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Documenting Skilled Outpatient Services

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Introduction

Accurate and detailed documentation is essential to the occupational therapy profession. Documentation allows clients to receive relevant and evidence-based services that help them progress toward their goals. Medical note-taking also facilitates reimbursement for services and allows for effective communication across healthcare providers from multiple disciplines. In addition, documentation helps all OT practitioners adhere to the OT code of ethics as well as other legal and regulatory requirements. Despite all of its benefits, documentation can be cumbersome. This is especially the case between various practice settings, as each specialty has its nuances. Outpatient clinics, especially those that operate independent of larger organizations, likely feel the pressure to have concise and impactful documentation to demonstrate their value. Therapists working in this setting must also pay close attention to the additional processes and communication channels they must fulfill as both providers and liaisons.

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Section 1: Overview of Outpatient Occupational Therapy

References: 1

Outpatient clinics are one of several settings where occupational therapists provide services. However, not all outpatient clinics are alike. Many outpatient clinics offer specialized care in one (or more) practice areas. These may include but are not limited to:

- **Aquatics:** Rehabilitation that takes place inside a therapy pool
- **Cancer:** Treatment for individuals managing active cancer diagnoses or recovering from cancer

- **Dementia:** Care for individuals with dementia living within the home and other community settings
- **Drivers rehabilitation:** Services that assess and remedy driving readiness by offering adaptive solutions or exploring alternative mobility methods
- **Ergonomics:** Services to help individuals avoid cumulative overuse injuries; these may be available to the general population, but often are catered to employees to address work-related risk factors
- **Hand therapy:** Treatment for upper extremity injuries and conditions that affect anywhere between the hand and shoulder; some clinics and OT providers also include concerns related to the neck
- **Hippotherapy:** Rehabilitation that involves therapeutic bonding and activities with horses
- **Lymphedema:** Care for individuals with chronic swelling affecting the upper and/or lower extremities; these services may be provided as part of cancer rehabilitation or separately, depending on the cause of lymphedema
- **Maternal health:** Services for women who are trying to conceive, currently pregnant, or have recently given birth
- **Neurological:** Treatment for conditions affecting the central nervous system such as Parkinson's, Multiple Sclerosis, and stroke
- **Orthopedic:** Rehabilitation for any individual who has musculoskeletal conditions or injuries affecting the joints and muscles
- **Pain management:** Treatment for individuals with chronic pain as a result of long-term medical conditions

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- **Pelvic floor:** Care for pelvic floor dysfunction, which may involve incontinence, sexual health concerns, and more
- **Sports medicine clinics:** Treatment for athletes of any age who experience musculoskeletal conditions or injuries
- **Work hardening:** Services for individuals who sustained an injury that requires rehabilitation geared toward a gradual return to work

It is common for some outpatient clinics to offer a combination of orthopedic and neurological care, and they often employ therapists with experience in both areas. Some large healthcare organizations with satellite outpatient clinics may partner with therapists who work at a hospital half of the time and their outpatient clinic part of the time. This allows them to develop expertise in the full continuum of care for many conditions.

In addition, therapists may have one specialty while working in a more general outpatient setting. For example, many orthopedic clinics employ general practitioners – who can treat most any condition a patient presents with – as well as some hand therapists to offer more specialized care.

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Evaluation & Intervention Processes

The purpose of an outpatient occupational therapy evaluation is directly related to the specific services being provided. In order to better understand this, let's use institution-based services (such as those provided in hospitals and skilled nursing facilities) as an example. Services provided in these locations have the overarching purpose of rehabilitating individuals so they can return to their home or another community location such as an assisted living facility. Since individuals seeking care in outpatient clinics are already living within the community, it's understandable that the greater majority of outpatient services are geared toward

helping individuals remain in their home. Most outpatient specialties do this by helping someone overcome an injury or manage an illness, avoid or slow a functional decline, and maintain their quality-of-life.

Other outpatient specialties have slightly different focuses pertaining to their evaluations and interventions. For example, hippotherapy is an outpatient service that helps individuals of all ages to build life skills, strengthen their emotional regulation skills, and address sensory integration concerns. Therefore, the evaluation process for hippotherapy involves a deeper exploration of a client's mental health and sensory regulation than perhaps an orthopedic OT evaluation would.

Section 1 Personal Reflection

How might an OT evaluation in a work hardening program differ from an evaluation in a sports medicine clinic?

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Section 2: Referral Process

References: 2, 3, 4, 5, 6

Referrals are the first step toward seeking care at most outpatient facilities. There are some potential exceptions to this. One of these is ergonomics, as this service is typically sought out by an individual or employer directly and is offered on a consultative basis. The other is maternal health, as many boutique clinics offer services in this realm. However, maternal health may also be offered as a specialty service at more traditional outpatient clinics, so it's possible that referrals are needed to access this service in some locations.

In general, the referral process for outpatient occupational therapy services is most commonly initiated by a primary care physician who will have MD or DO credentials. Referrals can also be written by physical therapists (only those with DPT credentials), physician assistants (PA-Cs) and general nurse practitioners with DNP or ARNP credentials. Specialist nurse practitioners such as family nurse practitioners (FNPs), adult-gerontology nurse practitioners (AGNP), women's health nurse practitioners (WHNP), and psychiatric/mental health nurse practitioners (PMHNP) are also equally qualified to write OT referrals.

When a referral is given for occupational therapy services, this may either be at the request of a patient or based on the ordering provider's clinical judgment. A healthcare provider may write a referral for outpatient occupational therapy after informally observing a patients' functional concerns or after interpreting results from standardized medical assessments. Referrals are written in such a way that patients can receive services at any local clinic. However, referring providers often have partnerships with local outpatient facilities where they send their patients. Patients are usually advised to utilize these recommendations, as established healthcare professionals who write referrals tend to have a good working knowledge of the providers/clinics in their area and what expertise each has. Alternatively, referring providers can offer patients a list of locations and allow them to choose. This may be especially desirable for patients who are self-pay, as they have the liberty to compare prices and determine what is best for their budget.

Referrals include specific diagnoses from the 11th edition of the International Classification of Diseases (ICD-11), which was created by the World Health Organization. Therapists use ICD-11 codes from a patient's referral to inform the evaluation process. This sheds light on at least some of the patient's presenting concerns (and possibly also their medical history) while also allowing them to prepare standardized assessment measures. This is why accuracy and specificity

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are so important in treatment codes. It's typically recommended that referring providers avoid ICD-11 codes such as:

- Z73.6: Limitation of activities due to disability
- Z74.0: Reduced mobility
- Z74.01: Bed confinement status
- Z74.09: Other reduced mobility
- R53.1: Weakness
- M62.81: Muscle weakness, generalized
- R69: Illness, unspecified

It is far more helpful for providers to add the corresponding ICD-11 code for the patient's medical diagnosis. For example, let's say a provider is writing an outpatient OT referral for someone who has Multiple Sclerosis. At the very least, this provider should write G35 on the referral, as this is the ICD-11 code for this diagnosis. But more detail is better in this case, so the provider should pair such diagnoses codes with symptom-based codes that point toward the patient's presenting problem. For this patient with Multiple Sclerosis, a provider might also add R20.2, paresthesia of the skin, which indicates the patient has numbness and tingling in the upper body they would like help managing. A referral for a patient with Carpal Tunnel Syndrome in the right upper extremity should have the diagnosis code G56.01 and may also have R22.3 for edema of the upper extremity, M25.531 for pain in the right wrist, and R27.8 other and unspecified lack of coordination.

