Clinical Practice Guideline: **Occupational Therapy Medical Policy/Guideline**

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Product: **Specialty**

This American Specialty Health – Specialty (ASH) Clinical Practice Guideline (CPG) provides an overview of ASH Occupational Therapy Guidelines; including the following:

- Verifying that services submitted for an initial trial of care meet the definition of Medical Necessity;
- Verifying that services submitted for continuing care meet the definition of Medical Necessity;
- Denial of coverage of services submitted for not meeting the definition of Medical Necessity; and
- Identifying cases suggesting the need for referral or coordination of care.

Please note: Client exceptions to ASH clinical practice guidelines can be found in the applicable client summary.

This policy is not intended to convey benefit coverage but rather provides a description of the full qualifications and scope of abilities, based on educational background, of occupational therapists within the health care system and community. This policy also describes appropriate use of occupational therapy codes and intended purpose.

Other supporting resources and documentation include the following:

- CR 1: Credentialing Program
- UM 1: Clinical Services Program
- UM 2: Medical Necessity Review
- UM 8: Medical Necessity Definition
- CPG 2: Practice Parameters and Review Criteria
- CPG 3: Quality Patient Management
- CPG 5: Selected List of References – Physical and Occupational Therapy
- CPG 12: Medical Necessity Decision Assist Guideline for Musculoskeletal Conditions and Somatic / Neuropathic Pain Disorders.
- CPG 14: Clinical Guidelines and Criteria.
- CPG 30: Cold/Cool Laser-Low Laser Light Therapy (LLLT)
- CPG 110: Medical Record Documentation
- CPG 111: Patient Assessments: Medical Necessity Decision Assist Guideline for Evaluations and Re-evaluations.
- CPG 113: Exercise Therapy for Treatment of Neck Pain

- CPG 121: Passive Physiotherapy Modalities
- CPG 135: Physical Therapy Medical Policy/Guideline
- CPG 144: Prosthetics Training and Evaluation
- CPG 143: Strapping and Taping
- CPG 148: Wheelchair Management
- CPG 149: Sensory Integrative Techniques
- CPG 152: Orthotic Training and Evaluation
- CPG 156: Wound Care
- CPG 157: Lymphedema
- CPG 165: Autism Spectrum Disorder (ASD) – Outpatient Rehabilitation Services (Speech, Physical, and Occupational Therapy)

GENERAL BACKGROUND

According to the American Occupational Therapy Association, occupational therapists and occupational therapy assistants help people across their lifespan participate in the things they want and need to do through the therapeutic use of everyday activities (occupations). Occupational therapy addresses physical, cognitive, psychosocial, sensory, communication, and other areas of performance in various contexts and environments in everyday life activities that affect health, well-being, and quality of life (American Occupational Therapy Association [AOTA], 2004). The overarching goal of occupational therapy is "to support [people's] health and participation in life through engagement in occupations" (AOTA, 2008, p. 626). Common occupational therapy interventions include helping children with disabilities to participate fully in school and social situations, helping people recovering from injury to regain skills, and providing supports for older adults experiencing physical and cognitive changes. Occupational therapy services typically include:

- an individualized evaluation, during which the patient/family and occupational therapist determine the person's goals;
- customized intervention to improve the person's ability to perform daily activities and reach the goals, including family/caregiver instruction as needed; and
- an outcomes evaluation to ensure that the goals are being met, including making necessary changes to the intervention plan as needed and appropriate.

Occupational therapy services may include comprehensive evaluations of the patient's home and other environments (e.g., workplace, school), recommendations for adaptive equipment and training in its use, and guidance and education for family members and caregivers. Occupational therapy practitioners have a holistic perspective, in which the focus is on adapting the environment to fit the person, and the person is an integral part of the therapy team.

