Telehealth in Occupational Therapy Practice:
Establishing the Client/Provider Relationship

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**Background/Introduction**

“Occupational therapy practitioners enable people of all ages to live life to its fullest by helping them promote health, and prevent—or live better with—injury, illness, or disability.”

*American Occupational Therapy Association*

An estimated 118,070 occupational therapy practitioners (OTP) are employed within the United States (U.S. Bureau of Labor Statistics, May 2016), in a variety of settings, including hospitals, skilled nursing facilities, schools, community-based practice settings, higher education, and elsewhere. The American Occupational Therapy Association (AOTA) identifies six primary practice areas for occupational therapy (OT): Children & Youth, Health & Wellness, Mental Health, Productive Aging, Rehabilitation & Disability, and Work & Industry.

The use of telehealth is emerging as a service-delivery model in the field of occupational therapy (AOTA, 2014). AOTA defines telehealth as “The application of evaluative, consultative, preventative, and therapeutic services delivered through telecommunication and information technologies” (AOTA, 2014, p. S69). The body of research-evidence within the field of occupational therapy supports the use of telehealth as effective by increasing access to specialist care and preventing delays in provision of services (Cason, 2014), providing increased collaboration and carry-over of treatment strategies (Gibbs & Cohen, 2011), and improving overall therapist/client satisfaction (Ashburner, et al., 2016; Criss, 2013; Reifenberg, et al., 2017; Zylstra, 2013). The use of a telehealth service-delivery model is recognized in AOTA’s OT Practice Framework (3rd Edition).

An occupational therapy practitioner might utilize a telehealth service-delivery model to observe a client during desired occupations, to assess performance patterns and performance skills, and/or to conduct direct or consultative treatment sessions. An occupational therapist might select and use specific OT assessment tools via telehealth to measure performance skills and patterns (OT Practice Framework, 3rd Edition, S14). Occupational therapy students are beginning to acquire telehealth-related skills in accredited OT programs (Cason, 2014), and the Accreditation Council for Occupational Therapy Education (ACOTE) requires that students demonstrate an understanding of technology, including but not limited to, technologies such as the use of telehealth (ACOTE, 2013; Cason, 2014). The legality and reimbursement of the use of a telehealth service-delivery model in occupational therapy differs depending on the state in which the therapist is licensed to practice (Calouro, Kwong, & Gutierrez, 2014). Reimbursement for occupational therapy services delivered via telehealth is not universal (Cason, 2014), and as of this writing, reimbursement policies for occupational therapy services delivered via telehealth continue to vary on a state-by-state basis.

Although it is emerging, the amount and type of research regarding the use of telehealth in occupational therapy is limited in scope. Further research is needed to explore the efficacy and comparative effectiveness of this service-delivery model, as well as specific barriers and supports to the use of telehealth as a component of occupational therapy practice.
Several important issues exist within occupational therapy regarding the use of telehealth, including licensure, reimbursement, ethical, security and privacy considerations, as well as establishing the client/provider relationship via telehealth. The remainder of this document focuses on licensure and reimbursement issues within the context of establishing the client/provider relationship (conducting an initial evaluation) in occupational therapy via telehealth.

**Establishing the Client/Provider Relationship via Telehealth in Occupational Therapy**

As healthcare professionals, occupational therapy practitioners establish the client/provider relationship via an initial evaluation. States have varying requirements for establishing the client/provider relationship. For example, in some states a physician referral is required to initiate an occupational therapy evaluation; in other states this referral is not required and there is direct access to occupational therapy services.

The AOTA State Affairs Group has written a comprehensive document detailing state-specific telehealth requirements as stated within OT licensure documents (Occupational Therapy and Telehealth State Statutes, Regulations and Regulatory Board Statements, May 2017 (available to AOTA members)). According to this document, several state occupational therapy licensure regulations outline requirements for establishing the client/provider relationship via a telehealth service-delivery model. In the state of Texas, for example:

“The occupational therapist is responsible for determining whether any aspect of the provision of services may be conducted via telehealth or must be conducted in person” (p. 17).