In some cases, a patient may have little to no outward symptoms or vague health concerns that are still in the process of being diagnosed. If this occurs and a provider believes the patient can benefit from OT services to assist their

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functional performance, the referring provider should add ICD-11 codes that point toward the patient's deficits.

Direct Access

Nearly every state offers some form of direct access to occupational therapy services. Direct access in the medical field means that a prescription, referral, order, or other piece of medical documentation is not necessary for someone to access evaluations and treatments from a healthcare provider. Regardless of what states offer direct access to OT, many have restrictions in place. These limitations say that patients can access a certain number of visits (most states set this at 10) without an order as long as they are evaluated and treated by an occupational therapist who has at least 3 years of clinical experience. After that point, progress notes and other therapy documentation must be sent to the patient's physician for review and approval, similar to what occurs at the re-evaluation period for a patient who received an order for OT services.

As with all legislation, direct access laws are subject to change. This makes it especially crucial for therapists to be aware of their state's direct access legislation – both before working as an OT in their state and before treating patients in accordance with direct access standards. OT providers should also understand the other purposes associated with prescriptions and referrals for therapy services. This documentation is often known as a requirement for service reimbursement. However, doctor's orders also help ensure medical necessity for the services that are recommended, which helps regulate service utilization and manages costs for all. This documentation also allows therapists to operate in compliance with state practice acts. Therefore, therapists should know that the vast majority of insurance companies will require some form of medical documentation from a

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patient's doctor in order to reimburse for those services. Prescriptions, orders, and referrals are all acceptable for this purpose.

Referring Provider Involvement

It is essential for any referring provider to be involved in the therapy process. Firstly, having a patient's referring provider certify a therapist's progress notes assists in avoiding gaps in insurance reimbursement. But a working partnership between the referring and treating provider also has a range of benefits for the patient. This level of involvement allows for smooth communication and the alignment of multiple aspects in a patient's treatment plan. Physician involvement also helps prevent more complex problems from arising. For example, if a therapist notices that a patient seems to be declining while under their care, the OT should make the patient's referring provider aware so they can assess them. Their response may include running new tests, making medication adjustments, or starting new medications. Any of these changes should be relayed to therapists, as they directly impact their care.

In institutions such as hospitals and nursing facilities, it may be easier for a physician to stop by a patient's room within a matter of hours after contacting them about a potential concern. However, outpatient offices – even those that are part of larger healthcare groups – are separated from where doctors see patients. This means it may be more complicated for providers in different facilities to stay updated on each of their patients' conditions in the absence of close involvement and steady communication.

Section 2 Key Words

Boutique clinic - Aesthetic- or medical-based practices that offer more upscale care; boutique clinics are known for their highly personalized care, more intimate

care approaches, and for their fee structure in the form of retainers and concierge services

Direct access - State legislation that waives the requirement warranting a healthcare provider to receive a prescription, referral, or other piece of medical documentation before completing an evaluation or treatment; there are direct access laws for both PT and OT, though they differ between professions and states

DPT - A title given to a rehabilitation provider who holds a clinical doctorate degree in physical therapy

ICD-11 code - A framework that includes procedure codes (to assist with billing for specific therapeutic and medical treatments) and diagnoses codes (to assist in determining medical necessity for billing)

Medical necessity - Any healthcare service, piece of equipment, or procedure that is required for proper, evidence-based diagnosis and treatment of a medical problem (chronic condition, illness, injury, etc.)

Self-pay - A financing option where patients pay entirely out-of-pocket for their services; this may be utilized by patients who do not have health insurance or those who choose to work around their insurance for whatever reason

Section 2 Personal Reflection

We mentioned some of the ways OTs and their patients benefit from involving PCPs in the therapeutic process. What are some ways primary care physicians benefit from having rehabilitation providers involved in their patient's care?

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Section 3: Initial Documentation

References: 7, 8, 9, 10, 11

While the referral process is one of the most crucial components to have in place before beginning outpatient treatment, therapists may also need to secure other paperwork in these early stages.

Letter of Medical Necessity (LMN)

A letter of medical necessity, also known as an LMN, is a piece of documentation detailing a patient's medical need for outpatient services. An LMN is written by a patient's referring provider (who actively oversees the patient's care) and specifically details what services are medically necessary for the patient. As we mentioned before, medical necessity must be verified throughout the plan of care in order to justify the establishment and continuation of services. However, whether or not a formal LMN is required is dependent on a few factors. Most often, policies set forth by a patient's insurance company are what dictate the need for an LMN. Some insurers may also request LMNs if a therapy office does not submit enough medical documentation to the patient's insurer or the level of detail in the aforementioned documentation is insufficient. In the event an LMN is required, it should contain some of the following information:

1. The referring provider's name, title/credentials, and complete contact information
2. The health insurer's complete contact information, including any relevant parties/departments the letter is directed to

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3. A subject line that describes the letter's intended purpose (e.g. "Requesting coverage for Patient X's OT services" or "Reimbursement for 10 OT visits for Patient Y")
4. The patient's diagnosis
    a. It's most important to highlight the main diagnosis leading the patient to require care here along with its corresponding ICD-11 code. Providers can mention other relevant diagnoses later in the letter.
5. The patient's name, date of birth, and any relevant medical history that contributes to their medical need for the requested services
    a. Providers should also include ICD-11 codes for these diagnoses.
6. The ICD-11 treatment codes the provider is requesting reimbursement for
7. The patient's potential for progress
    a. This can include any facilitating factors such as their internal motivation, active participation in care thus far, social supports, a supportive lifestyle, sound insight, or good health literacy.
8. Specifics regarding the treatment plan
    a. Therapy duration should be included here. 30-minute sessions are the most common, but 60-minute sessions may be requested due to the patient's condition or personal preference. Insurers must also know the therapy frequency, which may be one to three times per week. It is important that therapists add the frequency, since Medicare will assume one session per day if none is listed.
9. Specifics regarding the progress monitoring process

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a. Details in this section should describe how the referring provider will be involved in the therapy process (e.g. by reviewing progress notes or speaking with the treating therapist on the phone) and how often this will take place. Providers may complete rounds with treating providers weekly and review progress notes quarterly.

10. Duration of validity

a. It's considered best practice for referring providers to include the term for which their LMN is valid. This duration cannot exceed 1 year after the letter is signed. Most states automatically impose a 12-month time frame on any LMN that doesn't specifically list a term, as long as there have been no major changes in the patient's medical status. If a therapist's treatment lasts longer than the duration listed in the LMN, insurers will require a new letter before reimbursing for services.

When crafting an LMN, it is important for referring providers to attach any documentation that supports the information they included in the letter. This can include the completed occupational therapy evaluation, medical notes that show ongoing physician visits, standardized tests that demonstrate a patient's functional need for services, and more. In addition, insurers may have their own set of LMN requirements or even forms to be completed in lieu of narrative letters. These may vary between carriers, so therapists should research what is required of them before submitting any documentation.