MEDICAL NECESSITY

Occupational therapy services provided by an appropriate healthcare practitioner are considered medically necessary by ASH for the assessment of a physical impairment when the following criteria are met:

- Care delivered is appropriately documented and meets the ASH Medical Necessity definition and the member's benefit contract.
- The plan of care is individualized and designed to improve or assist with the loss or impairment of functions that impact activities of daily living.
- Significant therapeutic improvement is expected over a clearly defined period of time with documented quantifiable, attainable treatment goals.
- Any care for children includes active participation of a parent or guardian.

Medically necessary occupational therapy services are individualized and comprehensive, and are provided through the continuum of life and across many treatment settings. Medically necessary occupational therapy services are provided by or under the direction and supervision of a licensed occupational therapist consistent with the jurisdictional scope of practice and qualifications, and according to the needs of the patient. Occupational therapy, as part of an individual's health care, is considered medically necessary as determined by the licensed occupational therapist based on the results of a occupational therapy evaluation and when provided for the purpose of preventing, minimizing, or eliminating impairments, activity limitations, or participation restrictions.

Occupational therapy is delivered throughout the episode of care by the occupational therapist or under his or her direction and supervision. Occupational therapy requires the knowledge, clinical judgment, and abilities of the therapist; takes into consideration the potential benefits and harms to the patient; and is not provided exclusively for the convenience of the patient. Occupational therapy is provided using evidence of effectiveness and applicable occupational therapy standards of practice and is considered medically necessary if the type, amount, frequency and duration of services outlined in the plan of care increase the likelihood of meeting one or more of these stated goals and is verified as medically necessary by ASH:

- To improve function;
- Minimize loss of function; or
- Decrease risk of injury and disease.

Medically necessary occupational therapy services must be restorative or for the purpose of designing and teaching a home exercise program for the patient to carry out at home after discharge from occupational therapy to maintain or improve level of function. Many patients with neuromuscular, musculoskeletal or other movement impairment may experience improvement when following a home treatment program prescribed by their occupational therapist. Home treatment programs may include:

- Modifications to lifestyle;

- Splinting, supporting or wrapping; and
- Self-monitored, graded exercise therapy that does not require professional or medical supervision.

Medically necessary occupational therapy services must also relate to a written treatment plan of care and be of a level of complexity that requires the judgment, knowledge and skills of an occupational therapist to perform and/or supervise the services. The plan of care for medically necessary occupational therapy services is established by a licensed/registered occupational therapist. The amount, frequency and duration of the occupational therapy services must be reasonable (within regional norms and commonly accepted practice patterns); the services must be considered appropriate and needed for the treatment of the condition and must not be palliative in nature. Thus, once therapeutic benefit has been achieved, or a home exercise program could be used for further gains without the need for skilled occupational therapy, continuing supervised occupational therapy is not considered medically necessary. A maintenance program consists of activities that preserve the patient's present level of function and prevent regression of that function. During the last visits for rehabilitative treatment, it may be reasonable and medically necessary for the occupational therapist to develop a maintenance program, and instruct the patient, family member(s) or caregiver(s) in carrying out the maintenance program. Therapy performed repetitively to maintain a level of function is typically not eligible for reimbursement. Maintenance care for persons whose condition is neither regressing nor improving is typically not considered medically necessary. Occupational therapy services for asymptomatic persons or in persons without an identifiable clinical condition are also not considered medically necessary. Duplicate therapy (therapy that provides essentially redundant clinical effect) is not considered medically necessary. When individuals are receiving physical, occupational, or speech therapy concurrently, each therapist should provide different treatments that reflect each therapy discipline's unique perspective on the individual's impairments and functional deficits and not duplicate the same treatment. They must also have separate evaluations, treatment plans, and goals.

The following interventions are not currently considered medically necessary:

- Kinesio Taping/Taping: The clinical value of Kinesio taping/taping has not been established, and thus is considered investigational. . For more information, see ASH policy Strapping and Taping – CPG 143 – S.
- Anodyne® Therapy System: Clinical effectiveness is inconclusive and thus is considered experimental and investigational.
- Occupational therapy intended to improve or maintain general physical condition or enhance athletic performance is not considered medically necessary.
- Occupational therapy that duplicates services provided concurrently as part of an authorized therapy program through another rehabilitative discipline (e.g., physical therapy).

