Occupational therapy billing, coding and documentation requirements

Laurie Latvis
Director, Provider Outreach

Blue Cross Blue Shield of Michigan and Blue Care Network are nonprofit corporations and independent licensees of the Blue Cross and Blue Shield Association.
Documentation requirements – Identifying information

• The following must be documented in the patient’s medical record when occupational therapy is provided:
  • Patient’s name and address
  • Patient’s contract number (including prefix) and group number
  • Patient’s date of birth
  • Facility’s name and address (if applicable)
  • Facility case number (if applicable)
  • Location where services are provided
  • Attending physician’s name, address and phone number
  • Diagnosis
Orders – may be written by only an MD, DO, DPM, DDS, OD or physician assistant.

The physician’s order for therapy must be maintained in the occupational therapist’s patient medical record.

The physician order for occupational therapy must contain the following documentation:

- Date of order – orders expire after 90 days, after 90 days a new order, signed, and dated by the physician must be obtained. The date of the first treatment starts the 90 day period

- Medical diagnosis

- Contraindications, restrictions, and precautions (when applicable)

- Type of treatment to be provided (if known)

- Area of body to be treated (if for a specific injury)

Note: The diagnosis generally includes or implies the body part, so a separate statement of the affected area usually is not necessary. If the original diagnosis is very general, however, it might not be possible to identify the affected area. In this case, the therapy plan of care completed at the initial evaluation should be written to provide information about the part of the body being treated with specific interventions and the frequency and duration of treatments.
Documentation requirements – orders, physician involvement and Initial Evaluation

• The physician order for occupational therapy must contain the following documentation:
  - Changes in treatment plan or orders to continue treatment (when applicable)
  - Physician’s signature with credential and signature date
    
    **Note:** Verbal orders then written and signed by the person who receives the order are acceptable if subsequently signed by the physician. The request for the physician’s signature must be initiated within 10 days of the receipt of the verbal order and received within 30 days of the receipt of the verbal order.

• **Initial involvement – physician’s role**
  - When occupational therapy is provided in a physician’s office the physician must document the medical necessity for those services in the patient medical record.
  - When occupational therapy is provided in a location other than the physician’s office, the medical necessity for those services must be documented in the physician’s patient medical record and on the appropriate referral form or order from the physician to the occupational therapist.

• **Initial evaluation – occupational therapy practitioner’s role**
  - For an initial evaluation, the occupational therapist must document the following information in the patient medical record. The occupational therapist assistant may contribute to the evaluation but the final responsibility for the documentation, and the signature and credentials on the documentation must include that of the occupational therapist.
Documentation requirements - Initial Evaluation

• **Initial evaluation – occupational therapy practitioner’s role**
  - For an initial evaluation, the occupational therapist must document the following information in the patient medical record. The occupational therapist assistant may contribute to the evaluation but the final responsibility for the documentation, and the signature and credentials on the documentation must include that of the occupational therapist.
  - Patient’s name
  - Date of birth
  - Date of evaluation
  - Diagnosis - including medical and surgical history: including diagnoses for which treatment is being provided; dates of injury; onset or description and date of exacerbation of chronic condition;
    - Primary and all pertinent secondary diagnoses, including onset dates (diagnoses must be recognized medical diagnoses, not symptoms)
    - Prior hospitalization and surgeries, including dates
    - Other relevant patient history and change in medical status (such as exacerbation of a chronic illness, accidental injury, complicating medical problems) including onset dates, and where relevant, with references to cause.
  - Previous occupational treatment, including dates and the reason occupational therapy services are necessary at this time.
  - Functional level prior to the onset of current illness, injury or exacerbation in all areas of occupation, roles, and development
  - An occupational profile, including functional status in all areas of occupation, roles development, supports, and barriers
Documentation requirements – Initial Evaluation