Statement of Need

A statement of need – more formally known as the statement of need for skilled services – is another piece of documentation that must be in place before starting care. However, unlike the LMN, this comes directly from the evaluating

occupational therapist. The statement of need is just as crucial as the LMN, but it's less extensive than the letter of medical necessity and is traditionally tacked on to the end of the OT evaluation. This statement not only solidifies the therapist's professional opinion about the patient's therapy needs, but also highlights recommendations that will turn into the treatment plan moving forward. An effective statement of need should detail the specific deficits a patient demonstrates that warrant occupational therapy care and the patient's potential for improvement along with the suggested frequency (e.g. 2 times each week) and duration (e.g. 30 or 60 minute sessions) of care. Therapists can adjust the frequency and duration later, if needed. They can also edit the deficits when the patient is reevaluated.

CPT® Codes

The statement of need should offer an overview of the services the OT recommends for the patient. Therapists should also use billing-related information along with each service listed, but these will be treatment/procedure and not diagnosis codes. Many of the labels for treatments and procedures are called Current Procedural Terminology® (CPT®) codes and were developed by the American Medical Association (AMA).

There are four CPT® codes considered staples in all OT care and should be included in each statement of need for outpatient services: therapeutic activities (97530), therapeutic exercises (97110), neuromuscular reeducation (97112), and self-care training (97535). A great deal of the interventions OTs provide fall under these categories, so it's best practice to include each of them. While this is not relevant to the statement of need, therapists will use each of these codes to bill for 15 minutes of the corresponding activity. So, a therapist who provided 30 minutes of therapeutic activities during one treatment session will bill for 2 units

of 97530 when completing their daily documentation. We will discuss the use of billing units and other specific billing procedures more later.

Apart from these core CPT® codes, a range of others may be included depending on the patient's specific therapeutic needs and the exact outpatient setting. Most OT CPT® codes fall under Category I, which is designated for vaccines, devices, services, medications, treatments, and procedures. Common outpatient OT treatment codes include:

- 99072: Additional supplies, materials, and staff times that exceeds usual visit or non-facility services performed during a public health emergency
    - This was added in September 2020 as a result of the COVID-19 pandemic.
- 96161: Administration of a caregiver-focused health risk assessment instrument (including but not limited to depression inventories) for the benefit of the patient with scoring and documentation per standardized assessments *
- 97010: Application of a modality to one or more areas; hot or cold packs
- 97032: Application of electrical stimulation
- 97113: Aquatic therapy with therapeutic exercises
- 97755: Assistive technology assessment (direct, one-on-one contact) (15 minutes)
- 96127: Brief emotional/behavioral assessment with scoring and documentation per standardized assessment
- 97550: Caregiver training in strategies and techniques to facilitate the patient's functional performance in the home or community

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- 97129: Cognitive function training or retraining
- 97537: Community or work reintegration training
- 97597: Debridement of an open wound (first 20 sq. cm. or less)
    - If needed, therapists will use the code 97598 to bill for wound debridement of each additional 20 sq. cm.
- 96110: Developmental screening with scoring and documentation per standardized assessment
- 96112: Developmental test administration
- 97024: Diathermy
- 97014: Electrical stimulation, unattended
- 97113: Gait training
- 97552: Group caregiver training in strategies and techniques to facilitate the patient's functional performance in the home or community
- 96156: Health behavior assessment or reassessment *
- 96158: Health behavior intervention (individual and face-to-face) (initial 30 minutes) *
    - If needed, therapists will use the code 96159 to bill for each additional 15 minutes of individual health behavior intervention.
- 96167: Health behavior intervention (family-based, face-to-face, with the patient present) (initial 30 minutes) *

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    - If needed, therapists will use the code 96168 to bill for each additional 15 minutes of family-based health intervention with the patient present.

- 96170: Health behavior intervention (family-based, face-to-face, without the patient present) (initial 30 minutes) *
    - If needed, therapists will use the code 96171 to bill for each additional 15 minutes of family-based health intervention without the patient present.
- 96164: Health behavior intervention (group with 2+ patients and face-to-face) (initial 30 minutes) *
    - If needed, therapists will use the code 96165 to bill for each additional 15 minutes of group health behavior intervention.
- 97018: Hot wax treatment or paraffin bath
- 97610: Low frequency, non-contact, non-thermal ultrasound
- 97140: Manual therapy techniques
- 97124: Massage
- 97760: Orthotic(s) management and training, initial encounter (including assessment and fitting) (15 minutes)
- 97763: Orthotic(s)/prosthetic(s) management and/or training, subsequent encounters (15 minutes)
- 97761: Prosthetic(s) training for an extremity, initial encounter (15 minutes)
- 98970: Qualified nonphysician healthcare professional online digital evaluation and management service

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    - This code can only be used to bill for 5 to 10 minutes of cumulative treatment provided to established patients across a 7-day period. If needed, therapists will use the code 98971 to bill for 11 to 20 minutes of this service and 98972 to bill for 21 or more minutes of this service. Each of these codes can be billed only once in a 7-day period.

- 98975: Remote therapeutic monitoring (initial set-up and patient education on use of equipment)
- 98980: Remote therapeutic monitoring treatment management services (provided by a physician or other qualified healthcare professional)
    - This code can only be used to bill for 1 to 20 minutes of remote therapeutic monitoring treatment management services one time per calendar month. During this time, the provider should have at least one interactive communication with the patient being monitored or the patient's caregiver.
    - If needed, therapists will use the code 98981 to bill for each additional 20 minutes of this service.
- 97533: Sensory integration techniques
- 97150: Therapeutic procedures in a group setting
- 92606: Therapeutic service(s) for the use of non-speech-generating device (including modification and programming)
- 92526: Treatment of swallowing dysfunction and/or oral function for feeding
- 97035: Ultrasound or phonophoresis (15 minutes) [the therapist must be in constant contact with the patient to utilize this code]

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- 97542: Wheelchair management training, including management and assessment
- 97022: Whirlpool
- 97545: Work hardening or conditioning (first 2 hours)
    - If needed, therapists will use the code 97546 to bill for each additional hour of work hardening/conditioning.

CPT® codes with an asterisk (*) have some limitations specific to Medicare plans. Medicare will only reimburse for these services when they are provided and billed by occupational therapists in outpatient mental health treatment settings (specifically partial hospital programs and intensive outpatient programs). There are fewer restrictions placed on other healthcare providers offering these services due to regulations and specific scope of practice issues.

Each payer has specific regulations set forth, meaning not all health insurers will accept all CPT® codes. Before treating a patient, therapists (in conjunction with any administrative and billing staff at their practice) should identify that patient's health plan along with any restrictions they may outline. This will help avoid insurance denials, additional paperwork, and service delays, which can all ultimately prevent patients from accessing care.

HCPCS Codes

There are additional codes some therapists may need to utilize in the event their intervention of choice does not have a corresponding CPT® code. For example, there is no CPT® code for durable medical equipment evaluations or recommendations. These other codes are Healthcare Common Procedure Coding System (HCPCS) codes. HCPCS codes, colloquially known as G codes due to each code beginning with the same letter, have been created by the Centers for

Medicare and Medicaid Services (CMS). Therapists should use HCPCS codes when billing for services provided to patients who have Medicare or Medicaid health plans. There are a select number of private health insurers who will also accept HCPCS codes. Just as with CPT® codes, each payer has specific regulations set forth, meaning not all health insurers will accept all HCPCS codes.