- Work hardening programs, back school, and vocational rehabilitation because they are training in nature or are not an individualized program specific to a person's needs.

MODALITIES AND PROCEDURES

In some states, occupational therapists are required to hold a specific certification to use modalities in practice. The American Medical Association (AMA) Current Procedural Terminology (CPT) manual defines a modality as "any physical agent applied to produce therapeutic changes to biologic tissue; includes but is not limited to thermal, acoustic, light, mechanical, or electric energy" (AMA, 2011). Modalities may be supervised, which means that the application of the modality doesn't require direct one-on-one patient contact by the practitioner. Or modalities may involve constant attendance, which indicates that the modality requires direct one-on-one patient contact by the practitioner. Examples of supervised modalities include application of: hot or cold packs, mechanical traction, unattended electrical stimulation, vasopneumatic devices, whirlpool, paraffin bath, diathermy, and ultraviolet or infrared light. Modalities that require constant attendance include: contrast baths, ultrasound, electrical stimulation, and iontophoresis.

Passive modalities are most effective during the acute phase of treatment, since they are typically directed at reducing pain, inflammation, and swelling. They may also be utilized during the acute phase of the exacerbation of a chronic condition. Passive modalities are rarely beneficial alone and are most effective when performed as part of a comprehensive treatment approach. Some improvement should be seen within three visits. After one or two weeks, the clinical effectiveness of passive modalities begins to decline significantly. In some situations, passive modalities may be indicated for up to one or two months as part of comprehensive occupational therapy program. The need for passive modalities beyond two weeks should be objectively documented in the clinical record. For more information, see ASH policy Passive Physiotherapy Modalities - CPG 121 – S.

The AMA CPT manual defines therapeutic procedures as "A manner of effecting change through the application of clinical skills and/or services that attempt to improve function" (AMA, 2011). Examples of therapeutic procedures include therapeutic exercise to develop strength and endurance, range of motion and flexibility; neuromuscular re-education of movement, balance, coordination, kinesthetic sense, posture, and/or proprioceptive activities, aquatic therapy, and manual therapy techniques (e.g., mobilization/manipulation, manual lymphatic drainage, manual traction); or therapeutic activities using dynamic activities to improve functional performance (direct one-on-one patient contact by the practitioner).

Active therapeutic procedures are typically started as swelling, pain, and inflammation are reduced. The need for stabilization and support is replaced by the need for increased range of motion and restoration of function. Active care elements include increasing

range of motion, strengthening primary and secondary stabilizers of a given region, and increasing the endurance capability of the muscles. Care focuses on active participation of the patient in their exercise program. Activities of Daily Living (ADLs) training, muscle strengthening, movement retraining, and progressive resistive exercises are considered active procedures. In general, patients should progress from active procedures to a home exercise program.

Below is a description and medical necessity criteria, as applicable, for different treatment interventions, including specific modalities and therapeutic procedures associated with occupational therapy. This material is for informational purposes only and is not indicative of coverage, nor is it an exhaustive list of services provided.

Practitioners should practice only in the areas in which they are competent based on their education, training and experience. Levels of education, experience, and proficiency may vary among individual practitioners. It is ethically and legally incumbent upon a practitioner to determine if they have the knowledge and skills necessary to perform such services and whether the services are within their scope of practice. Depending on the service, ASH may request information related to education, training, experience, and/or certification. If the service would be most competently delivered by another health care practitioner who has more skill and training, it would be Standard of Practice to refer the patient to the more expert practitioner.