“The initial evaluation for a medical condition must be conducted in person and may not be conducted via telehealth” (p. 17).

“The occupational therapist must have real time interaction with the client during the evaluation process either in person or via telehealth” (p. 17).

“Intervention for a medical condition by an occupational therapy practitioner requires a referral from a licensed referral source” (p. 17).

“Occupational therapists may provide consultation or monitored services, or screen or evaluate the client to determine the need for occupational therapy services without a referral” (p. 17).

Alternatively, several states do not specifically mention telehealth in state licensure regulations, but state occupational therapy boards have provided guidance to practitioners in these states. Ohio, for example, has adopted the language from the AOTA telehealth position paper (2013) as guidance to practitioners and also states that “OTs providing telehealth services in Ohio must hold a valid Ohio license” (Occupational Therapy and Telehealth State Statutes, Regulations and Regulatory Board Statements, May 2017, p. 13). In another example, the state of South Dakota has no telehealth regulations or state statutes related to occupational therapy, but the board reports, “[telehealth] is allowed and [is] treated the same as normal practice” (Occupational Therapy and Telehealth State Statutes, Regulations and Regulatory Board Statements, May 2017, p. 15).
In other states, telehealth is not specifically mentioned in OT licensure regulations, and no guidance has been provided to OT practitioners (Occupational Therapy and Telehealth State Statutes, Regulations and Regulatory Board Statements, May 2017).

The U.S. Department of Labor (2016) highlights 13 states with the highest concentration of occupational therapy providers. Of these 13 states, nine (9) have no specific language regarding the use of telehealth (Occupational Therapy and Telehealth State Statutes, Regulations and Regulatory Board Statements, May 2017). Of these, three (3) of nine (9) states have provided recommendations to OT practitioners by referencing existing documents/policies regarding the use of telehealth. At the time of this writing, six (6) out of nine (9) of these states (Florida, Wisconsin, New Jersey, Massachusetts, Michigan, and Pennsylvania) have not provided guidance or recommendations regarding the use of telehealth in occupational therapy practice. (Note: approximately six (6) additional states have also not provided guidance or recommendations, but these are outside the scope of this resource).

During a two-month period (July-August 2017), state occupational therapy associations, licensing boards, and regional telehealth centers were contacted in an attempt to provide additional guidance on establishing the client/provider relationship via telehealth when state statutes and/or regulations do not specifically mention telehealth. The following questions were posed:

1. Can a practitioner/client relationship (conducting an initial occupational therapy evaluation) be completed virtually in your state?

2. Is a physician referral required for the completion of a virtual occupational therapy evaluation in your state?

3. In your state, do additional requirements exist for the completion of a virtual occupational therapy evaluation and/or subsequent treatment as indicated?

4. Do you have other guidance/comments related to OT telehealth policy in your state?

Comments (as available) are organized on a state-by-state basis, into the following themes: Licensure (telehealth permitted?), and Reimbursement (telehealth reimbursed?). Relevant legislation is also discussed, as applicable.

**Florida**

*OT evaluation permitted via telehealth?*

Because telehealth is not specifically addressed in the Florida OT licensure language, the Board does not offer guidance regarding telehealth to occupational therapy practitioners at this time, but refers practitioners to the Florida OT Practice Act (Florida Board of Occupational Therapy, personal communication, July 2017). The Florida Board of OT website states: “The use of telehealth technology by Florida licensed healthcare practitioners for the purpose of providing patient care within the state of Florida is not precluded by Florida law. Telehealth technologies
may be employed for patient care as long as such technologies are used in a manner that is consistent with the standard of care” (Florida Board of Occupational Therapy website).