- Assessment of areas of occupation, including rest and sleep, play, activities of daily living
- Assessment of client factors
  - Muscle strength (graded)
  - Range of motion measurements, passive and/or active
  - Sensory integration function
  - Cognitive skills
  - Sensory and perceptual skills
  - Pain levels (as reported by the patient), location, type, and the impact on function, occupation and the possible effect on the treatment program
- Analysis of occupational performance and documentation of the supports and barriers to performance
- Identification of occupational therapy problems, outcomes, and outcome measures
- Professional assessment of evaluation results and interpretation of subjective information gathered from the patient or family including self-assessments and self-report
- Signature and credentials of the occupational therapist and the occupational therapy assistant evaluating the patient
- Current status of the following:
  - Durable medical equipment and assistive devices used by the patient
  - Functional mobility, including short distances, household, and community including assistive devices used by the patient
  - Transfers – level of physical assist required to transfer the patient to and from, but not limited to: the mat, bed, wheelchair, toilet, bedside, commode, shower, chair, and car including transfer method (for example, mechanical lift, standing pivot, or sliding board) and durable medical equipment or assistive devices utilized
OCCUPATIONAL THERAPY PRACTITIONER ROLE

- For an intervention plan, the occupational therapist must document the following information in the patient medical record. The occupational therapy assistant may contribute to the intervention plan; however, the final responsibility for the documentation, and the signature and credentials on the documentation must include that of the occupational therapist.

Must include reference to the following:

- Areas of the body to be treated
- Modalities
- Types of occupation centered interventions, treatment techniques and therapeutic activities
- Patient, family and caregiver education

- Reasonable, objective and measurable long-term and short-term goals, inclusive of ADL and IADL, including time frame (therapeutic goals that are appropriate for the patient, the diagnoses, rehabilitation potential and the treatment to be provided)

- Rehabilitation potential (a realistic evaluation of the patient’s potential for rehabilitation or restoration)

- Anticipated frequency and duration of therapy (for example, three sessions per week for four weeks)
OCCUPATIONAL THERAPY PRACTITIONERS ROLE

• **Note:** A PRN* order does not meet the frequency and duration requirement. PRN* refers to need, while frequency refers to a specific number of times of an occurrence within a specified period. *In order to establish services as medically necessary and appropriate, the frequency of treatment must be specified.*

• Signature and credentials of the occupational therapist and the occupational therapy assistant completing the intervention plan

• **Note:** The occupational therapist must submit the intervention plan to the physician for approval and signature. Physician certification of the plan, by signature or verbal order, must be dated within the 30 days following the first day of treatment (which is the initial evaluation) and documented in the patient medical record. Payment may be denied if physician certification is not obtained

*PRN is Latin term that stands for “pro re nata” which means as the thing is needed.
OCCUPATIONAL THERAPY PRACTITIONER’S ROLE

• The occupational therapist or the occupational therapy assistant must document the following information in the patient medical record every time the patient is seen:
  • Date of service
  • Time of service if treatments are performed more than once per day (The use of a.m. or p.m. is acceptable.)
  • Duration of service if the billing unit is a time interval
  • Modalities, occupation centered interventions, treatment techniques and therapeutic activities provided during the treatment session
  • Patient’s response to treatment in objective language
  • Professional assessment and interpretation of objective and subjective information
  • Signature and credentials of the occupational therapy practitioner providing treatment

Note: The occupational therapist’s signature, credentials and date are not required on the documentation completed solely by an occupational therapy assistant.
Documentation requirements – Treatment summary or progress note

OCCUPATIONAL THERAPY PRACTITIONER’S ROLE

• The occupational therapist must document a treatment summary or progress note summarizing the patient’s response to treatment at least once every 30 days. The occupational therapy assistant may contribute to the re-evaluation and progress summary; however, the final responsibility for the documentation, and the signature and credentials, must include that of the occupational therapist.

• Every treatment summary and progress note in the patient medical record must contain the following documentation:
  - Date of treatment summary or progress note
  - Dates of service covered by the treatment summary or progress note
  - Specific and objective evaluation of the patient’s progress towards identified outcomes and response to treatment including, but not limited to:
    - Muscle strength
    - Range of motion
    - Functional mobility
    - Developmental milestones
    - Play
    - ADL: assistance required to complete feeding, bathing, dressing, etc.
    - IADL: assistance required to complete simple meal preparation, managing finances, cleaning the house, yard work, etc.
    - Pain level (as reported by the patient), location, type and the impact on function, occupation and the possible effect on the treatment program

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Documentation requirements – Treatment summary or progress note

OCCUPATIONAL THERAPY PRACTITIONER’S ROLE

• Changes in intervention plan with rationale for the changes and reference to the patient's readiness for discharge from treatment (include instructions to patient, family members and caregivers, if applicable), including goals achieved, revision of goals or addition of new goals and assessment of outcome results