There are two types of HCPCS codes. Level I codes are purely numeric and have an identical CPT® code that corresponds to them. Level II codes are alphanumeric and mostly cover non-physician supplies and products. Level II codes are also used for any procedures that do not have CPT® codes. Common HCPCS codes that pertain to outpatient OT care include:

- G2251: Brief communication technology-based service by a qualified healthcare professional who cannot report evaluation and management services, provided to an established patient
    - Medical discussion covered under this code cannot exceed 5 to 10 minutes.
- G0541: Caregiver training in direct care strategies and techniques to support care for patients with an ongoing condition or illness and to reduce complications (family-based, face-to-face, without the patient present) (initial 30 minutes)
    - If needed, therapists will use the code G0542 to bill for each additional 15 minutes of this service.
- G0281: Electrical stimulation for wound care
- G0283: Electrical stimulation (unattended), to 1 or more areas for indication(s) other than wound care, as part of a therapy plan of care

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- G0329: Electromagnetic therapy, to 1 or more areas for chronic Stage III and Stage IV pressure ulcers, arterial ulcers, diabetic ulcers and venous stasis ulcers not demonstrating measurable signs of healing after 30 days of conventional care as part of a therapy plan of care
- G0543: Group caregiver training in direct care strategies and techniques to support care for patients with an ongoing condition or illness and to reduce complications (family-based with multiple caregivers, face-to-face, without the patient present) (untimed)
- G0129: Occupational therapy services requiring the skills of a qualified occupational therapist, furnished as a component of a partial hospitalization or intensive outpatient treatment program (45 minutes or more)
- G2250: Remote assessment of recorded video and/or images submitted by an established patient, including interpretation with follow-up with the patient within 24 business hours

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The 8-Minute Rule

In order to fully understand proper usage of CPT and HCPCS codes, therapists must know about the 8-Minute Rule. This helps providers determine how many units of each code to bill for based on the amount of time they offer each service. The 8-Minute Rule sets forth minute-to-unit conversions to help with this:

- 1 unit: >8 - 22 minutes
- 2 units: >23 - 37 minutes
- 3 units: >38 - 52 minutes
- 4 units: >53 - 67 minutes

- 5 units: >68 - 82 minutes
- 6 units: >83 - 97 minutes
- 7 units: >98 - 112 minutes
- 8 units: >113 - 127 minutes

There are some additional rules to follow when determining billing units. CMS states that when a provider administers only one timed 15-minute HCPCS code in one day, they cannot bill for less than 8 minutes as that is what each unit interval is based on. When providing more than one unit, the initial and subsequent services must cumulatively total 15 minutes or more. If the last of those units is provided for 8 minutes or more, it is considered (1) full unit. Therapists cannot exceed the total treatment minutes for any timed code, as this is the reason timed codes are labeled as such. While providers can bill for timed and untimed codes on the same claim, they cannot include time spent on untimed service codes when calculating their timed-code service time. For more guidance specific to HCPCS codes and the 8-Minute Rule, you can reference Chapter 5, Section 20.2 of the Medicare Claims Processing Manual.

Let's go through some examples to help reinforce understanding of this structure. For instance, a therapist might complete a 60-minute session with a patient and want to bill for the 30 minutes of therapeutic activities they provided to that patient. When filling out a claim for that patient's session, the therapist would bill for 2 units of the CPT code 97530. In the event a therapist provides four separate 8-minute treatments totalling 32 minutes of treatment time, they would not bill for four 15-minute treatment units. Instead, they would report two units, which is between 23 and 37 minutes of treatment time. They are able to report a third unit when the treatment time total is between 38 and 52 minutes. Similarly, they can

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bill for a fourth unit when the treatment time total reaches 53 minutes but does not exceed 68 minutes.

Modifiers

When billing for certain services and patients, therapists must also use modifiers. These do not come up all the time and are used for specific circumstances. Either way, therapists must understand when and how to properly use them in order to accurately bill for the services they provide.

If a therapist has OTR/L credentials, they will use the GO modifier to designate services that were provided by a registered and licensed OT. If a therapist has COTA/L credentials, they will use the CO modifier to designate services that were provided by a registered and licensed OTA. If an occupational therapist, physical therapist, or speech-language pathologist provides services via telehealth, they will use the 95 modifier. For some insurers, the GT modifier is used for telehealth instead, so it's important to understand each insurer's guidelines when billing for patient treatment time. If a therapist provides at least two procedures on at least two different sites of the body during the same visit, they would use the 59 modifier, which is a distinct procedural service code. This would be appropriate for patients who have multiple musculoskeletal concerns, possibly as a result of arthritis or another chronic condition. For example, if a therapist provides paraffin wax and therapeutic massage on the patient's wrist and elbow during the same session, they would use the 59 modifier when billing for those services. If a service is provided by a different therapist during the same patient session, they would use the XP modifier when billing. This is most often used when OTRs and OTAs team up to perform a cotreatment for the sake of supervision, but the OTR has more expertise in a certain modality so they perform that one modality exclusively during the session. If a provider has confirmed a service is medically necessary for a patient who is past their therapy threshold, they would use the KX

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modifier. Lastly, DR and CR modifiers are used for services provided to Medicare patients during verified public health emergencies, such as the COVID-19 pandemic. If any modifiers require therapists to list the patient's location in their documentation, providers must note the patient's location as "in-person/in-clinic" if they are seen at the provider's facility and "home" for any type of telehealth services. These codes make reference to the location where the patient would have otherwise received services if telehealth was not an option.

Section 3 Key Words

CPT® code - A framework developed by the American Medical Association that consists of alphanumeric codes assigned to all diagnostic, surgical, medical, and treatment-based services

Intensive Outpatient Program - This outpatient setting offers between 2 and 4 hours of substance use disorder and/or mental health treatment several times each week; IOPs are for individuals who have moderate symptoms that cannot be properly addressed by less frequent talk therapy sessions; individuals may participate in an IOP for several weeks or months

HCPCS code - A framework developed by the Centers for Medicare and Medicaid Services that consists of numeric and alphanumeric codes assigned to medical procedures, services, and supplies

Partial Hospitalization Program - This outpatient setting offers between 4 and 6 hours of substance use disorder and/or mental health treatment daily; PHPs are for individuals who need frequent, intensive care for severe symptoms, but do not meet criteria for psychiatric hospitalization; individuals may participate in a PHP for several weeks or months

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Section 3 Personal Reflection

Aside from billing and reimbursement, what are some other practical purposes that CPT® and HCPCS codes may serve for occupational therapists and other healthcare providers?

Section 4: Outpatient Occupational Therapy Evaluations, Reevaluations, & Progress Notes

References: 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25

The outpatient occupational therapy evaluation must be thorough, so it often covers many of the same client factors and skill areas. These typically include:

- **Chief complaint/presenting problem**: This should briefly note the reason a patient is seeking care.
- **Prior level of function (PLOF)**: In many cases, a patient's PLOF might note that they were independent or had no concerns in the area they are seeking care for. If you are treating a patient with an extended illness, they may have needed assistance (but less of it) even before their condition worsened.
- **Employment/work history**: Since individuals who seek outpatient treatment are community-dwelling, they may or may not have a full-time job. For some people, being able to return to work or do their job better may be a priority.
- **Medical/surgical history**: The most important history will involve procedures or diagnoses that are relevant to the patient's presenting

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problem. However, therapists should get as much information as they can in this area.

