioners must be aware of the payment and reimbursement guidelines for occupational therapy services to ensure that the services they will provide are covered.

B. Practitioners must also be knowledgeable about specific documentation requirements of each payer source.

C. The Centers for Medicare and Medicaid Services (CMS) is the largest third-party payer in the United States, and many other payers of occupational therapy services follow Medicare's guidelines for payment of services. It is essential for occupational therapy practitioners to understand CMS regulations.

D. Some payer sources may limit the monetary amount of reimbursement, and others will limit the number of visits, the types of services, and the location or site where services can be provided.

II. Medicare

A. Medicare is a federal program initiated in 1965 as part of the Social Security Act (U.S. Social Security Administration, 2012).

B. This program is administered by CMS.

C. General eligibility requirements: Medicare covers most adults age 65 years or older; some people with disabilities younger than age 65 years, and people who have end-stage renal disease (CMS.gov, n.d.).

D. Payment for occupational therapy services under Medicare falls under Part A and Part B, considered "Original Medicare," and Part C, the Medicare Advantage Program.

E. General requirements for occupational therapy reimbursement under Medicare are as follows (see CMS, n.d.-a, section 220):

1. The client must be or have been under the care of a physician; therapy services must be medically necessary.
2. Services are provided following a written care plan that is approved and signed by the physician.
3. Services are performed by qualified occupational therapy providers (OTs or OTAs under appropriate supervision).
4. Services must be skilled and require the knowledge and expertise of occupational therapy practitioners.
5. The amount, duration, and intensity of the services must be "reasonable and necessary" for the client's condition.

F. Medicare contractors process claims for original Medicare services and can provide additional information and guidance to occupational therapy practitioners regarding Medicare coverage of services (McGuire, 2019).

G. Medicare requirements for reimbursement of services vary from setting to setting.

H. Medicare Part A is considered the "hospital insurance" part of Medicare. It covers part of the expenses for inpatient stays in hospitals, short-term stays at skilled nursing facilities (SNFs) for more acute conditions, hospice, and some services in home health. It generally does not require individuals to pay a monthly premium because payroll taxes for individuals or their spouses have already paid for it (Medicare.gov, n.d.-a, n.d.-b).

1. Hospital setting
   a. Medicare hospital services are paid through a prospective payment system (PPS), in which patients are assessed and classified into diagnosis-related groups (DRGs). Expected resource needs are based on the DRG. Medically necessary occupational therapy is covered under this system.
2. Inpatient rehabilitation facility (IRF)
   a. This type of facility treats clients who require rehabilitation services. IRFs admit specific percentages of clients with certain rehabilitation conditions.
   b. Medicare IRF services are paid through a PPS. Medically necessary occupational therapy is covered based on the rate for a patient's DRG (McGuire, 2019).
3. SNF
   a. Medicare Part A covers up to 100 days of the SNF stay, including skilled nursing and therapy services in a SNF if the person meets certain criteria, such as requiring skilled services a minimum of 5 days a week. Occupational therapy services are paid as part of the per diem PPS.
   b. In October 2019, a new case-mix model titled the Patient-Driven Payment Model (PDPM) went into effect. PDPM focuses on clinically relevant factors rather than codes and other patient characteristics as the basis for patient classification (AOTA, 2018a, para. 1).
4. Psychiatric hospital
   a. Psychiatric hospitals are paid by Medicare under an Inpatient Psychiatric Facility PPS, including a per diem rate using a client classification system.
5. Home health agency
   a. A client must be considered homebound and require skilled services (nursing, physical therapy, or speech-language pathology) to qualify for home health. At the time of this writing, occupational therapy can be covered after the person qualifies for home health.
   b. The Outcome and Assessment Information Set (OASIS) helps classify clients' needs for the home health agency and helps determine payment for services.
6. Hospice
   a. A person qualifies for Medicare Part A coverage for hospice when he or she meets the criteria of being terminally ill and has a prognosis of fewer than 6 months as determined by a physician.
   b. If occupational therapy services are required, they are focused on helping clients maintain their functioning or reducing symptoms (e.g., pain control) to participate in valued occupations to enhance quality of life.

I. Medicare Part B is considered the "supplementary medical insurance" part of Medicare. It covers some of the costs for outpatient care, such as physician visits and occupational therapy services, some home health services, and some supplies and equipment.