• Changes in medical status, which must be documented in clear, concise, objective language (that is, with specific reference to current physical capacity relevant to the patient’s disability and any significant comorbid conditions)

• Changes in mental status and level of participation, which must be documented in clear, concise, objective language

• Professional assessment of re-evaluation results and interpretation of subjective information gathered from the patient or family including self-assessments and self-report

• Signature and credentials of the occupational therapist and the occupational therapy assistant assessing the patient’s progress
PHYSICIAN’S AND OCCUPATIONAL THERAPIST’S ROLE

- The **physician** must re-evaluate the patient at least once every 90 days.
- The **occupational therapist** must communicate with the physician every 90 days. Communication may be in person, by phone or in writing. The occupational therapy assistant may contribute to the re-evaluation process; however, the final responsibility for the report and the signature and credentials on the report must include that of the occupational therapist.

- The communication must be documented, including the date of communication, as follows:
  - Both the physician and occupational therapist must document the substance of the verbal or written communication in their patient medical record.
  - If the communication is in writing, such as in the form of a treatment summary or progress note from the occupational therapist, the physician must include that document in the patient medical record and document that the information was reviewed and the plan for ongoing therapy approved.
  - If the physician believes that further evaluation is required or that the intervention plan must be changed or discontinued, then the physician must communicate directly with the occupational therapist. Both the physician and the occupational therapist must document the discussion in their patient medical records.
Physician’s and Occupational Therapist’s Role (Cont’d)

• An order for continued therapy (recertification) may be obtained in either of these ways:

  • Because the physician must re-evaluate the patient in person at least once every 90 days and document the patient’s response to treatment, the physician may submit the recertification order to the occupational therapist at that time.

  • The occupational therapist may incorporate the order for continued therapy within the treatment summary or progress note to the physician; it need not be a separate document. The physician’s signature on this document validates the order.
OCCUPATIONAL THERAPY PRACTITIONER’S ROLE

• The occupational therapist must document a discharge summary at the discontinuation of services. The occupational therapy assistant may contribute to the discharge summary; however, the final responsibility for the documentation and the signature and credentials on the report must include that of the occupational therapist.

• The discharge summary in the patient medical record must contain the following documentation:
  - Date of discontinuation
  - Date of discharge summary
  - Dates of service — initial evaluation to discontinuation
  - Specific and objective evaluation of the patient’s progress towards identified outcomes and response to treatment including, but not limited to:
    - Muscle strength
    - Range of motion
    - Functional mobility
    - Developmental milestones
    - Play
    - ADL: assistance required to complete feeding, bathing, dressing, etc.
    - IADL: assistance required to complete simple meal preparation, managing finances, cleaning the house, yard work, etc.
    - Pain level (as reported by the patient), location, type and the impact on function, occupation and the possible effect on the treatment program
Documentation requirements – Discharge summary

OCCUPATIONAL THERAPY PRACTITIONER’S ROLE (CONT’D)

• Goals achieved and not achieved with documentation indicating why goals were not achieved
• Outcome results
• Recommendations
• Signatures and credentials of the occupational therapy practitioners contributing to the discharge summary

Note: The occupational therapist’s signature, credentials and date are not required on the documentation completed solely by an occupational therapy assistant.
Covered services – PT, OT, SLP

Physical Therapy, Occupational Therapy and Speech Language Pathology covered services:

- The PT, OT, SLP benefit consists of occupational therapy services provided in the IOT’s (Individual Occupational Therapist) office, a patient’s home or a domiciliary facility. Services can also be provided in a physician’s office and the IOT is entitled to bill under his or her PIN.
- Most Blue Cross contracts have an outpatient visit or day maximum. Outpatient maximums are usually applied in one of three ways:
  - Number of visits per calendar year (each treatment date counts as one visit)
  - Number of visits per condition per calendar year (each treatment date per condition as one visit)
  - Number of consecutive calendar days per condition (days are counted starting with the first date of treatment and ending number of days later, regardless of how many services are provided during the number of days period)
- Most Blue Cross contracts also have a combined outpatient maximum for PT, OT, SLP services. Any services given to treat the same condition count toward meeting the maximum, regardless of who provides the services or where they are provided (outpatient hospital facility, freestanding OPT facility, or office).
- **Note**: Visits for physical medicine, rehabilitation modalities and therapeutic procedures performed by a chiropractor in conjunction with spinal manipulation are applied toward this maximum.
- Outpatient visits maximums may renew in one of these ways:
  - Each calendar year (if treatment overlaps into the following year, the start date changes to the date of the first visit of the new year)
  - Immediately after surgery for the condition treated
  - Following a documented acute aggravation of the patient’s condition

