

## Chapter OT 4

### PRACTICE AND SUPERVISION

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**OT 4.01 Authority and purpose.** The rules in this chapter are adopted by the board under the authority of ss. 15.085 (5) (b), 227.11 (2) and 448.965, Stats., to govern the standards of practice and supervision requirements for occupational therapists and occupational therapy assistants.

**History:** CR 02–026: cr. Register December 2002 No. 564, eff. 1–1–03.

**OT 4.02 Scope of practice. (1)** “Occupational therapy,” as defined at s. 448.96 (5), Stats., may include the following interventions:

(a) Remediation or restitution of performance abilities that are limited due to impairment in biological, physiological, psychological or neurological processes.

(b) Adaptation of task, process or environment, or the teaching of compensatory techniques, in order to enhance performance.

(c) Disability prevention methods and techniques which facilitate the development or safe application of performance skills.

(d) Health promotion strategies and practices which enhance performance abilities.

**(2)** Occupational therapy interventions include the following:

**Note:** A comprehensive list of occupational therapy interventions can be found in the Model Practice Act of the American Occupational Therapy Association (AOTA). The AOTA may be contacted on the web at [www.aota.org](http://www.aota.org) or by mail at American occupational therapy association, P.O. Box 31220, Bethesda, MD 20824–1220.

(a) Screening, evaluating, developing, improving, sustaining, or restoring skills in activities of daily living, work or productive activities, instrumental activities of daily living, play, leisure activities, rest and sleep, education and social participation.

(b) Evaluating, developing, remediating, or restoring sensorimotor, sensoriperceptual neuromusculoskeletal, emotional regulation, cognition, communication, social skills, or psychosocial components of performance.

(c) Designing, fabricating or training in the use of assistive technology, upper extremity orthotic devices and lower extremity positioning orthotic devices.

(d) Training in the use of prosthetic devices, excluding gait training.

(e) Adaptation of environments and processes, including the application of ergonomic principles, to enhance performance and safety in daily life roles.

(f) Application of physical agent modalities. Application is performed by an experienced therapist with demonstrated and documented evidence of theoretical background, technical skill and competence.

**Note:** An example of standards for evaluating theoretical background, technical skill and competence is the position paper on physical agent modalities issued by the American occupational therapy association (AOTA). AOTA may be contacted on the web at [www.aota.org](http://www.aota.org), and by mail at American Occupational Therapy Association, P.O. Box 31220, Bethesda, MD 20824–1220.

(g) Evaluating and providing intervention and case management in collaboration with the client, family, caregiver or other involved individuals or professionals.

(h) Educating the client, family, caregiver, or others in carrying out appropriate nonskilled interventions.

(i) Consulting with groups, programs, organizations, or communities to provide population–based services.

(j) Therapeutic use of occupations, exercises, and activities.

(k) Training in self–care, self–management, health management and maintenance, home management, community work reintegration, and school activities and work performance.

(L) Therapeutic use of self, including one’s personality, insights, perceptions and judgments, as part of the therapeutic process.

(m) Assessment, recommendation, and training in techniques to enhance functional mobility, including management of wheelchair and other mobility devices.

(n) Vision and low vision rehabilitation.

(o) Driver rehabilitation and community mobility.

(p) Management of feeding, eating, and swallowing to enable eating and feeding performance.

(q) Facilitating the occupational performance of groups, populations, or organizations through the modification of environments and adaptation processes.

(r) Use of a range of specific therapeutic procedures, including wound care management; techniques to enhance sensory, perceptual, and cognitive processing; and pain management, lymphedema management, and manual therapy techniques, to enhance performance skills.

**History:** CR 02–026: cr. Register December 2002 No. 564, eff. 1–1–03; CR 13–109: am. (2) (intro.), (a), (b), cr. (2) (j) to (r) Register September 2014 No. 705 eff. 10–1–14; CR 15–053: am. (2) (f) Register August 2016 No. 728, eff. 9–1–16.

**OT 4.03 Standards of practice.** Occupational therapists and occupational therapy assistants shall adhere to the minimum standards of practice of occupational therapy that have become established in the profession, including but not limited to the following areas:

**(1) SCREENING.** (a) An occupational therapist, alone or in collaboration with an occupational therapy assistant, when practicing either independently or as a member of a treatment team, shall identify individuals who present deficits or declines in performance of their occupations including occupational performance skills and performance patterns.

(b) Screening methods shall take into consideration the occupational performance contexts relevant to the individual.

(c) Screening methods may include interviews, observations, testing and records review to determine the need for further evaluation and intervention.

(d) The occupational therapist or occupational therapy assistant shall transmit screening results and recommendations to all appropriate persons.

**(2) REFERRALS.** Referrals may be accepted from advanced practice nurses, chiropractors, dentists, optometrists, physical therapists, physicians, physician assistants, podiatrists, psychologists, or other health care professionals.