1. Generally, most people must pay a premium each month to cover the cost of Medicare Part B (Medicare.gov, n.d.-a).
2. Medicare Part B covers 80% of the cost for medically necessary outpatient physical therapy, occupational therapy, and speech-language pathology. The client pays any deductible not met and 20% of the Medicare-approved costs (Medicare.gov, n.d.-a).
3. Outpatient occupational therapy
   a. Outpatient therapy is covered at comprehensive outpatient rehabilitation facilities, rehabilitation agencies, clinics, hospital outpatient departments, home health agencies, private occupational therapy practice, and in physicians' offices.
   b. Payment is based on the Medicare Physician Fee Schedule, which takes into account *Current Procedural Terminology* (*CPT*®) codes used during the provision of services (American Medical Association [AMA], 2020).
   c. The Medicare Part B Therapy Cap was repealed in 2018, but an annual threshold amount for occupational therapy remains; the threshold is updated each year on the basis of the Medicare Economic Index. Claims above that yearly threshold need to be billed with a KX modifier and must be medically necessary. Claims exceeding $3,000 in a year are subject to a targeted review; this amount will be adjusted in 2028 (AOTA, 2018a).
   d. Outpatient occupational therapy practitioners can also provide services in clients' homes and to Medicare beneficiaries who are inpatients in another institution under Medicare Part B.
4. Durable medical equipment (DME), safety equipment, and adaptive equipment
   a. *DME* is defined as "reusable medical equipment like walkers, wheelchairs, or hospital beds" (CMS, 2021b, p. 5). Medicare generally covers about 80% of the approved cost of DME, and the client generally pays the remaining 20% of the cost (CMS, 2021b).
   b. Occupational therapy practitioners sometimes recommend DME, adaptive equipment, and safety equipment to improve clients' safety and function.
   c. Most adaptive equipment—such as reachers or dressing sticks, bathtub seats, and grab bars—is not (as of the time of this writing) covered or reimbursed by Medicare.

J. Medicare Part C is the Medicare Advantage plan, which is offered by private companies that contract with Medicare (Medicare.gov, n.d.-a, n.d.-b).

1. A Medicare Advantage plan is a Medicare-approved plan from a private company that offers an alternative to original Medicare for health and drug coverage. These "bundled" plans include Part A, Part B and, usually, Part D.
2. A variety of Medicare Advantage plans are available, and each has different guidelines and coverage requirements. Occupational therapy practitioners will need to check specific policy requirements to determine coverage for their services.

K. Medicare Part D added prescription drug coverage to Original Medicare and some related plans. Costs and coverage varies depending on the plan (Medicare.gov, n.d.-a, n.d.-b).

III. Federal Employees Health Benefits Program

A. This health insurance covers many retired and active federal workers.

B. Coverage of specific types of services; requirements for the settings in which those services may be provided; out-of-pocket expenses; and limitations on coverage are

determined by each private plan with which the government contracts to administer health care services.

IV. U.S. Department of Defense health care: TRICARE

A. TRICARE is part of the Military Health System and provides coverage for active-duty service members, retirees, their families, survivors, and certain former spouses.

B. Nonmilitary and military providers may provide services under TRICARE.

C. Coverage for occupational therapy services may vary, depending on the specific regional plans.

V. Medicaid

A. Medicaid involves a partnership between state governments and the federal government. Although Medicaid has general eligibility requirements, the specific requirements for eligibility and coverage may vary from state to state.

B. The general eligibility requirement is income under a certain level (Medicaid.gov, n.d.-a).

C. Eligibility: People with disabilities are eligible in every state. In some states, people with disabilities qualify automatically if they get Supplemental Security Income benefits. In other states, a person may qualify depending on income level and financial resources.

D. Medicaid covers screening, diagnosis, and treatment for eligible people younger than age 21. This eligibility includes access to occupational therapy.

E. Medicaid covers services provided in nursing facilities, including occupational therapy for people age 21 and older.

F. Some, but not all, states cover occupational therapy for adults.

VI. State Children's Health Insurance Program (CHIP; Medicaid.gov, n.d.-a)

A. CHIP is funded by both the federal and state governments but is administered by each state.

B. CHIP provides health care to approximately 7 million children in low-income families with incomes too high to qualify for Medicaid (Medicaid.gov, n.d.-b).

C. Occupational therapy coverage under CHIP may vary from state to state.

VII. Individuals With Disabilities Education Act (IDEA; U.S. Department of Education, n.d.-a, n.d.-b)

A. IDEA, originally enacted in 1990 but reauthorized in 2004 as the Individuals With Disabilities Education Improvement Act of 2004, "makes available a free, appropriate public education to eligible children with disabilities throughout the [United States]. The IDEA governs how states and public agencies provide early intervention, special education and related services to more than 6.5 million eligible infants, toddlers, children and youth with disabilities" (U.S. Department of Education, n.d.-a, p. 1).

B. IDEA Part B covers children and young adults with disabilities ages 3–21.

C. IDEA Part C provides early intervention services to infants and toddlers ages 0–36 months.

D. Occupational therapy is a "related service" under IDEA Part B and an "early intervention service" under Part C (Center for Parent Information and Resources, 2017; U.S. Department of Education, n.d.-b). The services must be provided by a qualified therapist according to an individualized education plan (IEP) or an individualized family service plan (IFSP).

VIII. Workers' compensation (Roll, 2019; U.S. Department of Labor, n.d.)

A. Workers' compensation programs provide money and medical benefits to workers who are injured at work or acquire an occupation-related disease.

B. Occupational therapy practitioners may work with clients who have been injured on the job and are covered by workers' compensation insurance. The focus of occupational therapy for these clients is often to help them recover so they can return to their former job.

C. Guidelines for reimbursement for occupational therapy services for people who are covered under workers' compensation may vary from employer to employer.

IX. Private insurance

A. Many types of private insurance plans exist in the United States.

B. Each plan has its own requirements for coverage and reimbursement of occupational therapy services.

X. Coding and billing

A. Claims for occupational therapy services at most facilities are billed electronically following appropriate guidelines and regulations.