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Occupational therapy covered services

- **We pay for:**
  - Initial OT evaluation
  - OT visits and treatments
  - Re-evaluations

- **Occupational services must be:**
  - Prescribed by a doctor of medicine, osteopathy, or podiatry, a physician assistant, or a dentist
  - There must be a valid physician order included in the medical record documentation. Physician orders are valid for 90 days.
  - Given for a condition that can be significantly improved in a reasonable and generally predictable period of time (usually about six months)
  - Provided by a particular practitioner

- **Note:** IOT's may not participate per-claim

- Documented in the patient’s medical record

- **Note:** Special rules apply when occupational therapy services are provided to treat autism (discussed later)

- **Services are not payable if it has been determined that the patient is at maximum therapeutic potential and further therapy would not result in any significant improvement.** (can be determined by the medical record documentation)
“Incident to” therapy services

- Blue Cross reimburses providers for OT services “incident to” physician or nonphysician practitioner services in the outpatient setting when such services are performed by the physician or NPP, or registered occupational therapist.
  - Physicians, NPPs, IOTs, OPT facilities and outpatient hospitals can bill for the services of athletic trainers when such services are under the general supervision of an occupational therapist.
  - Therapy services performed by therapy aides, exercise physiologists, kinesiotherapists, low-vision specialists or other individuals are not eligible for Blue Cross reimbursement.
  - Blue Cross covers professional services in which students participate as long as the services are provided under the personal supervision and responsibility of the licensed professional supervising the student. Personal supervision means the supervising professional must be in attendance in the room during the performance of the procedure. Any services provided by a student are considered the professional services of the supervising professional. It is acceptable for students to provide documentation of services, and to sign their documentation, as long as the supervisor is also signing the documentation and is responsible for the documentation.
  - Only the physician or the independent occupational therapist may bill for OT services provided in their respective offices.

We pay for covered OT services performed by the following practitioners in these outpatient settings:

- **IOT office:** Independent occupational therapist
- **IOT office:** Occupational therapy assistant or athletic trainer under the general supervision of an independent occupational therapist

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Occupational therapy covered services

Evaluations and re-evaluations

• We pay for the initial evaluation to set goals and develop an effective treatment plan with the patient.

• The initial evaluation is not counted as a visit or a day of treatment. It is paid separately and is not applied toward the benefit maximum.

• We pay only for the initial evaluation per diagnosis.

• We pay for re-evaluations:
  - When there is a significant change in the patient's condition that would indicate a change in the therapeutic regime
  - At the time of discharge when a maintenance program is established
  - To adjust an established maintenance program and for periodic assessment of a patient on a maintenance program

• Re-evaluations are allowed once every 21 days after the first date of treatment.

• Re-evaluations are counted as visits and are applied toward the benefit maximum.
Occupational therapy non covered services

- The following services or items are not payable under the occupational therapy benefit. Some of them, however, may be covered under other benefits:
- Treatment solely to improve cognition (for example, memory, or perception), concentration and attentiveness, organizational or problem-solving skills, academic skills, impulse control or other behaviors for which behavior modification is sought
- **Note:** We may pay for treatment to improve cognition when part of a comprehensive rehabilitation plan of care
- Services received from other facilities independent of a hospital, such as an independent sports medicine clinic
- Therapy to treat long-standing, chronic conditions that have not responded to or are unlikely to respond to therapy
- Patient education and home programs (for example, home exercise programs)
- Educational, vocational, diversionary and recreational activities
- Injury prevention and conditioning services
- Recreational therapy
- Maintenance therapy
- Work-hardening therapy
Billing requirements – habilitative services

- PT, OT, and ST services can be reported on the same claim with the non-PT, OT, and ST services.
- Reimbursement will be on a fee basis at the procedure code level.