Hydrotherapy/Whirlpool/Hubbard Tank

These modalities involve supervised use of agitated water in order to relieve muscle spasm, improve circulation, or cleanse wounds e.g., ulcers, skin conditions. More specifically, Hubbard tank involves a full-body immersion tank for treating severely burned, debilitated and/or neurologically impaired individuals. Hydrotherapy is considered medically necessary for pain relief, muscle relaxation and improvement of movement for persons with musculoskeletal conditions. It is also considered medically necessary for wound care (cleansing and debridement). It is not appropriate to utilize more than one hydrotherapy modality on the same day. For more information, see ASH policy Passive Physiotherapy Modalities - CPG 121 – S.

Fluidotherapy®

This modality is used specifically for acute and subacute conditions of the extremities. Fluidotherapy® is a dry superficial thermal modality that transfers heat to soft tissues by agitation of heated air and Cellux particles. The indication for this modality are similar to paraffin baths and whirlpool and it is an acceptable alternative to other heat modalities for reducing pain, edema, and muscle spasm from acute or subacute traumatic or non-traumatic musculoskeletal disorders of the extremities, including complex regional pain syndrome (CRPS). A benefit of

Fluidotherapy® is that patients can perform active range of motion (AROM) while undergoing treatment.

Vasopneumatic Devices

These special devices apply pressure for swelling/edema reduction, either after an acute injury, following a surgical procedure, due to lymphedema, or due to pathology such as venous insufficiency. Education sessions for home use are considered medically necessary (up to two sessions).

Hot/Cold Packs

Hot packs increase blood flow, relieve pain and increase movement; cold packs decrease blood flow to an area for pain and swelling reduction and are typically used in the acute phase of injury or in the acute phase of an exacerbation. They are considered medically necessary for painful musculoskeletal conditions and acute injury. For more information, see ASH policy Passive Physiotherapy Modalities - CPG 121 – S.

Paraffin Bath

This modality uses hot wax for application of heat. It is indicated for use to relieve pain and increase range of motion of extremities (typically wrists and hands) due to chronic joint problems or post-surgical scenarios. For more information, see ASH policy Passive Physiotherapy Modalities - CPG 121 – S.

Infrared Light Therapy

This dry heat lamp is used to increase circulation to relieve muscle spasm. Other heating modalities are considered superior to infrared lamps. Infrared may also include low power laser or light therapy that utilizes laser or LED to treat damaged tissues. This does not refer to Anodyne® Therapy System. For more information, see ASH policies Passive Physiotherapy Modalities - CPG 121 – S and Cold/Cool Laser-Low Laser Light Therapy (LLLT) – CPG 30 – S.

Electrical Stimulation

Electrical stimulation is used in different variations to relieve pain, reduce swelling, heal wounds, and improve muscle function. Functional electric stimulation is considered medically necessary for muscle re-education (to improve muscle contraction) in the earlier phases of rehabilitation. For more information, see ASH policy Passive Physiotherapy Modalities - CPG 121 – S.

Iontophoresis

Electric current used to transfer certain chemicals (medications) into body tissues. Use to treat inflammatory conditions, such as plantar fasciitis and lateral epicondylitis.

Contrast Baths

This modality is the application of alternative hot and cold baths and is typically used to treat extremities with subacute swelling or CRPS. Contrast baths assist with hypersensitivity reduction and swelling reduction.

Ultrasound

This modality provides deep heating through high frequency sound wave application. Non-thermal applications are also possible using the pulsed option. Ultrasound is commonly used to treat many soft tissue conditions that require deep heating or micromassage to a localized area to relieve pain and improve healing. For more information, see ASH policy Passive Physiotherapy Modalities - CPG 121 – S.

Diathermy (e.g., shortwave)

This modality utilizes high frequency magnetic and electrical current to provide deep heating to larger joints and soft tissue structures for pain relief, increased healing, and muscle spasm reduction. Microwave diathermy presents a negative benefit:risk ratio and is not recommended. For more information, see ASH policy Passive Physiotherapy Modalities - CPG 121 – S.