**OT evaluation via telehealth reimbursable?**

Regional telehealth center refers practitioners to Florida Medicaid documentation for telemedicine (no mention of OT within document); also refers practitioners to Medicare Telehealth Fact Sheet (consistent nationwide as long as patient is in an HRSA-designated rural area) (Southeastern Telehealth Resource Center, personal communication, July 2017).

**Referral required for OT evaluation via telehealth?**

According to the Board website, “The Florida Occupational Therapy Practice Laws and Rules are silent on this issue, not stating that a Doctor’s prescription is required to provide professional OT services. However, there are different Facility requirements, and/or billing requirements that may mandate a Doctor’s prescription” (Florida Board of OT website FAQs).

**State legislation relevant to OT/telehealth**

CS/CS/HB 7087, approved by the Governor on 4/14/2016, requires collecting certain information regarding the use of telehealth in the state of Florida. A telehealth survey was distributed to Florida OT Practitioners and required as part of the Florida OT license renewal process (Florida Board of Occupational Therapy, personal communication, July 2017).

**Massachusetts**

[Association response pending as of August, 2017]

**Pending state legislation relevant to OT/telehealth**

H578; S549

**Michigan**

[Association response pending as of August, 2017]

**OT evaluation via telehealth reimbursable?**

Not reimbursable by Medicaid (State telehealth laws and reimbursement policies, Center for Connected Health Policy, April, 2017).

**New Jersey**

**OT evaluation permitted via telehealth?**

The New Jersey Occupational Therapy Association (NJOTA) board does not interpret laws, and defers to the Advisory Board in these cases. The Advisory Board advocates for the consumer, and in the case of the use of telehealth would encourage individuals to be mindful of
HIPAA/privacy and security considerations with the use of telehealth technologies. NJOTA suggests that occupational therapy (OT) practitioners considering the use of telehealth educate clients/families regarding the risks and benefits of the use of telehealth, and obtain written client consent prior to using this service-delivery model (New Jersey Occupational Therapy Association, personal communication, July 2017).

State legislation relevant to OT/telehealth

S291/652/1954, Approved P.L.2017, c.117

Occupational therapists are not specifically mentioned, but P.L. 2017, c.117 authorizes health care services delivered through telemedicine and telehealth:

““Health care provider” means an individual who provides a health care service to a patient, and includes, but is not limited to, a licensed physician, nurse, nurse practitioner, psychologist, psychiatrist, psychoanalyst, clinical social worker, physician assistant, professional counselor, respiratory therapist, speech pathologist, audiologist, optometrist, or any other health care professional acting within the scope of a valid license or certification issued pursuant to Title 45 of the Revised Statutes” (p. 1-2).

Additional excerpts from New Jersey P.L.2017, c.117 relevant to establishing the client/provider relationship via telehealth are cited below:

“(1) Any health care provider providing health care services using telemedicine or telehealth shall be subject to the same standard of care or practice standards as are applicable to in-person settings. If telemedicine or telehealth services would not be consistent with this standard of care, the health care provider shall direct the patient to seek in-person care” (p. 4).

“A health care provider engaging in telemedicine or telehealth shall review the medical history and any medical records provided by the patient. For an initial encounter with the patient, the provider shall review the patient’s medical history and medical records prior to initiating contact with the patient” (p. 3).

“The identity, professional credentials, and contact information of a health care provider providing telemedicine or telehealth services shall be made available to the patient during and after the provision of services. The contact information shall enable the patient to contact the health care provider, or a substitute health care provider authorized to act on behalf of the provider who provided services, for at least 72 hours following the provision of services” (p. 3).