Habilitative services

- When billing for habilitative services, use modifier SZ to distinguish habilitative visits from rehabilitative visits. Habilitative services billed without the SZ modifier would be counted as rehabilitative visits.
- See The Record – October 2016

Claims

- If Occupational therapy associated with work comp injury a claim code should be used when applicable in box 10d on the CMS1500 claim form

- W2 – duplicate of original claim
- W3 – level 1 appeal
- W4 – level 2 appeal
- W5 – level 3 appeal
Billing requirements – office setting

Evaluations and re-evaluations in an office setting

• An initial evaluation is not counted as a visit or a day of treatment. It is paid separately and is not applied toward the benefit maximum.
• Re-evaluation are allowed once every 21 days after the first date of treatment.
• Re-evaluations are counted as visits and are applied toward the benefit maximum

Reporting therapy services in an office setting

• When physical therapists, occupational therapists, or speech-language pathologists provide services in an office setting, including a physician’s office:
  • Should report the services on a CMS-1500 claim.
  • Must identify themselves as the rendering provider. If they want the payment to be made to them directly, they should enter their type 1 (individual) NPI in both field 33a and in the un-shaded portion of field 24J.
  • If the therapist is a member of a group and wants payment to be made to the group, he or she should enter the type 2 (group) NPI in field 33a and his or her type 1 (individual) NPI in the un-shaded portion of field 24J.
Billing requirements – date of treatment

Initial date of treatment

• The initial date of treatment is the first day the patient received therapy (not an evaluation) for a condition.

• When a physician, IPT, IOT or ISLP bills for services during the year treatment begins, report the initial date of service in field 14 of the CMS-1500 claim form.

• When billing for services in other situations, report the initial date of treatment as follows:

<table>
<thead>
<tr>
<th>Situation</th>
<th>Initial date of treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Treatment continues into the following year</td>
<td>The first visit in the new year</td>
</tr>
<tr>
<td>Treatment provided immediately after surgery</td>
<td>The first visit after surgery</td>
</tr>
<tr>
<td>Treatment follows a documented acute aggravation of patient’s condition</td>
<td>The first visit following the documented aggravation</td>
</tr>
</tbody>
</table>

• For every year in which the patient receives services, report a corresponding initial date of treatment on a claim, otherwise our system will reject it as if the basic benefits were exhausted.

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Billing requirements - modifiers

A modifier:

- May not always be required
- May affect the payment for the service
- May require you to attach further documentation to the claim
- Valid Modifiers: rehabilitative therapy

- CPT therapy codes ranging from G8978 – G8999 and G9158 – G9186
- Valid ABN modifiers: GA; GX; GY; GZ
- Valid level of severity modifiers for therapy codes:
  - CPT Modifiers: 25; 59; 76
  - HCPCS Modifiers: AO; CC; CH; CJ; CK; CL; CM; CN; GN; GO; GP; KX; PO; Q0; XE; XP; XS; XU
- Full modifier descriptions found in the Blue Cross Blue Shield Provider Manual and HCPCS manual Appendix 2
Billing requirements – pre approval

eviCore healthcare will manage Blue Cross Blue Shield of Michigan’s Medicare Plus Blue PPO members residing in MI who receive services from MI providers. (for dates of service after Jan 1 2017)

Providers can go straight to the eviCore web portal via web-Denis without having to separately sign o to eviCore website

To request an authorization, access the provider portal at www.bcbsm.com.

Observation care and skilled nursing facilities do not currently require pre-approval

For the first request, providers may evaluate and provide treatment as indicated at the initial visit. Providers will have seven (7) days from the start date to obtain authorization.

For request for continuing care, submit the request before treatment. Providers can submit as early as seven (7) days before the requested start date.

Separate authorizations are required for PT and OT services

The treating provider is responsible for obtaining authorizations.
Billing requirements – pre approval

• Providers should wait at least five days after the authorization of outpatient physical or occupational therapy service to submit claims for Medicare Plus Blue PPO members who reside in MI.

• Providers should include the following information to get approval for physical therapy and occupational therapy services:
  - Member’s name, date of birth, plan name an plan ID number
  - Ordering doctor’s name, NPI, TAX ID, and fax number
  - Place of service
  - Rendering facility name, NPI, TAX ID, street address and fax number
  - Services being requested (CPT codes and diagnosis codes)
  - All relevant clinical notes: Imaging and x-ray reports, patient history and physical findings

• Providers will be notified of both approval and denial decisions by fax, and decisions may also be viewed via the web portal.

• Authorizations are valid for 45 days, if services are not performed within 45 days of the issuance of the authorization, a new authorization must be requested.