B. Occupational therapy practitioners need to become familiar with coding and billing to ensure that services are properly coded and billed (McGuire, 2019).

1. Diagnosis codes (*International Classification of Diseases, Tenth Revision, Clinical Modification;* National Center for Health Statistics, 2019): "Some OTs incorrectly believe or are told that only physicians may assign *ICD-9/ICD-10* codes. *ICD-9/ICD-10* codes serve as medical diagnosis codes, as well as treatment diagnosis codes. Therapists must use their clinical judgment to select treatment diagnosis codes that correspond to the client's condition and the intervention" (AOTA, n.d.-a).
2. Procedure codes (*CPT*): Occupational therapy providers in certain settings may use the *CPT* codes to denote services they provided for billing (AMA, 2020). However, not all payers accept all *CPT* codes. Occupational therapy practitioners are encouraged to check with reimbursement sources to learn each one's specific regulations and procedures for reimbursement.

XI. Denials, audits, and the appeals process

A. Medicare Recovery Audit Program: Medicare may audit records of those who bill services to them. Improper payments include overpayments and underpayments.

B. When a client's occupational therapy services are denied reimbursement by the payer source, the occupational therapy clinician, facility, or both may go through the payer's appeals process to see whether any technical errors can be corrected or to provide justification for payment of the services.

C. Frequent causes for denial of occupational therapy services include using an experimental intervention, writing documentation that does not demonstrate that the skills of an OT or an OTA under the supervision of an OT were needed, and exceeding the number of allowable visits.

D. Occupational therapy practitioners should become familiar with the appeals process for their major payer sources because the appeals process may vary from payer to payer.

XII. Medicare fraud and abuse and other pertinent regulations (see also the Ethics topic outline)

A. *Fraud* includes any of the following (CMS, 2021c, p. 6):

1. Knowingly submitting, or causing to be submitted, false claims or making misrepresentations of fact to obtain a federal health care payment (e.g., deliberately billing for services that were not furnished or for supplies that were not provided).
2. Knowingly soliciting, receiving, offering, or paying remuneration (e.g., kickbacks, bribes, or rebates) to induce or reward referrals for items or services reimbursed by federal health care programs
3. Making prohibited referrals for certain designated health services.

B. *Abuse* "describes practices that may directly or indirectly result in unnecessary costs to the Medicare Program" (CMS, 2021c, p. 7). Examples include billing for unnecessary medical services, charging excessively for services or supplies, or misusing codes on a claim.

C. *False Claims Act:* Sections of this act protect "the Government from being overcharged or sold substandard goods or services" (CMS, 2021c, p. 8). Criminal penalties such as fines, imprisonment, or both may result if this act is violated.

D. *Anti-Kickback Statute:* This statute "makes it a criminal offense to knowingly and willfully offer, pay, solicit, or receive any remuneration directly or indirectly to induce or reward patient referrals or the generation of business involving any item or service reimbursable by a Federal health care program" (CMS, 2021c, p. 9). Violators may face fines, imprisonment, and exclusion from participating in federal health care programs.

Regulatory Compliance

Key Resources

- American Occupational Therapy Association. OT Student Guide to Licensure (2021)
- American Occupational Therapy Association. *AOTA 2020 Occupational Therapy Code of Ethics* (2020)
- American Occupational Therapy Association. Practice Essentials: Ethics (n.d.)
- National Board for Certification in Occupational Therapy. Certification (n.d.)

I. *Policies and procedures:* Occupational therapy practitioners may need to develop or help modify their organization's compliance policies and procedures as changes occur.

II. *Ethics:* Occupational therapy practitioners should strive to practice ethically. *The AOTA 2020 Occupational Therapy Code of Ethics* (AOTA, 2020a), state regulatory boards, and the organization's own policies and procedures help provide guidance for ethical practice. Refer to the lesson on ethics for further information.

III. *State regulations:* Occupational therapy practitioners need to be aware of state regulations affecting occupational therapy practice such as licensure, certification, or registration.

A. Examination and licensure are important steps in complying with regulations.

1. The national NBCOT® OTR® and COTA® certification examinations are based on the results of practice analysis studies conducted every 5 years.
2. State regulatory boards for occupational therapy may also require licensure, certification, and registration to provide occupational therapy services in the state.

B. *License renewal:* State regulatory boards require occupational therapy practitioners to renew their license, certification, or registration at specific intervals (e.g., generally 1 or 2 years). One condition of renewal often required relates to continuing competency (e.g., staying current in the field through continuing education and other means).

C. *NBCOT certification renewal:* NBCOT certification allows occupational therapy practitioners to use its certification marks (OTR or COTA). Occupational therapy practitioners are not required by NBCOT to recertify. However, if practitioners choose not to recertify, their credentials would be changed to OT and OTA. Occupational therapy practitioners should verify whether their state regulations mandate NBCOT renewal to practice in the state.

D. *Disciplinary actions:* State regulatory boards are responsible for ensuring the safety of consumers and disciplining practitioners for ethical or practice issues. (*Note:* Please refer to the lesson on ethics for further information on this topic.)

E. State regulatory boards may differ in how they delineate requirements for supervision and roles of occupational therapy assistants and aides.