“3. a. Any health care provider who engages in telemedicine or telehealth shall ensure that a proper provider-patient relationship is established. The establishment of a proper provider-patient relationship shall include, but shall not be limited to: (1) properly identifying the patient using, at a minimum, the patient’s name, date of birth, phone number, and address. When properly identifying the patient, the provider may additionally use the patient’s assigned identification number, social security number, photo, health insurance policy number, or other appropriate patient identifier associated directly with the patient; (2) disclosing and validating the provider’s identity and credentials, such as the provider’s license, title, and, if applicable, specialty and board certifications; (3) prior to initiating contact with a patient in an initial encounter for the
purpose of providing services to the patient using telemedicine or telehealth, reviewing the patient’s medical history and any available medical records; and (4) prior to initiating contact with a patient for the purpose of providing services to the patient using telemedicine or telehealth, determining whether the provider will be able to provide the same standard of care using telemedicine or telehealth as would be provided if the services were provided in person. The provider shall make this determination prior to each unique patient encounter. b. Telemedicine or telehealth may be practiced without a proper provider-patient relationship, as defined in subsection a. of this section, in the following circumstances: (1) during informal consultations performed by a health care provider outside the context of a contractual relationship, or on an irregular or infrequent basis, without the expectation or exchange of direct or indirect compensation; (2) during episodic consultations by a medical specialist located in another jurisdiction who provides consultation services, upon request, to a properly licensed or certified health care provider in this State; (3) when a health care provider furnishes medical assistance in response to an emergency or disaster, provided that there is no charge for the medical assistance; or (4) when a substitute health care provider, who is acting on behalf of an absent health care provider in the same specialty, provides health care services on an on-call or cross-coverage basis, provided that the absent health care provider has designated the substitute provider as an on-call provider or cross-coverage service provider” (p. 5-6).

Refer to the full-text of P.L.2017, c.117 for further information.

**Pennsylvania**

*OT evaluation via telehealth permitted?*

The Board is not authorized to provide an advisory opinion. Counsel refers practitioners to the Pennsylvania Occupational Therapy Practice Act found at www.dos.pa.gov/ProfessionalLicensing/BoardsCommissions/OccupationalTherapy/, as well as Section 42.24 (Code of Ethics) of Board’s regulations, (Pennsylvania Department of State, Office of Chief Counsel, Personal Communication, July 2017).

*OT evaluation via telehealth reimbursable?*

See pending legislation section

**Pending legislation relevant to OT/telehealth**

SB 780 of the General Assembly of Pennsylvania (pending; referred to the Banking & Insurance committee June, 2017)

According to the Pennsylvania Health Care Facilities Act (July, 1979), a health care provider is defined as “An individual who is authorized to practice some component of the healing arts by a license, permit, certificate or registration issued by a Commonwealth licensing agency or board” (p. 5).

Excerpts from the proposed Pennsylvania SB 780 relevant to establishing the client/provider relationship via telehealth are cited below:

“(1) A health care practitioner shall: (i) establish a practitioner-patient relationship with the
individual in accordance with subsection (c); (ii) prior to treatment of the individual, provide an appropriate virtual examination initiated through a consultation using telemicine technologies and any peripherals and diagnostic tests necessary to provide an accurate diagnosis, if an in-person examination would otherwise be medically appropriate in the provision of the same service not delivered via telemicine, as reasonably determined by the professional independent judgment of the health care practitioner; or (iii) establish a telemicine practitioner-patient relationship that meets standards included in evidence-based telemicine clinical practice guidelines. (2) The same standards of care applicable to traditional, in-person health care services shall apply to treatment and consultation recommendations made via telemicine. (4) The health care practitioner shall have an emergency action plan in place for medical emergencies and referrals when needed” (p. 4-5).

“(b) Exceptions.--This section shall not apply to the following: (1) Consultation by a health care practitioner with another health care practitioner who has an ongoing practitioner-patient relationship with the individual that was established through an in-person or appropriate virtual examination and agrees to supervise the individual's care” (p. 5).