• eviCore will conduct a retrospective review if requested within 90 days from the date of service. The services must meet clinical criteria for appropriateness. Claims submitted for authorized procedures are subject to denial, and providers may not seek reimbursement from members.
Physical, occupational and speech therapy

Professional billing, using the CMS-1500 form

For the professional billing of physical, occupational or speech therapy, practitioners should follow the guidelines shown below:

- The appropriate physical medicine and rehabilitation or other appropriate “CPT code should be used.
- The appropriate therapy modifier should be used.
- If both an evaluation and a treatment are provided on the same day, each should be shown on a separate line.
- Individual dates should be shown when more than one day is billed.

Note: Only one per-diem fee is payable per therapy type (PT, OT or ST) per day for the same member. When multiple CPT codes are used for the same therapy type of the same date of service, the per-day rate is used to pay only one CPT code. Whether therapy is provided in the physician office or elsewhere, there is a maximum per-day payment that applies to each therapy type. In addition, therapy services require authorization prior to the start of therapy. Each therapy type requires a separate authorization. Global referrals do not apply to physical, occupational or speech therapy.
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CP T codes for occupational therapy

- On Jan 1 2017 new codes went into effect for occupational therapy evaluations, treatment codes remain the same (these codes replaced codes 97001-97004)
- 97535 for treatment
- 97165 Occupational therapy evaluation, low complexity
  - Requires occupational profile and medical and therapy history, patient presents with no comorbidities that affect occupational performance, modification of tasks or assistance is not necessary, typically 30 minutes spent face-to-face with patient and/or family.
- 97166 Occupational therapy evaluation, moderate complexity
  - Requires occupational profile and medical and therapy history, assessment that identifies three to five deficits in performance, patient may present with comorbidities that affect occupational performance, typically 45 minutes spent face-to-face with patient and/or family
- 97167 Occupational therapy evaluation, high complexity
  - Requires occupational profile and medical and therapy history, assessment that identifies three to five deficits in performance, patient presents with comorbidities that affect occupational performance, typically 60 minutes spent face-to-face with patient and/or family
- 97168 Re-evaluation of occupational therapy established plan of care
  - An assessment of changes in patient functional or medical status with revised plan of care, update to initial occupational profile, a revised plan of care, typically 30 minutes are spent face-to-face with patient and/or family
CPT codes for therapeutic procedures