IV. Health Insurance Portability and Accountability Act (HIPAA): HIPAA (Pub. L. 104-191) governs the electronic exchange of health care data and the protection of the security and privacy of personally identifiable health care information. Key provisions are as follows:

- **A. *National Provider Identifier (NPI):* This unique number consists of 10 digits, and each health care provider and practitioner who bills for services must obtain one.**
- **B. *Health information privacy:* Occupational therapy practitioners must take care to protect the identifiable health information of consumers. HIPAA regulations give consumers the right to obtain or review their medical records and limit disclosure of information.**
- **C. *Security:* This part of HIPAA discusses privacy and confidentiality of electronic health information to ensure that it is not improperly accessed or altered.**
- **D. *Note:* Please refer to the documentation section of this lesson for information on abiding by HIPAA regulations when completing documentation.**

V. *Accrediting organizations (and requirements):* Occupational therapy managers and practitioners need to be cognizant of the various accrediting organizations related to their practice setting and those organizations' requirements for accreditation related to occupational therapy practice.

- **A. *Joint Commission:* The purpose of this accrediting body 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" (Joint Commission, n.d., para. 2). The commission assesses accreditation on a voluntary basis for hospitals or certain other health care entities.**
- **B. CARF International: This organization is "an independent, nonprofit organization focused on advancing the quality of services you use to meet your needs for the best possible outcomes" (CARF International, n.d., para. 1).**

VI. Other areas in which compliance issues arise:

- **A. *Americans With Disabilities Act (ADA) Amendments of 2008* (Pub. L. 110-325): This act is important for occupational therapy practitioners to understand; it does not just apply to clients (Collmer, 2019; Roll, 2019; U.S. Department of Justice, 2020).**
  1. "The ADA prohibits discrimination on the basis of disability in employment, State and local government, public accommodations, commercial facilities, transportation, and telecommunications" (U.S. Department of Justice, 2020, para. 1).
  2. Under the ADA, businesses with 15 or more employees are required to provide reasonable accommodations.
  3. These guidelines also relate to occupational therapy students with disabilities on fieldwork (Costa, 2019).
- **B. *Copyright issues:* Copyright is an important area of compliance for occupational therapy practitioners.**

1. Copyright protects authors of published and unpublished works by prohibiting the use of that work without attribution or permission.
2. Occupational therapy practitioners may be able to use some copyrighted material under the "fair use" exception.
3. The same rules about plagiarism that apply in academic settings also apply in practice settings: Do not use other people's work, whether copyrighted or not, without attribution or permission.

C. *Malpractice:* Malpractice can occur in occupational therapy if occupational therapy practitioners do not provide at least the typical standard of care for a client, resulting in injury to a client (Kornblau, 2019). Strategies for reducing malpractice risk and reducing the risk of harm to clients include the following elements:

1. Ensuring that adequate supervision of practitioners is provided
2. Educating employees and staff in methods to keep their clients safe from harm and encouraging continuing education related to safety
3. Having employees perform a peer review of others' occupational therapy treatment sessions
4. Documenting occupational therapy sessions accurately and in a timely manner
5. Clearly and respectfully communicating with clients (Kornblau, 2019).

D. *Fraud and abuse:* Occupational therapy clinicians should ensure that they are following appropriate reimbursement guidelines to avoid breaking any laws or committing fraud and abuse (Cheng & Kornblau, 2019).

1. Medicare regulations prohibit Medicare fraud and abuse, and penalties will result for those who commit these crimes.
2. Occupational therapy practitioners should be aware of legislation related to fraud and abuse (CMS, 2021c) such as:
   a. Anti-Kickback Statute (42 U.S.C. §§ 1320a–7b(b))
   b. Stark Law (42 U.S.C. § 1395nn)
   c. False Claims Act (31 U.S.C. §§ 3729–3733)
3. *Note:* Please refer to the insurance part of this lesson for further information on fraud and abuse regulations.

Intraprofessional Practice (Supervision, Roles, and Responsibilities)

Key Resources

- American Occupational Therapy Association. Importance of collaborative occupational therapist–occupational therapy assistant intraprofessional education in occupational therapy curricula (2018)
- American Occupational Therapy Association. Guidelines for supervision, roles, and responsibilities during the delivery of occupational therapy services (2020)
- American Occupational Therapy Association. Standards of practice for occupational therapy (2021)
- Gentile, P. A. (2023). Supervision of occupational therapy practice. In G. Gillen & C. Brown (Eds.), *Willard and Spackman's occupational therapy* (14th ed., pp. 1287–1308). Wolters Kluwer.

I. Overview: Occupational therapy practitioners must understand their roles and responsibilities in supervision of occupational therapy and non–occupational therapy personnel.

A. AOTA (2018d, 2020b, 2021e) has published several official documents that identify the roles and responsibilities of occupational therapists and occupational therapy assistants as well as how to manage nonprofessional staff (e.g., aides).

B. Occupational therapy practitioners must be prepared to effectively collaborate intraprofessionally in the delivery of occupational therapy services. An understanding of roles and respect for the knowledge and skills of OTs and OTAs in service delivery are fundamental to effective intraprofessional practice.

C. Intraprofessional collaboration is a key component of professional practice. Intraprofessional collaboration between OTs and OTAs is mandated by educational, ethical, and licensure guidelines making the relationship vital to clinical service delivery and client outcomes (Bryant, 2023).