**(3) EVALUATION.** (a) The occupational therapist directs the evaluation process. An occupational therapist alone or in collaboration with the occupational therapy assistant shall prepare an occupational therapy evaluation for each individual referred for occupational therapy services. The occupational therapist interprets the information gathered in the evaluation process.

(b) The evaluation shall consider the individual's medical, vocational, social, educational, family status, and personal and family goals, and shall include an assessment of how performance skills, and performance patterns and their contexts and environments influence the individual's functional abilities and deficits in the performance of their occupations.

(c) Evaluation methods may include observation, interviews, records review, and the use of structured or standardized evaluative tools or techniques.

(d) When standardized evaluation tools are used, the tests shall have normative data for the individual's characteristics. If normative data are not available, the results shall be expressed in a descriptive report. Collected evaluation data shall be analyzed and summarized to indicate the individual's current status.

(e) Evaluation results shall be documented in the individual's record and shall indicate the specific evaluation tools and methods used.

(f) Evaluation results shall be communicated to the referring health care professional, if any, and to the appropriate persons in the facility and community.

(g) If the results of the evaluation indicate areas that require intervention by other health care professionals, the individual shall be appropriately referred or an appropriate consultation shall be requested.

(h) Initial evaluation shall be completed and results documented within the time frames established by the applicable facility, community, regulatory, or funding body.

**(4) PROGRAM PLANNING.** (a) The occupational therapist is responsible for the development of the occupational therapy intervention plan. The occupational therapist develops the plan collaboratively with the client, and may include the occupational therapy assistant and team working with the client, including the physician — as indicated.

(b) The program shall be stated in measurable and reasonable terms appropriate to the individual's needs, functional goals and prognosis and shall identify short and long term goals.

(c) The program shall be consistent with current principles and concepts of occupational therapy theory and practice.

(d) In developing the program, the occupational therapist alone or in collaboration with the occupational therapy assistant shall also collaborate, as appropriate, with the individual, family, other health care professionals and community resources; shall select the media, methods, environment, and personnel needed to accomplish the goals; and shall determine the frequency and duration of occupational therapy interventions provided.

(e) The program shall be prepared and documented within the time frames established by the applicable facility, community, regulatory, or funding body.

**(5) PROGRAM IMPLEMENTATION.** (a) The occupational therapy program shall be implemented according to the program plan previously developed. The occupational therapist may delegate aspects of intervention to the occupational therapy assistant dependent on the occupational therapy assistant's demonstrated and documented service competency.

(b) The individual's occupations, occupational performance, skills, occupational performance patterns, and occupational performance contexts and environments shall be routinely and systematically evaluated and documented.

(c) Program modifications shall be formulated and implemented consistent with the changes in the individual's occupational performance skills, occupational performance patterns and occupational performance contexts and environments.

(d) All aspects of the occupational therapy program shall be routinely and systematically reviewed for effectiveness and efficacy.

**(6) DISCONTINUATION OF SERVICES.** (a) Occupational therapy services shall be discontinued when the individual has achieved the program goals or has achieved maximum benefit from occupational therapy.

(b) A comparison of the initial and current state of functional abilities and deficits in occupational performance skills, and occupational performance patterns, affecting performance in the individual's occupations shall be made and documented.

(c) A discharge plan shall be prepared, consistent with the interventions provided, the individual's goals, and the expected prognosis. Consideration shall be given to the individual's occupational performance contexts and environments including appropriate community resources for referral, and environmental factors or barriers that may need modification.

(d) Sufficient time shall be allowed for the coordination and effective implementation of the discharge plan.

(e) Recommendations for follow-up or reevaluation shall be documented.

**History:** CR 02–026: cr. Register December 2002 No. 564, eff. 1–1–03; correction in (2) (e) made under s. 13.92 (4) (b) 6., Stats., Register November 2011 No. 671; CR 13–109: am. (1) (a), (2) (title), (a), (c) to (e), (3) (a), (b), (f), (4) (d), (5) (b), (c), (6) (b), (c) Register September 2014 No. 705, eff. 10–1–14; CR 15–053: am. (2) (title), r. (2) (a), am. (2) (b), r. (2) (c) to (e), am. (3) (a), (f) Register August 2016 No. 728, eff. 9–1–16; renum. (2) (b) to (2) under s. 13.92 (4) (b) 1., Stats., Register August 2016 No. 728.

**OT 4.04 Supervision and practice of occupational therapy assistants.** (1) An occupational therapy assistant must practice under the supervision of an occupational therapist.

Supervision is an interactive process that requires both the occupational therapist and the occupational therapy assistant to share responsibility for communication between the supervisor and the supervisee. The occupational therapist is responsible for the overall delivery of occupational therapy services and shall determine which occupational therapy services to delegate to the occupational therapy assistant or non-licensed personnel based on the establishment of service competence between supervisor and supervisee, and is accountable for the safety and effectiveness of the services provided.