- **97110**
  - therapeutic procedure 1 or more areas, each 15 min
- **97112**
  - neuromuscular reeducation of movement, balance, coordination, etc
- **97113**
  - aquatic therapy with therapeutic exercises
- **97116**
  - gain training (includes stair climbing)
- **97150**
  - massage, including effleurage, petrissage and/or tapotement (stroking, compression, percussion)
- **97530**
  - therapeutic activities, direct (one-on-one) patient contact (use of dynamic activities to improve functional performance), each 15 minutes
- **97532**
  - development of cognitive skills to improve attention, memory, problem solving (includes compensatory training), direct (one-on-one) patient contact, each 15 minutes
- **97535**
  - self care/home management training, direct one-on-one contact, each 15 minutes
- **97537**
  - community/work reintegration training, direct one-on-one contact, each 15 minutes
<table>
<thead>
<tr>
<th>Diagnosis Description</th>
<th>ICD 10 CM codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bursitis</td>
<td>M06.211 – M06.29; M70.20 thru M70.42; M77.8; M76.40 thru M76.42; M71.10 thru M71.19; M71.50; M71.58</td>
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<tr>
<td>Tendinitis</td>
<td>M76.6-; M75.2-; M65.27-; M65.23-; M65.24-; M65.26-; M65.29; M65.25-; M75.3-; M65.28; M65.22-; M76.0-; M76.5-; M76.81-; M76.82-</td>
</tr>
<tr>
<td>Carpal Tunnel Syndrome</td>
<td>G56.0-</td>
</tr>
<tr>
<td>Cervicalgia</td>
<td>M54.2</td>
</tr>
<tr>
<td>Disturbance of Skin Sensation</td>
<td>R20.1; R20.2; R20.3; R20.8; R20.9</td>
</tr>
<tr>
<td>Drug underdosing</td>
<td>Z91.128; Z91.138; Z91.130; Z79.120</td>
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<tr>
<td>Enthesopathy</td>
<td>M77.9; M76.811 thru M76.819; M77.8; M77.5; M76.821 thru M76.829</td>
</tr>
<tr>
<td>Injuries (causes, activity)</td>
<td>V89.0-; V89.2-; W19.-; W10.9-; Y93.51</td>
</tr>
<tr>
<td>Joint pain</td>
<td>M25.50; M25.551 thru M25.559; M79.671 thru M79.676;</td>
</tr>
<tr>
<td>Lateral Epicondylitis</td>
<td>M77.10 thru M77.12</td>
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<tr>
<td>Diagnosis description</td>
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<td>Limb pain</td>
<td>M79.609; M79.621 thru M79.629; M79.631 thru M79.639; M79.641 thru M79.646; M79.661 thru M79.651 thru M79.659; M79.671 thru M79.676</td>
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<tr>
<td>Lumbago</td>
<td>M54.5</td>
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<tr>
<td>Neuritis</td>
<td>M79.2</td>
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<tr>
<td>Radiculitis</td>
<td>M54.10 thru M54.13</td>
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<tr>
<td>Sciatica</td>
<td>M54.30 thru M54.32; M54.40 thru M54.42</td>
</tr>
<tr>
<td>Sprains (subluxation and/or dislocation of joints and/or ligaments)</td>
<td>S43.00 thru S43.19; S56.011 thru S56.019; S56.411 thru S56.019</td>
</tr>
<tr>
<td>Strain (injury of muscle, fascia, and/or tendon)</td>
<td>S46.001 thru S46.099; S46.201 thru S46.222; S46.101 thru S46.299</td>
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<tr>
<td>Tobacco Use Disorder</td>
<td>Z72.0; Z71.6; F17.209; F17.201; F17.203</td>
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<tr>
<td>Decreased ADL’s</td>
<td>Z73.6; Z74.09; Z74.1; Z73.9</td>
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<td>Diagnosis description</td>
<td>ICD 10 CM codes</td>
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<td>Austic disorder</td>
<td>F84.0</td>
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<tr>
<td>Brachial plexus disorders</td>
<td>G54.0</td>
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<tr>
<td>Delayed milestone in childhood</td>
<td>R62.0</td>
</tr>
<tr>
<td>Specific development disorder of motor function</td>
<td>F82</td>
</tr>
<tr>
<td>Anesthesia of skin</td>
<td>R20.0</td>
</tr>
<tr>
<td>Hypoesthesia of skin</td>
<td>R20.1</td>
</tr>
<tr>
<td>Paresthesia of skin</td>
<td>R20.2</td>
</tr>
<tr>
<td>Hyperesthesia</td>
<td>R20.3</td>
</tr>
<tr>
<td>Other disturbances of skin sensation</td>
<td>R20.8</td>
</tr>
<tr>
<td>Unspecified disturbances of skin sensation</td>
<td>R20.9</td>
</tr>
<tr>
<td>Edema</td>
<td>R60.0; R60.1; R60.9</td>
</tr>
<tr>
<td>Feeding difficulties and mismanagement</td>
<td>R63.3</td>
</tr>
<tr>
<td>Hemiplegia, unspecified affecting unspecified side</td>
<td>G81.90; G81.91; G81.92; G81.93 G81.94;</td>
</tr>
<tr>
<td>Diagnosis description</td>
<td>ICD 10 CM codes</td>
</tr>
<tr>
<td>--------------------------------------------------------------------------------------</td>
<td>------------------------------------------</td>
</tr>
<tr>
<td>Paraplegia</td>
<td>G82.20</td>
</tr>
<tr>
<td>Infantile cerebral palsy, unspecified</td>
<td>G80.9</td>
</tr>
<tr>
<td>Lack of coordination</td>
<td>R27.0; R27.8; R27.9</td>
</tr>
<tr>
<td>Lack of normal physiological development unspecified</td>
<td>R62.50; R62.59</td>
</tr>
<tr>
<td>Mixed development disorder</td>
<td>F82</td>
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<tr>
<td>Muscle weakness (generalized)</td>
<td>M62.81</td>
</tr>
<tr>
<td>Other joint derangement, not elsewhere classified, involving hand</td>
<td>M24.841; M24.842; M24.849; M25.241; M25.249; M25.341; M25.342; M25.349</td>
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<tr>
<td>Other specified delays in development</td>
<td>F88</td>
</tr>
<tr>
<td>Stiffness of joint, not elsewhere classified, involving unspecified site</td>
<td>M25.60</td>
</tr>
<tr>
<td>Unspecified delay in development</td>
<td>F81.9; F89</td>
</tr>
</tbody>
</table>
Sample occupational therapy SOAP note