Therapeutic Exercises

This procedure includes instruction, feedback, and supervision of a person in an exercise program for their condition. The purpose is to increase/maintain flexibility and muscle strength. Therapeutic exercise is performed with a patient either actively, active-assisted, or passively. It is considered medically necessary for loss or restriction of joint motion, strength, functional capacity or mobility which has resulted from disease or injury. Note: Exercising done subsequently by the member without a physician or therapist present and supervising would not be covered. For more information, see ASH policy Exercise Therapy for Treatment of Chronic Non-Specific Low Back Pain - CPG 112 – S and Exercise Therapy for Treatment of Neck Pain - CPG 113 – S.

Neuromuscular Reeducation

This therapeutic procedure is provided to improve balance, coordination, kinesthetic sense, posture, and proprioception to a person who has reduced balance, strength, functional capacity or mobility which has resulted from disease, injury, or surgery. The goal is to develop conscious control of individual muscles and awareness of position of extremities. Body mechanics, including kinetic and isotonic exercise (e.g., body scheme recalibration), are also included. The procedure may be considered medically necessary for impairments which affect the body's neuromuscular system (e.g., poor static or dynamic sitting/standing balance, loss of gross and fine motor coordination) that may result from musculoskeletal or neuromuscular disease or injury such as severe trauma to nervous system, post orthopedic surgery, cerebral vascular accident and systemic neurological disease.

Aquatic Therapy

Pool therapy (aquatic therapy) is provided individually, in a pool, to debilitated or neurologically impaired individuals. (The term is not intended to refer to relatively normal functioning individuals who exercise, swim laps or relax in a hot tub or Jacuzzi.)

Massage Therapy

Massage involves manual techniques that include applying fixed or movable pressure, holding and/or causing movement of or to the body, using primarily the hands. These techniques affect the musculoskeletal, circulatory-lymphatic, nervous, and other systems of the body with the intent of improving a person's well being or health. The most widely used forms of basic massage therapy include Swedish massage, deep-tissue massage, sports massage, neuromuscular massage, and manual lymph drainage. Massage therapy may be considered medically necessary in combination with another therapeutic procedure or activity on the same day, when designed to restore muscle function, reduce edema, improve joint motion, or for relief of muscle spasm, and determined not duplicative to other modalities/procedures.

Myofascial Release

This manual technique is considered a soft tissue mobilization through manipulation of the muscle, fascia, and skin. Skilled manual techniques (active and/or passive) are applied to soft tissue to effect changes in the soft tissues, articular structures, neural or vascular systems. Examples are facilitation of fluid exchange, restoration of movement in acutely edematous muscles, or stretching of shortened connective tissue. This procedure is considered medically necessary for treatment of restricted motion of soft tissues in involved extremities, neck, and trunk. For more information, see ASH policy Graston Technique – CPG 89 – S.

Joint Mobilization

Joint mobilization is utilized to reduce pain and increase joint mobility. Most often mobilizations are indicated for extremity, especially the hand. . For more information, see ASH policies Spinal Manipulation for Treatment of Acute, Sub-Acute, and Chronic Low Back Pain - CPG 115 - S, Spinal Manipulation for Treatment of Acute and Chronic Neck Pain - CPG 116 - S, Spinal Manipulation for Treatment of Acute, Sub-Acute, and Chronic Thoracic Spine Pain - CPG 117 - S, and Spinal Manipulative Therapy for Non-Neuromusculoskeletal Conditions - CPG 119 – S.

Therapeutic Activities

This procedure involves using functional activities (e.g., bending, lifting, carrying, reaching, pushing, pulling, stooping, catching and overhead activities) to improve functional performance in a progressive manner. The activities are usually directed at a loss or restriction of mobility, strength, balance or coordination. Hemispheric dominance and compensation strategies and perceived motor competence and perceptual motor therapy are included here. They require the professional skills of a practitioner and are designed to address a specific functional need of the member. This intervention may be appropriate after a patient has completed exercises focused on strengthening and range of motion but need to be progressed to more function-based activities. These dynamic activities must be part of an active treatment plan and directed at a specific outcome.