(2) Supervision of an occupational therapy assistant by an occupational therapist shall be either close or general. The supervising occupational therapist shall have responsibility for the outcome of the performed service.

(3) When close supervision is required, the supervising occupational therapist shall have daily contact on the premises with the occupational therapy assistant. The occupational therapist shall provide direction in developing the plan of treatment and shall periodically inspect the actual implementation of the plan. The occupational therapist shall cosign evaluation contributions and intervention documents prepared by the occupational therapy assistant.

(4) (ad) In this subsection, "direct contact" means face-to-face communication or communication by means of telephone, electronic communication, or group conference.

(ah) When general supervision is allowed, the supervising occupational therapist shall, except as provided under par. (ap), have direct contact with the occupational therapy assistant and face-to-face contact with the client by every tenth session of occupational therapy and no less than once per calendar month.

(ap) When general supervision is allowed, and occupational therapy services are provided to a client once per calendar month or less frequently than once per calendar month, the supervising occupational therapist shall have direct contact with the occupational therapy assistant and face-to-face contact with the client no less than every other session of occupational therapy.

(at) Direct contact with the occupational therapy assistant under pars. (ah) and (ap) shall include reviewing the progress and

effectiveness of treatment, and may occur simultaneously or separately from face-to-face contact with the client.

(b) The occupational therapist shall record in writing a specific description of the supervisory activities undertaken for each occupational therapy assistant. The written record shall include client name, status and plan for each client discussed.

(5) Close supervision is required for all rehabilitation, neonate, early intervention, and school system services provided by an entry level occupational therapy assistant. All other occupational therapy services provided by an occupational therapy assistant may be performed under general supervision, if the supervising occupational therapist determines, under the facts of the individual situation, that general supervision is appropriate using established professional guidelines.

**History:** CR 02–026: cr. Register December 2002 No. 564, eff. 1–1–03; CR 08–050: am. (3), renum. (4) to be (4) (a) and am., cr. (4) (b) and (c) Register January 2009 No. 637, eff. 2–1–09; CR 19–108: renum.(4) (a) to (4) (ah) and am., cr. (4) (ap), (at), renum. (4) (c) to (4) (ad) and am. Register February 2020 No. 770, eff. 3–1–20.

**OT 4.05 Supervision of non-licensed personnel and therapy aides.**

(1) An occupational therapist or occupational therapy assistant must provide direct supervision of non-licensed personnel at all times. Direct supervision requires that the supervising occupational therapist or occupational therapy assistant be available to assist, either on premises or through technology and equipment meeting the requirements of s. OT 6.03.

(2) When an occupational therapist or occupational therapy assistant delegates to non-licensed personnel maintenance or restorative services to clients, the occupational therapist or occupational therapy assistant must be within audible and visual range of the client and the non-licensed personnel, either on premises in the immediate area or through technology and equipment meeting the requirements of s. OT 6.03.

(3) An occupational therapist or occupational therapy assistant may delegate to non-licensed personnel only non-skilled, specific tasks which are neither evaluative, assessive, task selective nor recommending in nature, and only after ensuring that the

non-licensed person has been appropriately trained for the performance of the task.

(4) Occupational therapists and occupational therapy assistants must exercise their professional judgment when determining the number of non-licensed persons they can safely and effectively supervise to ensure that quality care is provided at all times. A limit of 2 is recommended.

(5) Any duties assigned to non-licensed personnel must be determined and appropriately supervised by an occupational therapist or occupational therapy assistant and must not exceed the level of training, knowledge, skill and competence of the individual being supervised. The licensed occupational therapist or occupational therapy assistant is responsible for the acts or actions performed by any non-licensed person functioning in the occupational therapy setting.

(6) An occupational therapist or occupational therapy assistant may delegate to non-licensed personnel duties or functions, including the following services:

- (a) Transportation of clients.
- (b) Preparation or setting up of treatment equipment and work area.

- (c) Attending to clients' personal needs during treatment.
- (d) Clerical, secretarial or administrative duties.

(7) Duties or functions that an occupational therapist or occupational therapy assistant may not delegate to non-licensed personnel include, but are not limited to, the following:

- (a) Interpretation of referrals or orders for occupational therapy services.
- (b) Evaluative procedures.
- (c) Development, planning, adjusting or modification of treatment procedures.

(d) Acting on behalf of the occupational therapist or occupational therapy assistant in any matter related to direct client care which requires judgment or decision making.

**History:** CR 02–026: cr. Register December 2002 No. 564, eff. 1–1–03; CR 13–109: am. (6) (intro.), (7) (a) Register September 2014 No. 705, eff. 10–1–14; CR 21–033: am. (1), (2) Register July 2023 No. 811, eff. 8–1–23.