
Guidelines for Documentation of Occupational Therapy

Documentation of occupational therapy services is required whenever professional services are provided to a client.¹ Occupational therapy practitioners² identify the types of documentation required and record all necessary components of services provided within their scope of practice. This document, based on the *Occupational Therapy Practice Framework: Domain and Process* (3rd ed.; American Occupational Therapy Association [AOTA], 2014b), describes the purpose, types, and content of professional documentation used in occupational therapy.

AOTA's (2015c) *Standards of Practice for Occupational Therapy* states that an occupational therapy practitioner documents the occupational therapy services and "abides by the time frames, formats, and standards established by practice settings, federal and state laws, other regulatory and payer requirements, external accreditation programs, and AOTA documents" (p. 4). These requirements apply to both electronic and written forms of documentation though may vary considerably by practice setting and facility. AOTA's (2015a) *Occupational Therapy Code of Ethics* states that occupational therapy practitioners "shall promote fairness and objectivity in the provision of occupational therapy services" (p. 5) and "shall provide comprehensive, accurate, and objective information when representing the profession" (p. 6).

Occupational therapy documentation reflects the nature of services provided, shows the clinical reasoning of the occupational therapy practitioner, and provides enough information to ensure that services are delivered in a safe and effective manner. Documentation describes the depth and breadth of services provided to meet the complexity of client needs and responses to occupational therapy services at the individual, group (community), or population levels.

The purpose of documentation is to

- Communicate information about the client's occupational history and experiences, interests, values, and needs;
- Articulate the rationale for provision of occupational therapy services and the relationship of those services to client outcomes;
- Provide a clear chronological record of client status, the nature of occupational therapy services provided, client response to occupational therapy intervention, and client outcomes; and
- Provide an accurate justification for skilled occupational therapy service necessity and reimbursement.

¹In this document, *client* may refer to persons, groups, and populations (AOTA, 2014b).

²When the term *occupational therapy practitioner* is used in this document, it refers to both occupational therapists and occupational therapy assistants (AOTA, 2015b). *Occupational therapists* are responsible for all aspects of occupational therapy service delivery and are accountable for the safety and effectiveness of the occupational therapy service delivery process. *Occupational therapy assistants* deliver occupational therapy services under the supervision of and in partnership with an occupational therapist (AOTA, 2014a).

Types of Documentation

Documentation of occupational therapy service is maintained in a professional and legal fashion (i.e., complete, concise, accurate, timely, legible, clear, grammatically correct, objective) for each client served. Table 1 outlines common types of documentation used by occupational therapy practitioners.

Documentation types may be identified differently or combined and reorganized to meet the specific needs of the client and setting. Occupational therapy documentation provides a record of the practitioner's activity in the areas of screening, evaluation and reevaluation, intervention, and outcomes (AOTA, 2014b) in accordance with practice guidelines and payer, facility, and state and federal guidelines and requirements. In addition, Box 1 lists the fundamental elements of documentation.

Content of Documentation

- I. **Screening Report**—Documents the referral source and the reason for occupational therapy screening.
 - A. *Referral information*—Date and source of referral, services requested, and reason for referral.
 - B. *Client information*—Description of client's occupational history, experiences, and performance; health status; and applicable medical, educational, and developmental diagnoses, precautions, and contraindications.
 - C. *Brief occupational profile*—Client's reason for seeking occupational therapy services; areas of occupation in which the client is successful and challenged; contexts and environments that support and hinder occupational performance (e.g., patterns of living, interest, values); medical, educational, and work history; client's priorities; and targeted goals (AOTA, 2017).

Table 1. Common Types of Occupational Therapy Documentation

Process Area	Type
I. Screening	A. Screening Report
II. Evaluation/Reevaluation	A. Evaluation Report B. Reevaluation Report
III. Intervention	A. Intervention Plan B. Contact Report C. Progress Report D. Transition Plan
IV. Outcomes	A. Discharge/Discontinuation Report

Box 1. Fundamentals of Documentation

- Documentation practices and storage and disposal of documentation must meet all state and federal regulations and guidelines, payer and facility requirements, practice guidelines, and confidentiality requirements.
- Client's full name, date of birth, gender, and case number, if applicable, are included on each page of the documentation.
- Identification of type of documentation and the date service is provided and documentation is completed are included in the documentation.
- Acceptable terminology, acronyms, and abbreviations are defined and used within the boundaries of the setting.
- Clear rationale for the purpose, value, and necessity of skilled occupational therapy services is provided. The client's diagnosis or prognosis is not the sole rationale for occupational therapy services.
- Professional signature (first name or initial, last name) and credential; cosignature and credential when required for documentation of supervision; and, when necessary, signature of the recorder are included with each documentation entry.
- All errors are noted and initialed or signed.

- D. *Assessments used (if any) and results*—Types of assessments used and results (e.g., interviews, record reviews, observations).
- E. *Recommendation*—Professional judgments regarding need for complete occupational therapy evaluation, based on results of the assessments.