Activities of Daily Living (ADL) Training

Training of impaired individuals in essential activities of daily living and self care activities, including: bathing; feeding; preparing meals; toileting; dressing; walking; making a bed; and transferring from bed to chair, wheelchair or walker. This procedure is considered medically necessary to enable the member to perform essential activities of daily living related to the patient's health and hygiene, within or outside the home, with minimal or no assistance from others, and to assist with efficiencies of daily living activities. Services provided concurrently by physical therapists and occupational therapists may be considered medically necessary if there are separate and distinct functional goals.

Cognitive Skills Development/Sensory Integration

This procedure is considered medically necessary for persons with acquired cognitive defects resulting from head trauma, or acute neurologic events including cerebrovascular accident or pediatric developmental condition. It is not appropriate for persons without potential for improvement. Occupational/speech/physical therapists with specific training typically provide this care. This procedure should be aimed at improving or restoring specific functions which were impaired by an identified illness or injury. Tactile and tactile-location functions- active and passive are considered within the procedure. For more information, see ASH policy Sensory Integrative Techniques - CPG 149 – S.

Orthotic Training

Training and re-education with braces and/or splints (orthotics, arm-hand postures). For more information, see ASH policy Orthotic Training and Evaluation - CPG 152 – S.

Prosthetic Checkout

These assessments are considered medically necessary when a device is newly issued or there is a modification or re-issue of the device. These assessments are considered medically necessary when a member experiences loss of function directly related to the orthotic or prosthetic device (e.g., pain, skin breakdown, or falls.) This is usually completed in 1-2 sessions. For more information, see ASH policy Prosthetics Training and Evaluation - CPG 144 – S.

Prosthetic Training

Training and re-education with prosthetics devices. Considered medically necessary for persons with a medically necessary prosthetic. Periodic return visits beyond the third month may be necessary. For more information, see ASH policy Prosthetics Training and Evaluation - CPG 144 – S.

Certain physical medicine modalities and therapeutic procedures are considered duplicative in nature and it would be inappropriate to perform or bill for these services during the same session, such as:

- Functional activities and ADLs;

- More than one deep heating modality;
- Massage therapy and myofascial release;
- Orthotics training and prosthetic training; and
- Whirlpool and Hubbard tank.

The medical necessity of neuromuscular reeducation, therapeutic exercises, and/or therapeutic activities, performed on the same day, must be documented in the medical record.

Only one heat modality would be considered medically necessary during the same treatment session, with the exception of use of one form of superficial heat and one form of deep heat (i.e., ultrasound or diathermy and hot packs). Use of two forms of deep or superficial heat would not be acceptable.

There are Cochrane systematic reviews and other reviews that have been published regarding occupational therapy for various conditions (see list of references at end of this document). The reviews in general found that that there is improvement seen with occupational therapy however, evidence with respect to specific interventions is limited.

DOCUMENTATION GUIDELINES

Initial Examination/Evaluation/Diagnosis/Prognosis

The occupational therapist performs an initial examination and evaluation to establish a working diagnosis, prognosis, and plan of care prior to intervention.

The occupational therapist examination:

- Is documented, dated, and appropriately authenticated by the occupational therapist who performed it;
- Identifies the occupational therapy needs of the patient;
- Incorporates appropriate tests and measures to facilitate outcome measurement;
- Produces data that are sufficient to allow evaluation, prognosis, and the establishment of a plan of care.

The occupational therapist establishes a plan of care and manages the needs of the patient based on the examination, evaluation, and prognosis; identifies goals and outcomes; describes the proposed intervention, including frequency and duration; includes documentation that is dated and appropriately authenticated by the occupational therapist who established the plan of care.

The written plan of care should be sufficient to determine the medical necessity of treatment, including:

- The diagnosis along with the date of onset or exacerbation of the disorder/diagnosis;

- A reasonable estimate of when the goals will be reached;
- Long-term and short-term goals that are specific, quantitative and objective;
- Occupational therapy evaluation;
- The frequency and duration of treatment;
- The specific treatment techniques and/or exercises to be used in treatment; and
- Signatures of the patient's occupational therapist.