II. Role of the occupational therapy assistant (OTA) (AOTA, 2020b)

A. OTAs, after completing initial certification and meeting state or jurisdictional regulatory requirements, receive supervision from an occupational therapist when delivering occupational therapy services.

B. Occupational therapy assistants deliver occupational therapy services in partnership with occupational therapists.

C. The OT and OTA collaborate to determine the mutually preferred plan of supervision.

III. Service competency

A. "The purpose of the supervisory process is to ensure that safe and effective services are delivered and that professional competence is fostered" (Gentile, 2023, p. 1305).

B. To ensure that services are safe and effective, the supervising occupational therapist establishes service competency with the OT or OTA being supervised.

1. *Service competency* is "the process of teaching, training, and evaluating in which the occupational therapist determines that the [OT or OTA] performs tasks in the same way that the supervising occupational therapist would and achieves the same outcomes" (Gentile, 2023, p. 1305).
2. "After initial service competency is established, the therapist supervisor will need to periodically recheck service competency to ensure that it is maintained" (Y Gentile, 2023, p. 1305).

IV. General principles of supervision (AOTA, 2020b)

A. *Supervision* refers to overall guidance and promotion of professional growth and competency. The OT and OTA must determine the suitable quality and frequency of supervision. Both the OT and the OTA must identify when supervision is warranted and match supervision to level of competence.

B. Supervision is a process aimed at ensuring the safe and effective delivery of occupational therapy services and fostering professional competence and professional development.

C. **Supervision is a cooperative process in which two or more people participate in a joint effort to establish, maintain, and/or elevate competence and performance.**

D. **To ensure safe and effective occupational therapy services, it is the responsibility of occupational therapy practitioners to recognize when they require peer supervision or mentoring that supports current and advancing levels of competence and professional development.**

E. **The specific frequency, methods, and content of supervision may vary depending on the client (person, group, or population); number of clients; setting requirements; practitioner knowledge and skill; service delivery approach; payer; and other regulatory requirements.**

F. **More frequent supervision may be necessary with complex clients; the occupational therapy process is complex, diverse, and changing; or the OT and OTA collaborate and determine that additional supervision is necessary to ensure safe and effective delivery of occupational therapy services.**

V. Methods of supervision

A. ***Direct, face-to-face:*** **observation, modeling, demonstration with a client, discussion, teaching, and instruction.**

B. ***Indirect:*** **phone and virtual interactions, telehealth, written correspondence, and other forms of secure electronic exchanges.**

VI. Documentation of supervision

A. **Supervision documentation must meet site-specific and state requirements (Gentile, 2023).**

B. **Supervision documentation should include frequency, method and type, content reviewed, evidence that supports competency, and names and credentials of the OTA and OT (AOTA, 2020b).**

VII. The Standards of Practice for Occupational Therapy are requirements for occupational therapists and occupational therapy assistants for the delivery of occupational therapy services. The OT is responsible for all aspects of occupational therapy service delivery and is fully accountable for the safety and effectiveness of the evaluation, intervention planning, intervention implementation, intervention review, and outcome evaluation (AOTA, 2021e).

A. Evaluation

1. The OT performs the evaluation and directs all parts of the evaluation process.
2. The OT interprets the gathered data and creates an intervention plan.
3. The OTA may contribute to the evaluation process by performing delegated assessments and delivering reports of observations and client capacities to the OT.
4. The OT analyzes the feedback from the OTA and incorporates that information into the evaluation process.

B. Intervention planning

1. The OT is responsible for creating the intervention plan, but the OT and OTA partner with the client to develop this plan.
2. The OTA must understand the evaluation results and be able to offer client-centered input into the intervention plan.

C. Intervention implementation

1. The OT is responsible for implementation but may delegate components to the OTA while offering adequate supervision.
2. The OTA must be knowledgeable about the client's goals and will choose appropriate therapeutic activities and interventions and modify them as needed, adhering to client goals and demands of the practice setting.

D. Intervention review: The OT determines a client's need to continue, modify, or stop occupational therapy services on the basis of information and documentation from the OTA about the client's feedback and performance during the intervention process.

E. Outcome evaluation

1. The OT selects, measures, and analyzes outcomes as they pertain to a client's occupational engagement.
2. The OTA must understand the client's specific outcomes and then document and provide information related to progress.
3. The OTA may measure outcomes and offer clients discharge resources.

VIII. Occupational therapy practitioners may be fieldwork educators.

A. The purpose of fieldwork education is to transform occupational therapy students into occupational therapy clinicians (AOTA, 2016).

B. Who may conduct fieldwork supervision varies by fieldwork level.

1. Level I fieldwork supervision: Occupational therapy students may be supervised by a licensed OT or credentialed OT, as well as by other health care professionals noted in the ACOTE® guidelines (2018, p. 63).
2. Level II fieldwork supervision: Supervision at this level is conducted by a "currently licensed or credentialed occupational therapy practitioner who has a minimum of 1 year of practice experience subsequent to initial certification and is adequately prepared to serve as a fieldwork educator" (AOTA, 2018b, p. 1).
3. Level II occupational therapy students have an OT as a supervisor, and Level II occupational therapy assistant students have an OT or an OTA (in conjunction with the supervising OT) as a supervisor (ACOTE®, 2018, p. 67).
4. Initial suggested supervision for Level II fieldwork students should be direct and can gradually decrease to less direct supervision, as appropriate (AOTA, 2018b, p. 2).
5. Some payers regulate the type of supervision required for students in certain settings (Costa, 2019).