- **Occupational profile**: The American Occupational Therapy Association outlines the following components as part of an occupational profile: occupations that are successful or unsuccessful, personal values and interests, contexts and client factors that support or inhibit engagement (OTs should cover environmental and personal contexts along with values/beliefs/spirituality, body functions, and body structures), performance patterns, and client priorities.

- **Prognosis**: This is determined using the therapist's clinical judgment and is based on the nature and acuity of the patient's condition/injury, their past medical history, comorbidities, patient motivation and willingness for change, and lifestyle factors.

- **Descriptors of patient's condition**: This section can be used to describe various aspects of the patient's condition and may include injury/disease severity, irritability related to symptoms, stage, and level of medical stability. If a patient's main presenting concern is pain, a therapist should add details about the location and type of pain (e.g. shooting, aching, dull, throbbing, etc.).

- **Objective testing**: Each outpatient evaluation should include basic objective testing in core skill areas. Staples for this part of the evaluation are active/passive range of motion (AROM/PROM) to assess motion, manual muscle testing (MMT) to gauge strength, and Visual Analog Scale (VAS) to evaluate pain. Based on the patient's presenting problem(s) and the therapist's observations, the provider should supplement with other formal tests that cover other skill areas. Some outcome measures that may be beneficial for therapists completing evaluations in this setting include:

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- ADL function: Assessment of Motor and Process Skills, Katz Index of Independence in Activities of Daily Living, Barthel Index, ADL Profile
- Balance: 30-Second Chair Stand Test, Berg Balance Scale, Four Square Step Test
- Cognition: Montreal Cognitive Assessment, Mini-Mental State Exam, Mini-Cog, Saint Louis University Mental Status Examination
- Condition-specific assessments: Boston Carpal Tunnel Outcomes Questionnaire, National Institutes of Health Stroke Scale, MS Quality of Life, Fugl-Meyer Assessment of Motor Recovery After Stroke, Clinical Disease Activity Index, Postural Assessment Scale for Stroke Patients, Stroke Impact Scale, Functional Assessment of Cancer Therapy
- Endurance: Borg Dyspnea Scale, Assessment of Chronic Illness Therapy – Fatigue, Multidimensional Fatigue Inventory, 6-Minute Walk Test
- Falls: Falls Efficacy Scale, 30-Second Chair Stand Test, The Activities-specific Balance Confidence Scale
- Fine motor skills: 9-Hole Peg Test, Jebsen-Taylor Test of Hand Function, Quality of Upper Extremity Skills Test, Box and Block Test, Disabilities of the Arm, Shoulder and Hand, QuickDASH, Manual Ability Measure
- Gross motor skills: Gross Motor Function Measure
- IADL function: Functional Independent Living Scales, Instrumental Activities Of Daily Living Scale, The Lawton Instrumental Activities of Daily Living Scale, Kohlman Evaluation of Living Skills

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- Leisure: Nottingham Leisure Questionnaire, Leisure Interest Index, Leisure Checklist, Leisure Activity Participation Index
- Maternal mental health: Edinburgh Postnatal Depression Scale, Postpartum Social Support Screening
- Mental health: Beck Depression Inventory, Mental Health Screening Form III, UCLA PTSD Reaction Index, Occupational Performance History Interview-II, Personal Adjustment and Role Skills, The Model of Human Occupation Screening Tool, Distress Thermometer, Canadian Occupational Performance Measure, Activity Card Sort
- Mobility: Timed Up and Go Test, Rivermead Mobility Index
- Pain: Brief Pain Inventory, Dallas Pain Questionnaire, The Chronic Pain Acceptance Questionnaire, Numeric Pain Rating Scale, Pain Disability Index
- Pediatric feeding: Children's Eating Behavior Inventory
- Pediatric IADL function: Casey Life Skills
- Pediatric mental health: Child Occupational Self Assessment, Children's Sleep Habits Questionnaire, Pediatric Evaluation of Disability Inventory, The Pediatric Quality of Life Inventory, Perceived Efficacy and Goal Setting System, Pediatric Activity Card Sort, Pediatric Interest Profiles
- Pediatric motor skills: Bayley Scales of Infant and Toddler Development, Bruininks-Oseretsky Test of Motor Proficiency, Peabody Developmental Motor Scales, ABILHAND-Kids
- Pelvic floor: Female Sexual Function Index, Pelvic Floor Disability Index, Pelvic Floor Impact Questionnaire

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    - Sensory integration: Adolescent/Adult Sensory Profile, Sensory Integration and Praxis Tests, Sensory Profile, Sensory Integration Inventory–Revised for Individuals with Developmental Disabilities, Sensory Processing Measure
    - Social skills: Social Communication Questionnaire
    - Strength: Dynamometer Grip Strength, Pinch Strength
    - Visual motor skills: Beery-Buktenica Developmental Test of Visual-Motor Integration
    - Work function: Work and Social Adjustment Scale
- **Goals**: Based on the results of testing, the therapist should devise short-term and long-term goals to serve as the basis for the patient's treatment plan. As with all therapy goals, this section should use the SMART format. This means, in order to be effective, each goal must be specific, measurable, achievable/attainable, realistic, and time-sensitive.

Occupational therapists may need to adjust the patient's diagnosis more appropriately in their evaluation after receiving the prescription/referral. While OTs do not have diagnostic capabilities and should not be adding any diagnoses codes that they don't have the qualifications to add, they can add other relevant diagnoses codes. Some appropriate codes include those that refer to immobility, gait abnormalities, muscle weakness, pain, edema, motor incoordination, and other visible symptoms a patient presents with during the evaluation. It is not appropriate for an occupational therapist to add a diagnosis of carpal tunnel syndrome, for example, to an OT evaluation for someone who does not already have this diagnosis from their doctor.

As we mentioned in the last section, the end of the OT evaluation is also where an occupational therapist will add the patient's statement of need along with the

CPT® or HCPCS codes for all of the services they recommend. In addition to this, therapists should also add the CPT® codes for the OT evaluation itself. These are determined based on the complexity of the patient's case. The CPT® code for a low-complexity OT evaluation is 97165, a moderate-complexity OT evaluation is 97166, and a high-complexity OT evaluation is 97167. An OT reevaluation of any kind is coded using 97168.

The AMA, who developed CPT® codes, notes that all OT evaluations should include an occupational profile and the patient's medical and therapy history (including records review to supplement patient information). In addition, each OT evaluation has varying degrees of complexity related to clinical decision-making. These are as follows:

1. Low-complexity OT evaluation (these require around 30 minutes of time spent with the patient/their caregiver)
    a. The occupational profile and medical/therapy/surgical history review are brief due to the absence of a long history.
    b. The problem-focused assessment process identifies 1-3 performance deficits that result in activity limitations.
    c. The patient presents with no comorbidities that affect occupational performance.
    d. The clinical decisions therapists are required to make for this evaluation are of low complexity due to there being a limited number of potential treatment options.
    e. The patient does not need task modification or any form of assistance during the evaluation process.