II. Evaluation Report—Documents the referral source and data gathered through the occupational therapy evaluation process.

- A. *Referral information*—Date and source of referral, services requested, and reason for referral.
- B. *Client information*—Description of client's occupational history, experiences, and performance; health status and previous services required and accessed; and applicable medical, educational, and developmental diagnoses, precautions, and contraindications.
- C. *Occupational profile*—Client's reason for seeking occupational therapy services; areas of occupation in which the client is successful and challenged; contexts and environments that support and hinder occupational performance; medical, educational, and work history; occupational and psychosocial history (e.g., patterns of living, interest, values); client's priorities; and targeted goals (AOTA, 2017).
- D. *Assessments used and results*—Types of assessments used (e.g., interviews, record reviews, observations, standardized or nonstandardized³ assessments) and description of results.
- E. *Analysis of occupational performance*—Analysis of occupational performance and identification of factors that support and hinder performance and participation (objective and measurable identification of performance skills, performance patterns, contexts and environments, activity demands, outcomes from standardized or nonstandardized assessments, and client factors).
- F. *Summary and analysis*—Interpretation and summary of the occupational profile and occupational performance issues, identification of targeted areas of occupation and occupational performance to be addressed, and expected outcomes. The American Medical Association's (2018) *Current Procedural Terminology (CPT)* requires that procedural codes based on levels of complexity (low, moderate, high) be identified for the three main components of the occupational therapy evaluation: (1) occupational profile and medical and therapy history, (2) assessments of occupational performance (including identification of performance deficits to be addressed in the plan of care), and (3) clinical decision making. Medicare, Medicaid, and other insurance providers and payers use these codes to identify service reimbursement (Centers for Medicare and Medicaid Services [CMS], 2017a).

When required for clients covered by Medicare or Medicaid, data on the client's primary functional limitation is reported in the form of quality data codes (G-codes) with their corresponding severity and therapy modifiers (CMS, 2017b). Functional limitation reporting (FLR) provides G-codes in the areas of mobility and self-care. When addressing population health needs, an environmental scan or SWOT (strengths, weaknesses, opportunities, threats) is often used to document the summary and analysis (Jacobs, Van Witteloostuijn, & Christe-Zeyse, 2013).

- G. *Recommendation*—Judgment regarding necessity for skilled occupational therapy services or other services.

III. Reevaluation Report—Documents the occupational therapy reevaluation process. Continual assessment is a component of ongoing therapy services. Formal reevaluation is conducted when,

³Nonstandardized assessment tools are considered a valid form of information gathering that allows for flexibility and individualization when measuring outcomes related to the status of an individual or group through an intrapersonal comparison. Although not uniform in administration or scoring or possessing full and complete psychometric data, nonstandardized assessment tools have strong internal validity and represent an evidence-based approach to occupational therapy practice (Hinojosa, Kramer, & Christ, 2010). Nonstandardized tools should be selected on the basis of the best available evidence and the clinical reasoning of the occupational therapist.

in the professional judgment of the occupational therapist, new clinical findings emerge, a significant change in the patient's condition requiring further tests and measures is observed, the client demonstrates a lack of response as expected in the plan of care, or additional information is required for discharge (CMS, 2017b) or when required by practice guidelines and payer, facility, and state and federal guidelines and requirements.

- A. *Client information*—Description of client's occupational history, experiences, and performance; health status; and applicable medical, educational, and developmental diagnoses, precautions, and contraindications.
- B. *Occupational profile*—Updates on current areas of occupation that are successful and problematic; contexts and environments that support or hinder occupations; summary of any new medical, educational, and work information; and updates or changes to client's priorities and targeted outcomes (AOTA, 2017).
- C. *Reevaluation results*—Focus of reevaluation, specific types of outcome measures from standardized or nonstandardized assessments used, and results.
- D. *Analysis of occupational performance*—Analysis of occupational performance and identification of factors that support and hinder performance and participation (objective and measurable identification of performance skills, performance patterns, contexts and environments, activity demands, outcomes from standardized and nonstandardized assessments, and client factors).
- E. *Summary and analysis*—Interpretation and summary of occupational profile and performance issues, identification of targeted areas of occupation and occupational performance to be addressed, and expected outcomes. There is one CPT code available for the identification of the service of reevaluation (CMS, 2017a). In the case of clients covered by Medicaid and Medicare, FLR G-codes with their corresponding severity and therapy modifiers may be required (CMS, 2017b).
- F. *Recommendations*—Changes to occupational therapy services; revision or continuation of interventions; goals and objectives; frequency of occupational therapy services; and recommendation for referral to other professionals or agencies, as applicable.

IV. Intervention Plan (Plan of Care)—Documents the goals and the intervention types and approaches to be used in the occupational therapy process on the basis of the results of evaluation or reevaluation processes. Physician certification of Intervention Plans (Plans of Care) may be required by state practice acts and third-party payers, including Medicare and Medicaid.