C. Billing for students' occupational therapy services is limited to Level II fieldwork students.

1. According to AOTA, "Level II occupational therapy fieldwork students may provide occupational therapy services under the supervision of a qualified occupational therapist in

compliance with state and federal regulations. Occupational therapy assistant fieldwork students may provide occupational therapy services under the supervision of a qualified occupational therapist or an occupational therapy assistant who is under the supervision of an occupational therapist in compliance with state and federal regulations" (AOTA, 2018b, p. 1).
2. "Occupational therapy services provided by students under the supervision of a qualified practitioner will be billed as services provided by the supervising licensed occupational therapy practitioner" (AOTA, 2018b, p. 2).
3. Some payers regulate the conditions under which reimbursement of a student's services can occur (Costa, 2019).

Communication

I. Overview

Communication with clients and with other professionals is a key component of most aspects of intraprofessional practice as well as of interprofessional practice.

A. *Communication* refers to interaction that can occur in person or virtually. It includes written and face-to-face contact.

B. Nonverbal communication is just as important as verbal communication. The primary components of nonverbal communication are as follows:

1. Voice volume, pitch, tone, or emphasis on certain words
2. Use of silence
3. Gestures
4. Body positioning, distance between people communicating
5 Eye contact
6. Facial gestures

C. Occupational therapy practitioners can use several strategies for effective communication with colleagues (Humbert, 2019; Phipps, 2019).

1. Determine the best time for communication.
2. Determine the length of the communication process (e.g., 15 minutes, 1 hour).
3. Identify strategies for communication (e.g., in person, email,video conference).
4. Contemplate and put thought into the communication.
5. Plan for pertinent communication (e.g., use notes to remind you of important points).
6. Take notes as needed during communication.

II. Communication in practice

A. *Motivating colleagues:* Occupational therapy practitioners need to be aware of what motivates their colleagues and the people they supervise, such as occupational therapy assistants (Phipps, 2019). Even when not in a supervisory role, colleagues need to work together cooperatively. General strategies for improving motivation are as follows:

1. Provide positive reinforcement, praise, and rewards.
2. Treat colleagues fairly.
3. Listen to colleagues' concerns.

4. Delegate tasks and responsibilities to colleagues appropriately (i.e., colleagues should never feel like work is being dumped on them for someone else's convenience).
5. Include colleagues in decision making as appropriate.

B. *Practitioner–client relationship:* The relationship between the client and the occupational therapy practitioner is the subject of extensive literature throughout the allied health professions (see, e.g., Taylor, 2020). Occupational therapy practitioners should be familiar with this literature and incorporate a variety of techniques into their practice.

C. *Communicating with clients:* Much communication with clients incorporates elements of instruction and feedback on performance. Occupational therapy practitioners should understand how to communicate instructional content effectively and how to provide feedback on performance constructively so that the client has a positive experience (see Humbert, 2019; Phipps, 2019). Consider factors such as the client's reading literacy, health literacy, preferred communication mode (e.g., verbal, written, video), and cognitive state.

D. *Resolving conflicts:* Conflicts may occur in the occupational therapy work environment, and practitioners must be aware of strategies to resolve conflicts in an efficient and effective manner. Evidence-based strategies for resolving conflicts include the following (Phipps, 2019):

1. Encourage active communication.
2. Use "I" statements.
3. Use effective listening.
4. Use joint problem solving.
5. Achieve a solution mutually agreeable to all.
6. Stay positive.
7. Avoid uncontrolled emotions.
8. Comment on the idea rather than attacking people personally.
9. Try to come to a resolution.
10. Stay focused on the topic at hand.
11. Be aware of nonverbal communication.

Practice Improvement

Key Resources

- American Occupational Therapy Association. Everyday Advocacy (n.d.)
- American Occupational Therapy Association. Everyday Advocacy Decision Guide (n.d.)
- American Occupational Therapy Association. Knowledge Translation Toolkit (n.d.)
- American Occupational Therapy Association. Standards for Continuing Competence (2021)
- Centers for Medicare and Medicaid Services. QAPI Description and Background (n.d.)
- NBCOT. Certification (n.d.)
- World Health Organization. Quality of Care (n.d.)

I. Overview

Practice improvement involves the use of quality principles, evidence-based practice (EBP), and knowledge translation (KT) to improve practice. Practitioners can improve client care through ongoing reflection, assessment, and refinement of occupational therapy services across practice settings.

II. Quality

Quality is "the extent to which health care services provided to individuals and patient populations increase the likelihood of desired health outcomes" (World Health Organization, n.d.).

A. The concept of quality includes being efficient; practicing timely, effective, and informed care; utilizing measurement; monitoring outcomes; and focusing on process improvement.