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2. Moderate-complexity OT evaluation (these require around 45 minutes of time spent with the patient/their caregiver)
    a. The occupational profile and medical/therapy/surgical history review are expanded due to some relevant history.
    b. The detailed assessment process identifies 3-5 performance deficits that result in activity limitations.
    c. The patient may present with comorbidities that affect occupational performance.
    d. The clinical decisions therapists are required to make for this evaluation are of moderate complexity due to there being several potential treatment options.
    e. The patient needs minimal to moderate task modification and/or assistance during the evaluation process.
3. High-complexity OT evaluation (these require around 60 minutes of time spent with the patient/their caregiver)
    a. The occupational profile and medical/therapy/surgical history review are extensive due to a significant amount of relevant history.
    b. The comprehensive assessment process identifies 5 or more performance deficits that result in activity limitations.
    c. The patient presents with comorbidities that affect occupational performance.
    d. The clinical decisions therapists are required to make for this evaluation are of high complexity due to there being multiple potential treatment options.

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e. The patient needs significant task modification and/or assistance during the evaluation process.

4. OT reevaluation (these require around 30 minutes of time spent with the patient/their caregiver)

    a. The therapist updates the occupational profile based on changes to the patient's medical condition or environment that stand to affect the plan of care.

    b. If this is a formal reevaluation (e.g. the time is being billed for), the therapist must also revise the plan of care. These plan of care revisions must be made if there are significant documented changes in the patient's function or medical condition or if the plan of care is now largely inappropriate for the patient.

Once the initial OT evaluation (and related plan of care) are completed, Medicare requires a nonphysician practitioner (NPP) or a licensed physician to sign and date the document within 30 days. Surprisingly, Medicare does not have any requirements that the physician or NPP who signs the plan of care be the patient's regular physician. In some cases, physicians will not sign this documentation unless they have at least one visit with the patient, but this is not a requirement by Medicare. CMS does state that the certifying provider can be a podiatrist, optometrist (only in the case of referrals for vision rehabilitation), osteopath, or a doctor of medicine. The only exclusions CMS lists for certifying providers are doctors of dental medicine or surgery and chiropractors. CMS states these providers cannot refer patients to OT nor can they supervise a therapy plan of care.

Outpatient OT Evaluation Checklists

In addition to the above components that should be standard in many outpatient evaluations, the American Occupational Therapy Association highlights the importance of some other areas when evaluating older adults. In particular, they have created a Medicare Part B evaluation checklist that integrates specialty measures from the Quality Payment Program (QPP) Merit-Based Incentive Payment System (MIPS). These specialty measures are identified as high priority areas all therapists should cover in their evaluation:

- Urinary incontinence in women ages 65 and older
- A neurological evaluation in individuals with diabetes mellitus who are at risk of or have peripheral neuropathy (diabetic foot/ankle care)
- An evaluation of footwear in individuals with diabetes mellitus who are at risk of or have pressure ulcers (diabetic foot/ankle care)
- Documentation of current medications listed in the patient's medical record
- Screening and follow-up plan, if needed, for clinical depression
- Functional status change for those with knee impairments
- Functional status change for those with hip impairments
- Functional status change for those with lower leg, foot, and/or ankle impairments
- Functional status change for those with lower back impairments
- Functional status change for those with shoulder impairments
- Functional status change for those with elbow, wrist, and/or hand impairments

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- Functional status change for those with neck impairments
- A cognitive assessment for individuals with dementia
- Safety concern screening and related follow-up for those with dementia
- Education and support for caregivers of patients who have dementia
- A cognitive assessment for individuals with Parkinson's disease
- Screening for social determinants of health
- Improvement or maintenance of functioning for people with mental and/or substance use disorder(s)
- Connection to community service provider(s)
- Elder maltreatment screening
- Depression screening
- Screening and cessation intervention for those who use tobacco

AOTA has also compiled a Section GG Medicare Functional Assessment according to CMS guidelines, which is helpful for therapists to use with patients in all post-acute care settings. This outlines specific functional levels in each ADL area at admission, as part of goal setting, and at the time of discharge. This breaks down some ADLs into smaller parts, therefore, it includes:

- Eating
- Oral hygiene
- Toileting hygiene
- Personal hygiene
- Washing the upper body

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- Bathing or showering oneself
- Dressing the upper body
- Dressing the lower body
- Donning/doffing footwear
- Rolling to the left and right
- Repositioning from sitting to lying down
- Repositioning from lying down to sitting edge of bed
- Going from sitting to standing
- Chair or bed to chair transfer
- Toilet transfer
- Tub or shower transfer
- Car transfer
- Walking 10 feet
- Walking 50 feet while making 2 turns
- Walking 150 feet
- Walking 10 feet on uneven surfaces
- Ascending 1 step (or a curb)
- Ascending 4 steps
- Ascending 12 steps
- Picking up an object from the floor

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- Propelling a wheelchair 50 feet while making 2 turns (if the patient is a wheelchair user)
- Propelling a wheelchair 150 feet (if the patient is a wheelchair user)

Reevaluations

Reevaluations and progress notes may be confused with one another since they have similar purposes. The main difference between reevaluations and progress notes is that the former is a billable service and the latter is not. Reevaluations are comprehensive reassessments, which often take place after the patient experiences a major medical or functional change. However, payers often set forth requirements regarding how often reevaluations must be completed. For example, CMS mandates OTRs to complete reevaluations on their patients every 30 days. Once a reevaluation has been completed, the next non-reevaluation session for that discipline starts the next 30-day period counting down to the next reevaluation. If a patient is receiving more than one outpatient service (such as PT and OT at the same time), a qualified provider from each discipline (e.g. OTRs and MPTs or DPTs) must complete their own reevaluation.

In order to complete a full reassessment, therapists must readminister any standardized testing that was completed during the evaluation and take a specific look at what remaining deficits the patient displays. This not only speaks to the effectiveness of the therapy that has been provided, but offers justification for continued services. In a reevaluation report, OTs must include plans for future sessions with the patient, such as new interventions they recommend and any changes to the patient's existing goals. Reevaluation reports also allow therapists the opportunity to adjust the patient's diagnosis and therapy frequency/duration, if needed.

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Progress Notes

Progress notes are more brief, routine updates completed more frequently than reevaluations. Specifically, therapists must complete progress notes for Medicare patients every 10 visits. Other payers may or may not set forth their own guidelines regarding how often progress notes must be submitted. If other insurers do not set a cadence for progress notes, many therapists follow CMS' guidance to remain consistent. Progress notes should include basic information such as the patient's name, date of birth, account number (or other facility identifier), and the date/time of the session connected with the note. Progress notes should also include the therapist's name and credentials; a brief overview of the patient's functional status; the patient's therapy goals and progress toward each one; brief details associated with each of the interventions the patient has received thus far (e.g. duration/frequency of ultrasound, repetitions of therapeutic exercise, etc.); the patient's response to these interventions – either as a whole or separately if responses vary between interventions; any necessary changes to plan of care interventions or frequency/duration; and any necessary changes to the patient's goals.