SOAP Notes

S (Subjective)
Client's perspective on treatment (WHAT THE CLIENT REPORTS or SAYS)
- Pain (do they have it? Complain?)
- Pt. stated, "My shoulder hurts" when asked to complete upper body dressing *must be relevant to treatment
- Clients level of interest/motivation for activity
  ex: Pt. reports intentions to continue to practice proper body mechanics at work

O (Objective)
Record measurable, quantifiable and observable data obtained during treatment
(WHAT THE CLIENT DEMONSTRATES)
*Includes assistance levels
*Strictly what you observed
ex: Pt. required transfer bench for...
  ex: Pt. demonstrates independence in performing the home exercise program

A (Assessment)
- "Therapist" interpretation of the data contained in the note (what has already been mentioned)
- Includes problems (continuing limitations), progress, and rehabilitation potential
 (expected benefit from continued OT intervention) (WHAT THE CLIENT IS WORKING ON)
  ex: Pt. expressed a desire to return, but does not yet demonstrate the capacity for the required sitting tolerance

P (Plan)
- Anticipated frequency and duration of OT services
  - Frequency: how often, how long each time
  - Duration: how long in total
- Specific interventions you will use to achieve client's goals
  - Purpose of continued OT intervention (RECOMMENDATIONS)
- Any changes to the goals/objectives
  ex: Recommend the use of lumbar support and regular performance of home program

Blue Cross Blue Shield of Michigan and Blue Care Network are nonprofit corporations and independent licensees of the Blue Cross and Blue Shield Association.
Rhonda, who had a stroke nine weeks ago, spent 12 days in an inpatient rehab facility before receiving treatment for the past five weeks in a skilled nursing facility. The 82-year-old, who is now under your care, lost her husband five months ago and is having a hard time coping; she previously was going to a support group, but now is unable to attend. Nowadays, Rhonda is staying with her 53-year-old daughter, who provides routine care and assistance. Rhonda, who’s legally blind and has type 1 insulin-dependent diabetes, had a knee replacement a year ago and is presenting with short-term memory deficits as well as decreased ability to complete tasks. She’s also presenting with muscle weakness, a hemiplegic gait pattern, and proprioceptive deficits on her right side. Due to increased physical and cognitive deficits, Rhonda can no longer perform household chores like vacuuming, dusting, and doing laundry. These restrictions have forced you, the OT, to provide assistance and modify some of her evaluation activities during visitation.
• **Correct CPT Code: 97166 (Moderate-Complexity OT Evaluation)**

• Because Rhonda has such an extended history of physical, cognitive, and psychosocial issues that relate to—and impact—her current functional performance, you must conduct an expanded review of her records (i.e., one that is much more intensive than a patient with a brief medical history). Furthermore, after completing Rhonda’s OT assessment, you conclude she has seven performance-related deficits that hinder her ability to complete everyday activities and household tasks. However, even though the number of performance deficits exceeds the number included in the code description for a moderate-complexity evaluation, Rhonda’s case—as a whole—is not complex enough to warrant a high-complexity evaluation (remember, when there are elements of different levels of complexity in any given evaluation, you typically should code down). Thus, it makes sense to code for moderate complexity.
### Coding Example – ICD 10 CM answer

<table>
<thead>
<tr>
<th>Diagnosis description</th>
<th>ICD 10 CM code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Muscle weakness</td>
<td>M62.81</td>
</tr>
<tr>
<td>Hemiplegic gain pattern</td>
<td>R26.89</td>
</tr>
<tr>
<td>Decreased ADL’s</td>
<td>Z73.6</td>
</tr>
</tbody>
</table>
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References

- Reminder: billing for physical, occupational, and speech therapy, The Record, August 2015
- Blue Cross Blue Shield Blue Care Network of Michigan; Physical therapy and Occupational Therapy Services Frequently Asked Questions; Prior Authorization program topics; pp 1-5
- Here are answers to frequently asked questions about therapy services documentation, The Record, June 2017
- https://sps-corp/sites/ebig/Broadcast%20Messages/web-DENIS%20only%20-%20Provider% Broadcast message posted: New codes in effect for physical and occupational therapy; Category: Blue Care Network (PT, OT billing); posting start date: 01/09/17; posting end date: 01/23/17