“(c) Practitioner-patient relationship.--For purposes of subsection (a)(1), a practitioner-patient relationship is established when the health care practitioner satisfies each of the following: (1) Verifies the location and identity of the individual receiving care each time health care services are provided through telemicine. (2) Discloses the health care practitioner's identity, geographic location and medical specialty or applicable credentials. (3) Obtains informed consent regarding the use of telemicine technologies from the individual or other person acting in a health care decision-making capacity for the individual. (4) Establishes a diagnosis and treatment plan, as reasonably determined by the professional independent judgment of the health care practitioner. (5) Creates and maintains an electronic medical record or updates an existing electronic medical record for the patient within 24 hours. An electronic medical record shall be maintained in accordance with electronic medical records privacy rules under the Federal Health Insurance Portability and Accountability Act of 1996 (Public Law 104-191, 110 Stat. 1936). (6) Provides a visit summary to the individual” (p. 6).

Regarding reimbursement, proposed Pennsylvania SB 780 bill states:

“A health insurance policy or ancillary service plan shall not exclude a health care service for coverage solely because the service is provided through telemicine” (p. 7).

“(2) An insurer, corporation or health maintenance organization shall reimburse the health care practitioner for health care services delivered through telemicine if the insurer, corporation or health maintenance organization reimburses for the same service through in-person consultation. Payment for telemicine encounters shall be established between the health care practitioner and insurer” (p. 7).

“The Department of Human Services shall provide medical assistance coverage and reimbursement, including medical assistance fee-for-service and managed care programs, for health care services delivered through telemicine in accordance with this act” (p. 7-8).

Refer to the full-text of proposed SB 780 for further information.

Wisconsin
OT evaluation via telehealth permitted?

The board is not authorized to make a recommendation, but OT practitioners are required to follow the Wisconsin OT practice Act Scope & Standards regardless of service-delivery model. WOTA refers practitioners to Chapters 1 & 4 of WI OT Practice Scope & Standards (Wisconsin Occupational Therapy Association, personal communication, August 2017).

OT evaluation via telehealth reimbursable?

Wisconsin Medicaid does not cover OT services delivered via telehealth (Great Plains Telehealth Resource & Assistance Center, personal communication, July 2017).

Referral required for OT evaluation via telehealth?

Physician referral is not required to complete an OT evaluation in the state of Wisconsin (practice without referral became effective Summer 2016). Note: Some reimbursement sources require physician referral (Wisconsin Occupational Therapy Association, personal communication, August 2017).

Conclusion

The use of telehealth is emerging as a service-delivery model in occupational therapy. Although it is limited in scope, the current body of research-evidence supports the use of telehealth as effective via a variety of mechanisms. While the majority of U.S. states provide guidance to OT practitioners regarding the use of telehealth, several states do not. Additional policies and procedures are needed to provide state-specific guidelines for OT practitioners using a telehealth service-delivery model. Guidelines and policies for establishing the client/OT relationship via telehealth should integrate best-practices based on current evidence from the field of occupational therapy and existing telehealth legislation.

Additional resources

- American Occupational Therapy Association: aota.org
- American Telemedicine Association: http://www.americantelemed.org/home
- Center for Connected Health Policy: http://www.cchpca.org/
- Florida Board of Occupational Therapy: http://floridasoccupationaltherapy.gov/
- Great Plains Telehealth Resource & Assistance Center: http://www.gptrac.org/
- Massachusetts Association for Occupational Therapy: http://maot.org/
- Michigan Occupational Therapy Association: http://www.mi-ota.com/
- Mid-Atlantic Telehealth Resource Center: http://www.matrc.org/
- National Board for Certification in Occupational Therapy: nbcot.org
- New Jersey Occupational Therapy Association: http://www.njota.org/
- Northeast Telehealth Resource Center: http://netrc.org/
Pennsylvania State Board of Occupational Therapy:  
http://www.dos.pa.gov/professionallicensing/boardscommissions/occupationaltherapy/Pages/default.aspx


Upper Midwest Telehealth Resource Center:  http://www.umtrc.org/

Wisconsin Occupational Therapy Association:  http://www.wota.net/

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References