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According to Medicare's definition of medical necessity and criteria for progress notes, this documentation should convey that:

- The patient's condition: (1) continues to suggest the potential for improvement and/or (2) is readily/currently improving in response to current therapeutic interventions
- The patient has yet to reach their maximum level of improvement anticipated by the evaluating and/or treating therapist

- The therapist has clinically sound reasoning to support the expectation that future improvement for this patient is realistic, reasonable, and attainable within a moderate amount of time

Progress notes should utilize objective measurements wherever possible to support the aforementioned statements. If a therapist finds at any time during the progress reporting period that a patient's rehabilitation potential is insignificant compared to the duration and frequency of therapy services warranted to achieve their goals, rehabilitation is no longer considered medically necessary or reasonable. Therapists should always offer objective, honest reports of their patient's abilities and potential for improvement. Medicare (and other health insurers) look for certain verbiage to express good rehabilitation potential and medical necessity. These include: 'predictable period of time, 'improvement,' 'expectation,' and 'reasonable.' This means not only must a patient be expected to improve, but it should also be stated that the patient will do so within a reasonable time frame. Therapists can use these terms across various statements in a patient's progress report or include them in the last few statements of the report as a summary. The exact phrasing is, of course, up to the therapist writing the report. Some examples of ways to incorporate these terms into progress reports and similar documentation include:

- It is the expectation that Mrs. Smith will demonstrate sufficient improvement in a predictable period of time.
- This therapist expects Mr. Rollins to achieve his goals within a reasonable time frame, specifically by the next recertification/progress reporting period or sooner.
- It is this therapist's clinical opinion that Ms. Farley will continue to improve at the same rate as she currently is, which would allow her to reasonably meet her long-term objectives within the next (1) calendar month.

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- In summary, this therapist believes Mr. Jiminez will achieve his remaining goals within a predictable period of time, allowing him to be discharged by the end of the next reporting period.

While somewhat less common, outpatient occupational therapists may also write progress reports for patients receiving maintenance therapy. The medical necessity criteria in these instances is understandably different. Medical necessity for maintenance therapy includes treatment that is required in order to prevent, maintain, or slow further deterioration of a patient's level of functioning. In addition, OTs must use progress reports to mention that maintenance therapy services cannot be safely or effectively provided by the patient themselves, their caregiver(s), or family member(s). This is a proper demonstration of medical necessity for such services, which may be recommended for patients with cancer, severe contractures related to a stroke or other neurological injury, or a terminal and potentially medically complex diagnosis.

Therapists should also note scope of practice restrictions in place pertaining to progress notes, which govern protocols for OTAs who treat patients under the supervision of an OTR. An OTR must solely implement one billable service to each of an OTA's patients during one (or more) service dates within the period outlined by the progress note. When supervising occupational therapists sign off on progress notes completed by OTAs, they are certifying their compliance with this regulation. For example, an occupational therapist must sign off on an OTA's progress note that addresses Patient X's gains between April 10th and May 15th. The OTR will remain in compliance with supervision and scope of practice policies if they provide a cotreatment with the treating OTA on April 20th. In the event the OTR has a scheduling conflict and can only be present for 10 minutes of the cotreatment, they can provide and bill for one unit on April 20th along with providing and billing for one unit on April 24th (or the patient's next regularly

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scheduled visit). These cotreatments fall within the range of the progress note period and allow the OTR to effectively sign off on the content of the OTA's report.

Recertifications

Recertification is another term therapists must know; however, it is not a piece of documentation a therapist must complete and submit. The onus for a reevaluation is on the therapist, who must compile quantifiable data that proves the patient is making progress yet still has remaining deficits that require continued therapy. The recertification, on the other hand, is moreso the responsibility of the health plan. When a therapist's progress notes, reevaluation, and other documentation indicate the patient is making slow progress and not performing as expected, this is when a recertification comes into play. Recertifications typically involve sending the payer additional information so they can confirm the patient does truly need additional services. Each payer has various recertification requirements, which therapists should be familiar with if they treat an array of patients. For example, CMS states that all Medicare patients must have their plan of care recertified after 90 days of treatment.

Section 4 Key Words

Client factors - Personal factors that may support or hinder occupational engagement; client factors include body functions, body structures, values, beliefs, and spirituality

Community-dwelling - An adjective used to describe individuals who live in community settings such as homes, apartments, condos, or anywhere else outside of care facilities

Cotreatment - Direct collaboration between at least two healthcare providers to provide skilled services to patients during one treatment session; cotreatments most often occur between providers of similar disciplines, such as OT and PT or OT and SLP, but may also take place to fulfill supervision requirements for providers within the same field (such as OTRs and OTAs)

Nonphysician practitioner (NPP) - A healthcare provider who does not have the title of MD or DO, but does have some of the same advisory duties as a physician; examples of NPPs include physician assistants (PAs), advanced registered nurse practitioners (ARNPs or APRNs), and clinical nurse specialists (CNSs)

Performance patterns - Habits, rituals, roles, and routines related to a person's occupational engagement

Plan of care - A piece of therapy documentation that details a specific schedule or strategy of treatments to address outlined medical symptoms and/or functional deficits

Rehabilitation potential - The probability of a patient's functional, cognitive, and/or physical skills improving as a direct result of rehabilitation services; this is considered a rough assessment of how readily someone is expected to recover from any given illness or injury

Section 4 Personal Reflection

How might an outpatient occupational therapy evaluation for a young child differ from an outpatient occupational therapy evaluation for a 75-year-old patient?

Section 5: Daily Treatment & Discharge Notes

References: 26, 27, 28, 29, 30, 31

Daily treatment notes are not nearly as elaborate as other aspects of outpatient documentation. However, they are still essential logs of what occurred during patient treatment sessions. CMS specifically outlines why daily notes are so crucial, by stating their use as a record of all interventions as well as time spent with a patient. In addition, all billing codes a therapist claims must align with their daily notes. Therapy documentation helps keep the therapist accountable by ensuring continuity between service provision and billing/coding. It is beneficial to all parties involved if therapists offer enough detail in daily notes to allow a neutral third party to understand why the selected codes were chosen. This is especially helpful in the event a therapist or their facility undergoes an audit, which we will discuss later.

CMS goes on to state that daily therapy documentation is a requirement for each day a patient is scheduled to receive treatment (whether they actually do or not) and for each and every therapy service. All treatment notes should follow policies and protocols set forth by the healthcare facility where the therapist is employed. While therapists do not need training in different daily documentation styles, it is important for their notes to be of a similar structure to the notes of other therapists at their facility.

Contrary to what therapists may believe based on content covered thus far, therapists do **not** need to demonstrate medical necessity in their daily treatment notes. These notes also do not need to justify how appropriate therapy services are based on the patient's plan of care. As we mentioned earlier, the statement of skilled need, plan of care, progress notes, and reevaluations all have a much heavier focus on medical necessity. While therapists can include as much detail in their daily notes as they like, providers also do not need to offer detailed descriptions of interventions provided, especially if they are the same over a defined span of time (as may be the case with certain physical agent modalities

such as therapeutic ultrasound). It is more appropriate and beneficial to include this information in the patient's plan of care and/or progress notes.