B. Continuous quality improvement (CQI) is both a management philosophy and a management method (Braveman, 2019).

1. CQI provides a framework for identifying improvement opportunities and managing CQI teams tasked with analyzing problems so that solutions can be identified and implemented. CQI approaches such as the Plan–Do–Study–Act (PDSA) cycle are commonly used in health care (Braveman, 2019, p. 23).
2. The PDSA cycle includes these 4 steps (Institute for Healthcare Improvement, n.d.-b):
   a. Plan: The change to be tested or implemented
   b. Do: Carry out the test or change
   c. Study: Examine the data before and after the change and reflect on what was learned
   d. Act: Plan the next change cycle or full implementation.

C. Quality and Quality Management (Roberts et al., 2019)

1. The National Strategy for Quality Improvement in Health Care established 3 overarching aims:
   a. *Better care,* with the focus on improving overall quality by making health care more patient centered, reliable, accessible, and safe;
   b. *Healthy People/Healthy Communities* (HHS, n.d.), with the focus on improving the health of the U.S. population by supporting proven interventions to address behavioral, social, and environmental determinants of health in addition to delivering higher quality care; and
   c. *Affordable care,* which focuses on reducing the cost of quality health care (Agency for Healthcare Research and Quality [AHRQ], 2017).

D. The Institute for Healthcare Improvement (n.d.-a) has developed the Triple Aim to use as a foundation in achieving the National Quality Strategy. The Triple Aim framework is designed to improve the patient experience, improve the health of populations, and reduce the cost of health care concurrently.

E. CMS (n.d.-d) has established the need for essential services in the hospital systems to have a Quality Assurance and Performance Improvement (QAPI) plan, which addresses measurement of compliance with standards (quality assurance) and continuous improvement of processes to meet standards (performance improvement).

III. Evidence-based practice

A. Evidence-based practice is an approach to practice that integrates a systematic search, appraisal and synthesis of relevant research, clinical expertise, and patient preferences and values.

B. "Evidence based medicine [practice] is the conscientious, explicit, and judicious use of current best evidence in making decisions about the care of individual patients. The practice of evidence-based medicine [health care] means integrating *individual clinical expertise* with *the best available external clinical evidence* from systematic research . . . and in the more thoughtful identification and compassionate use of *individual patients' predicaments, rights, and preferences* in making clinical decisions about their care" (Sackett et al., 1996, p. 71).

C. Evidence-based practice (EBP) is a problem-solving approach to the delivery of health care that integrates the best evidence from studies and patient care data with clinician expertise and patient preferences and values. When delivered in a context of caring and in a supportive organizational culture, the highest quality of care and best patient outcomes can be achieved.

D. When assessing research to support clinical decision making, practitioners should understand which types of studies provide the strongest evidence (Centre for Evidence-Based Medicine, n.d.). Systematic reviews and randomized controlled trials should be the primary sources of support for a given intervention. Common study types, listed in order of the strength of evidence they provide (strongest to weakest), are listed in the table below.

Types of Studies	
Study Design	**Description**
Systematic review	A high-quality systematic review is considered the most reliable source of evidence to guide clinical practice. The purpose of a systematic review is to deliver a meticulous summary of all the available primary research in response to a research question. The *American Journal of Occupational Therapy's* "Guidelines for Systematic Reviews" offer additional information.
Meta-analysis	A meta-analysis is conducted after a systematic review is completed. If the population, intervention, and outcomes are the same in multiple high-quality studies, the findings from those studies can be combined and a statistical analysis conducted.
Randomized controlled trial (RCT)	An RCT is an experimental design. It is the only research design that can show if an intervention caused the outcomes of interest.
Two-group, nonrandomized studies	Nonrandomized studies with controls are quasi-experimental designs. This design is like an RCT, without the randomization.
Cohort and case-control studies	Cohort studies and case-control studies are two types of observational studies that aid in evaluating associations between variables.
Ecological studies	An ecological study is an observational study that analyzes data at the population or group level, rather than at the individual level.

Types of Studies	
Study Design	**Description**
One-group non-randomized pretest/posttest study	In a pretest/posttest study, data is collected on one group of participants before the intervention then again after the intervention.
Case series	Case series are collections of reports on the treatment and outcomes of individual patients or of reports on a single patient. All patients have the same condition.

IV. Knowledge translation

A. *Knowledge translation* (KT) is a broad term often used to describe the process of integrating research findings into routine practice. The goal of the KT process is to improve the quality of services provided to various client populations (Barwick et al., 2020). KT is quite complex and challenging, and it can delay the speed at which practitioners are able to deliver evidence-based care across practice settings.

B. There is a 17-year lag (the "research–practice gap") in the health care system between significant research discoveries and their adoption into real-world practice (Hanney et al., 2015; Morris et al., 2011). Barriers include a lack of time, insufficient resources and personnel, limited organizational support, and decreased awareness or competence delivering a particular EBP (Juckett et al., 2022).

C. KT strategies are designed to address barriers and increase the use of evidence within practice at the client, provider, and organization levels.

V. Professional development and continuing competence

A. "Continuing competence is a process of "self-assessment, reflecting on, in, and toward action to advance the knowledge, professional reasoning, interpersonal skills, performance skills, and ethical practice necessary to perform current and future roles and responsibilities within the profession" (AOTA, 2021d, p. 1).

