Gait Training: PT or OT? That should not be a question.

Occupational therapy’s scope of practice encompasses a broad range of clinical interventions for diverse patient populations throughout the healthcare continuum. Gait analysis and gait training, however, are not in the profession’s repertoire of evidence-based evaluative tools and treatment modes. These areas fall within the purview of physical therapists. External reviewers, RACs, MACs and others are consistently denying gait training services when provided by Occupational Therapy. Unfortunately, in many cases there is a clear duplication of service between the two disciplines. Occupational therapists have an inherent role in evaluation and treatment pertaining to the clinical subcomponents and sub-skills directly related to gait training including, but not limited to:

- Visual perceptual prowess
- Spatial relations
- Righting reactions
- Biomechanical considerations
- Cognitive skills
- Sensorimotor skills

The quality in which occupational therapy may assist a patient to safely ambulate in their environment during a functional task is rooted in understanding the demands of the mobility activity on occupational performance and vice-versa. Additionally, occupational therapy plays an important role in the assessment of environmental hazards during functional mobility; thereby ensuring safety during ambulatory level ADL and IADL participation.

Patients whose rehabilitation goal is to ambulate often begin their course of therapy at a supine or seated level due to pain, medical complications, generalized weakness or an incapacitating fear of falling. At this point, pre-gait considerations may be addressed by occupational therapy as impediments to occupational performance and safety during task completion. This may include:

- Musculoskeletal alignment
- Strength
- Sitting balance
- Weight shifting
- Hip-hiking
As always, the clinician should maintain function and safety in the forefront of their documentation but should elaborate on such barriers as listed above, and the skilled techniques used to mitigate their negative impact on independent performance. The end goal for OT is twofold:

1. Improved patient role participation
2. Psychosocial well-being during activities of daily living

Progressing the patient safely and effectively from supine-to-sit, to stand, to anticipated ambulatory level during functional activities of daily living is often times a key objective in rehab. It demands communication and collaboration amongst the entire clinical team. At each stage of the rehab process, occupational therapy incorporates intrinsically motivating and functionally based treatments to challenge and encourage their patients. Occupational therapy provides the expertise and training to ascertain if there are other factors, both intrinsic and extrinsic, that may potentially contribute to abnormal gait patterns and risk of falls during ADL and IADL tasks. For example:

1. Patient who has difficulty visually anchoring within their environment may be at risk for falls, something that may be missed on a conventional Fall Risk Assessment
2. Patient who is unable to carryover new learning revealed in OT cognitive testing but has been issued a new ambulatory device. In this case, the ambulatory device may pose a greater risk to mobility safety than without it

It is critical, therefore, that information from an OT perspective be shared with the interdisciplinary team, particularly with physical therapy.

Occupational therapy should NOT bill their services under CPT 97116 (gait training – includes stair climbing, per CPT code description). Occupational therapy should NOT list gait disturbance as a treatment diagnosis or clinical focus. Occupational therapy should NOT document goals solely for ambulation. These are all items within physical therapy’s purview. It is, however, within the scope of OT practice to address areas that impact functional performance and safety, regardless of mobility level. Remaining focused on these two fundamental areas of practice: FUNCTION and SAFETY will ensure the clinical integrity of OT plans of care.

As therapists we have a responsibility to be accountable to not only be familiar with but to adhere to our Scope of Practice. If we are clear in our understanding and work closely with an interdisciplinary team we should not have issues or concerns regarding duplication of service.