Daily treatment notes are mostly consistent across the various outpatient specialties. Each daily note should include:

1. A self-report from the patient, which may include progress, new symptoms or concerns, questions about their home exercise program, etc.
    a. This section may also include relevant therapist observations, which may be plainly visible or noted based on brief assessments. This can include new patient impairments, functional changes, abnormal vital signs, or medical status changes since their last visit.
2. A list of the skilled interventions offered during the session, including details about the duration, intensity, and frequency. Patient and/or caregiver education also falls under this category. These details mostly apply to therapeutic exercises and physical agent modalities such as ultrasound and electrical stimulation. Remember that daily treatment notes should be concise, but detailed enough that any other OT can read them and replicate the treatment with the patient in your absence, if needed.
    a. Therapists should make mention of any activities or interventions that were upgraded or downgraded during this particular session as well as how these modifications pertain to the patient's goals.
3. The patient's response to interventions, such as improvements due to the level of assistance you provided, adverse reactions (if any), and motivation for participation.

There are several different formats outpatient treatment notes can take, with SOAP notes being the most common due to their simplicity and succinct inclusion of the aforementioned components. SOAP notes include a subjective section

(patient self-report), objective section (therapist interventions), assessment section (therapist interpretation of patient response to intervention), and plan section (any relevant changes to the plan of care or future sessions). Occupational therapists may also use narrative notes in some outpatient practice areas such as ergonomics and mental health.

Here is an example of a SOAP note for a 10-year-old child with Autism Spectrum Disorder. Note that the headings are not often included in actual notes, but are added here for the sake of clarity and instruction:

Subjective: High energy and some dysregulation upon arrival. Mom reports she did not want to give up her toy before coming into therapy.

Objective: Gentle rocking, linear swinging, body sock to assist with self-soothing. Peg game, lacing task, word copying, 3-step craft activity at tabletop.

Assessment: She responded well to verbal prompts to initiate sensory tasks at the start. Tabletop tasks with visual demo and mod verbal cues throughout. She needed 1-step directions to copy 3/20 letters and 3 sensory breaks to remain seated for a total of 12 minutes.

Plan: Continue therapy as outlined in POC as tolerated.

Discharge Notes

When it is time to discontinue outpatient services with a patient for any reason or length of time, occupational therapists must write a discharge note. Discharge notes offer information that will be used by several parties as the patient transitions away from services. Payers usually require discharge notes to ensure no reimbursement is provided after the end of care (EOC) date. In addition, patients may bring OT discharge reports to their primary care doctor as proof of completion or use the information on it for their own records.

In many cases, discharge notes serve as replacements for progress notes, such as when a patient is discharged at their next reporting period rather than continuing with services. Therefore, discharge notes must understandably include much of the same information progress reports do. These notes are often called discharge summaries since they offer a synopsis of the patient's time in therapy, including a brief overview of the goals they were working on, progress they made toward those goals, interventions received, and recommendations for the future.

We've already reviewed what to include under most sections in a discharge summary. The only section that is new thus far is future recommendations, which often depends on the patient's discharge reason. For example, if the patient is being discharged as a result of meeting their goals, the therapist might advise them to continue their home program to maintain the gains they achieved in therapy. If a patient is being discharged due to a hospital admission or other medical status change, a therapist should recommend they follow up with their primary care provider and/or return to outpatient OT as soon as they are medically stable and cleared.

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Section 5 Key Words

End of care - The last day of a patient's plan of care, which is usually the same day as the patient's last OT visit

Section 5 Personal Reflection

What is the main way SOAP notes differ from other styles of daily therapy note documentation?

Section 6: Amending Documentation, Audits, and Medical Record Maintenance

References: 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48

Since all forms of medical documentation are protected by legislation such as the Health Insurance Portability and Accountability Act (HIPAA), they must be completed, checked, and stored in a certain way for safety, accuracy, and compliance purposes.

Amending Documentation

One way of maintaining medical records properly is by ensuring any medical record errors are corrected appropriately and as soon as possible. Any errors must be corrected in a way that does not completely remove the original entry. This is mainly for the sake of audits and record keeping, so that anyone who reads the documentation sees the original entry and what it was changed to. The best way to amend any form of medical documentation is by using a pen to make a single, thin line through the error, then adding your initials and the date the error was adjusted next to the line. Then, the therapist can add the corrected information nearby, if adding new information is the reason for the amendment. Therapists cannot use white stickers, correction fluid, or any other mechanism to cover the error. This is because, in the event of an audit, anyone reviewing the medical records needs to see what was initially written and what changes were made afterwards. It is also best practice for therapists to add the reasoning for the error. In the case of paper charts, this must be handwritten and can be brief. Electronic medical record (EMR) software typically prompts providers to enter this reason either by making a selection or writing a brief description in a text box. Some reasons for amending documentation may include the entry being late, making an

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error in the initial documentation, or adding a duplicate note. Backdating is not typically allowed, so that's a common reason many late entry-related errors are made.

Documentation Maintenance

Outpatient healthcare facilities that offer medical or therapy services of any kind are required to safely store medical records for a certain time period. This requirement extends to all types of rehabilitation documentation – including evaluations, progress notes, recertifications, daily notes, and discharge summaries – as well as records of patient correspondence, doctor's orders, and requests for equipment/medication/services. The exact time frame to keep these documents varies across states and insurance carriers. HIPAA regulations require Medicare Fee-For-Service providers to retain all documentation for six years. CMS has a 10-year retention period for documentation pertaining to Medicare managed care programs. HIPAA determines these time frames by looking at the date on the documents and the date when the document was last in effect and adhering to the later of the two.

Clinics should develop processes for medical records requests they may receive, which all must be acknowledged and granted within 30 days of receipt. This is especially crucial when CMS, Medicare contractors, or other government entities make such requests. If a facility needs additional time to grant a records request, they must inform the requesting party of this in writing within the initial 30-day period. Extension requests must offer a reason and provide a projected date the request will be granted while keeping in mind the maximum extension period is another 30 days. These same stipulations apply if a patient personally requests their medical records. Any healthcare organizations who do not respond to medical records requests from any individual or agency may be fined for

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noncompliance and may even lose their Medicare enrollment status. CMS calculates ban length in cases with multiple noncompliance incidents. Noncompliance can take many forms, including:

- Not providing any of the requested documentation
- Providing only a portion of the requested documentation
- Providing related documentation that does not include what was requested (e.g. documentation from the same billing period but not the exact date needed)
- Providing other documentation that was not requested or is not directed to the attention of the party who requested it (e.g. Medicare contractor, CMS department, etc.)

Lastly, signatures are a component of medical record completeness, so documentation may be considered incomplete or insufficient for any of the following reasons: (1) notes are not properly signed by the provider and/or their supervisor (the latter is required in the case of OTAs and their supervising OTRs), (2) signature is illegible AND cannot be matched to a signature log or corresponding attestation, or (3) an electronic signature is made without a policy that outlines protocols for electronic signatures.

Audits

In the event therapists and/or their employers are noncompliant, this may result in a medical record audit. Audits are most often triggered by an observable pattern of noncompliance. They may also take place as a result of billing or coding errors, patient complaints, and randomized checks. Audits can be overwhelming and time-consuming for patient-facing healthcare providers, but they help

minimize abuse and fraud while maintaining accuracy and the provision of quality services.

Section 6 Personal Reflection

How can outpatient occupational therapists prevent noncompliance with medical records requests?

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