B. The *Standards for Continuing Competence*, an official document from AOTA (2021d), describes the standards for continuing competence for occupational therapy practitioners. It includes the following standards:

1. Standard 1: Knowledge
2. Standard 2: Professional reasoning
3. Standard 3: Interpersonal skills
4. Standard 4: Performance skills
5. Standard 5: Ethical practice

C. The rationale for continuing competence is as follows:

1. It reduces the risk of providing ineffective or harmful services to clients.
2. It improves client quality of care.
3. It improves job promotion opportunities.
4. It facilitates personal professional growth.
5. It meets regulations and requirements.

a. *National Board for Certification in Occupational Therapy (NBCOT) requirements:* At the time of this writing, occupational therapy practitioners must accrue 36 professional development units every 3 years as one component of maintaining their certification (NBCOT®, n.d.).
b. *Payer and reimbursement regulations:* Payers of occupational therapy services expect positive outcomes and may not pay for low-quality services.
c. *State regulatory board regulations:* Most occupational therapy state regulatory boards require a certain amount of continuing education to continue to practice in the state).
d. *Accreditation regulations:* Certain accrediting bodies stress the need for staff development and continuing competence.
e. *Employers:* Most employers expect that professionals will remain competent in their field and may assess competency during a performance review.

D. Occupational therapy practitioners can assess their skills and develop a professional development plan. The typical steps in developing a professional development plan are as follows:

1. Use self-assessment to identify areas of weakness.
2. Determine the learning that needs to occur on the basis of the results of the self-assessment.
3. Review current goals and objectives and determine progress toward prior personal professional development goals.
4. Determine available resources for meeting future goals.
5. Change or modify prior goals and objectives or determine new goals and objectives.

E. AOTA (2017) describes the continuing professional development (CPD) process as follows:

1. *Engage in reflection:* Identify the intrinsic and extrinsic "triggers" that will affect practice, such as changes in one's practice area, employer mandates, and licensure and regulatory requirements.
2. *Perform assessment of practice:* Identify professional development needs; determine one's knowledge, skills, and abilities for meeting the triggers in (a); and incorporate objective information and performance assessments from other sources, such as self-assessment tools and peer review.
3. *Develop a CPD plan:* Prioritize needs, establish goals, identify measures for goals, identify strategies for meeting goals, set a date for completion, and modify goals as needed.
4. *Implement the CPD plan:* Engage in the identified strategies to meet goals (e.g., formal learning, mentorship, advocacy) and document changes in performance.
5. *Document the effectiveness of the CPD plan* in relation to client or consumer outcomes, job performance, and personal satisfaction.

VI. Advocacy

A. *Advocacy* is "the act of speaking up or working on behalf of the interests of another person, group, or cause" (Hart, 2019, p. 707).

1. Advocacy at all levels is an important component of occupational therapy practice. It can occur at the daily practice, professional, or systems level. Although the word advocacy sometimes suggests large actions, such as taking part in a rally or meeting with one's congressional

representative, advocacy for occupational therapy can take many forms and support the client as well as the profession (AOTA, 2021a).

2. *Everyday advocacy* is the idea that opportunities for advocacy can be found throughout day-to-day occupational therapy practice. Sometimes occupational therapy practitioners need to advocate for services for a particular client, advocate for payment for services, or advocate for legislation that is beneficial for their clients.
3. Advocacy can be conducted at the local, state, and federal levels to affect everyday practice, from billing and compensation to the scope and reach of occupational therapy, and on behalf of the profession and the people occupational therapy practitioners serve.

B. The *OTPF-4* states that professional advocacy and self-advocacy contribute to influencing and distinguishing the profession of occupational therapy.

C. Another type of advocacy involves *promoting the profession*.

1. Promoting the profession includes explaining and spreading the word of the profession's distinct value. This type of promotion explains what occupational therapy practitioners do, why that matters, and how it could benefit the end user. It helps increase utilization of and demand for occupational therapy services.
2. The following federal legislation has had a significant effect on occupational therapy practice:
   a. Education for All Handicapped Children Act of 1975 (Pub. L. 94-142) mandated equal access to education for children with physical and mental disabilities.
   b. Individuals With Disabilities Education Act of 1990 (Pub. L. 101-476) provided for services for those younger than 3 years old.
   c. Americans With Disabilities Act of 1990 (Pub. L. 101-336) and the 2008 amendments to the act (Pub. L. 110-325) provided rights to people with disabilities
   d. Health Insurance Portability and Accountability Act (Pub. L. 104-191) protects consumers' private health information.
   e. Balanced Budget Act of 1997 (Pub. L. 105-133), along with several other laws, resulted in changes to the reimbursement of occupational therapy and related services under Medicare.
   f. Patient Protection and Affordable Care Act of 2010 (Pub. L. 111-148) created many changes in the health care system phased in over several years.
   g. Family Educational Rights and Privacy Act of 1974 (20 U.S.C. § 1232g) delineates requirements for maintaining confidentiality of a student's educational record, including school-based occupational therapy.
3. Examples of advocacy strategies are as follows:
   a. Study and read about the issues.
   b. Write letters or emails to policymakers.
   c. Visit policymakers and talk to them about issues.
   d. Testify on issues related to occupational therapy practice.
   e. Participate in political action committees.

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