The plan of care should be ongoing, (i.e., updated as the patient's condition changes), and treatment should demonstrate reasonable expectation of improvement. Occupational therapy services are considered medically necessary only if there is a reasonable expectation that occupational therapy will achieve measurable improvement in the patient's condition in a reasonable and predictable period of time.

The plan of care may result in recommendations for additional services to meet the needs of the patient. For example, the occupational therapist, in consultation with appropriate disciplines, plans for discharge of the patient taking into consideration achievement of anticipated goals and expected outcomes, and provides for appropriate follow-up or referral. Collaboration may be with physicians, dentists, nurses, educators, social workers, physical therapists, speech-language pathologists, audiologists and other personnel involved with the patient management.

The occupational therapy intervention:

- Is altered in accordance with changes in response or status;
- Is provided at a level that is consistent with current occupational therapy practice;
- Is interdisciplinary when necessary to meet the needs of the patient;
- Uses documentation of the intervention consistent with the professional standards and guidelines; and
- Is dated and appropriately authenticated by the occupational therapist or, when permissible by law, by the certified occupational therapist assistant.

Reevaluation

The occupational therapist reevaluates the patient as necessary during an episode of care to evaluate progress or change in patient status and modifies the plan of care accordingly or discontinues occupational therapy services.

The occupational therapist reevaluation:

- Is documented, dated, and appropriately authenticated by the occupational therapist who performs it; documents progress made toward the goals of occupational therapy. The treatment goals and subsequent documentation of treatment results should specifically demonstrate that occupational therapy services are contributing to such improvement. If progression of identified goals is made, clear documentation with an updated treatment plan is warranted;

- Includes modifications to the plan of care. If no improvement is documented after two weeks of consistent treatment, modifications of the treatment plan should be attempted. If no significant improvement is documented after a total of four weeks of consistent treatment, referral back to the patient's health care practitioner should be considered;
- Utilizes Functional Outcome Measures (FOMs) to establish goals are being met and improvement is occurring.

Discharge/Discontinuation of Intervention

The occupational therapist discharges the patient from occupational therapy services when the anticipated goals or expected outcomes for the patient have been achieved. The occupational therapist discontinues intervention when the patient is unable to continue to progress toward goals or when the occupational therapist determines that the patient will no longer benefit from occupational therapy.

The occupational therapy discharge documentation:

- Includes the status of the patient at discharge and the goals and outcomes attained;
- Is dated and appropriately authenticated by the occupational therapist who performed the discharge;
- Includes, when a patient is discharged prior to attainment of goals and outcomes, the status of the patient and the rationale for discontinuation;
- Includes initial, subsequent, and final FOMs scores;
- Includes proposed self care recommendations, if applicable; and
- Includes referrals to other health care practitioners/referring physicians as appropriate.

Standardized Tests and Measures/Functional Outcome Measures (FOMs)

Measuring outcomes is an important component of occupational therapists' practice. Outcome measures are important in direct management of individual patient care and for the opportunity they provide the profession in collectively comparing care and determining effectiveness.

The use of standardized tests and measures early in an episode of care establishes the baseline status of the patient, providing a means to quantify change in the patient's functioning. Outcome measures, along with other standardized tests and measures used throughout the episode of care, as part of periodic reevaluation, provide information about whether predicted outcomes are being realized. As the patient reaches the termination of occupational therapy services and the end of the episode of care, the occupational therapist measures the outcomes of the occupational therapy services. Standardized outcome measures provide a common language with which to evaluate the success of occupational therapy interventions, thereby providing a basis for comparing outcomes related to different intervention approaches. Measuring outcomes of care

within the relevant components of function (including body functions and structures), activity, and participation, among patients with the same diagnosis, is the foundation for determining which intervention approaches comprise best clinical practice.

References

(Please refer to ASH policy Selected List of References – Physical and Occupational Therapy – CPG 5 – S.)

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