- A. *Client information*—Precautions and contraindications.
- B. *Intervention goals*—Measurable and meaningful occupation-based long-term and short-term goals directly related to the client's ability and need to engage in desired occupations and to the justification of the need for skilled occupational therapy intervention to meet the goals. Goals are based on the evaluation or reevaluation in adherence with each payer source's documentation requirements (e.g., pain levels, time spent on each intervention).
- C. *Intervention approaches and types of interventions to be used*—Intervention approaches that include create/promote, establish/restore, maintain, modify, and prevent; types of interventions that include consultation, education process, advocacy, and the therapeutic use of occupations or activities used within individual or group sessions.
- D. *Service delivery mechanisms*—Service provider, service location, and frequency, intensity, and duration of services for the individual needs of the client.
- E. *Plan for discharge*—Discontinuation criteria, discharge setting (e.g., skilled nursing facility, home, community, classroom), and anticipated follow-up care.
- F. *Outcome measures*—Tools that assess occupational performance, adaptation, role competence, improved health and wellness, improved quality of life, self-advocacy, and occupational

justice. Standardized and nonstandardized assessment methods used at evaluation should be readministered periodically to monitor measurable progress and report functional outcomes as required by client's payer source and facility requirements.

Note: Occupational therapy practitioners working in school settings should note the specific distinctions between the individualized education program (IEP) and the intervention plan (IP). Whereas occupational therapy practitioners contribute to the establishment of goals and interventions on the client's IEP, the IP "directs the actions of the occupational therapy practitioner by outlining the occupation-based goals and occupational therapy interventions" (Frolek Clark & Handley-More, 2017, p. 70).

V. Contact Report (Daily Treatment Notes)—Documents the contacts between the client and the occupational therapy practitioner, the goals and the intervention types and approaches used in the occupational therapy process, and the therapy outcomes.

- A. *Client information*—Diagnosis, precautions, contraindications, and variables that influence the client's condition.
- B. *Therapy log*—Documentation of services provided that reflects the complexity of the client and the professional clinical reasoning and expertise of an occupational therapy practitioner required to provide safe and effective outcomes in occupational engagement and performance. Content includes date, length of service contact, type of contact, names and positions of persons involved, summary of significant information communicated during contact, client attendance and participation in intervention or reason service was missed, types and approaches of interventions used, client's self-report and response to intervention, adverse reaction or response to treatment, environmental or task modification, assistive or adaptive devices used or fabricated, statement of any training education or consultation provided, and client's present level of performance. Significant, unusual, or unexpected changes in clinical or functional status are reported. Objective measures used to assess outcomes should be repeated in accordance with payer and facility requirements and clearly documented to demonstrate measurable functional progress toward the goals of the client. SOAP (subjective, objective, assessment, plan) note format is commonly used in both electronic and traditionally written documentation to organize pertinent information (Gately & Borcharding, 2016).

VI. Progress Report—Documents a summary of the contacts between the client and the occupational therapy practitioner, the goals and the intervention types and approaches used in the occupational therapy process, and the therapy outcomes in accordance with practice guidelines and payer, facility, and state and federal guidelines and requirements (e.g., Medicare and Medicaid require at least 1 progress report every 10 treatment days; CMS, 2017a).

- A. *Client information*—Diagnosis, precautions, and contraindications.
- B. *Goals*—Goals addressed during the provision of therapy services.
- C. *Summary of services provided*—Brief statement of frequency and duration of services, types and approaches of interventions provided; data collection procedures (age-appropriate standardized and nonstandardized assessments, tests, and measures) and results; measurable progress (or lack thereof); environmental or task modifications provided; adaptive equipment or orthotics provided; medical, educational, or other pertinent client updates; client's response to occupational therapy services; and programs or training provided to the client or caregivers.
- D. *Current client performance*—Goal achievement and current performance in areas of occupations. In the case of clients covered by Medicaid and Medicare, FLR G-codes with their corresponding severity and therapy modifiers may be required.
- E. *Plan or recommendations*—Recommendations and rationale as well as client's input to changes or continuation of plan to include goals, frequency, intensity, or duration.

VII. Transition Plan—Documents the formal transition plan to support the client's transition from one service setting to another within a service delivery system.

- A. *Client information*—Diagnosis, precautions, and contraindications.
- B. *Client's current status*—Client's current occupational engagement and performance skills.
- C. *Transition plan*—Name of current service setting and name of setting to which client will transition, reason for transition, time frame in which transition will occur, and outline of activities to be carried out during the transition plan.
- D. *Recommendations*—Recommendations and rationale for occupational therapy services, modifications, or accommodations needed, as well as assistive technology and environmental modifications needed.

VIII. Discharge/Discontinuation Report—Documents the discharge plan to support the client's discharge from occupational therapy service.

- A. *Client information*—Diagnosis, precautions, and contraindications.
- B. *Summary of intervention process*—Date of initial and final service; frequency, number of sessions, and summary of interventions used; summary of progress toward goals; and occupational therapy outcomes, including initial and ending client status regarding engagement in occupations and client's assessment of efficacy of occupational therapy services. In the case of clients covered by Medicaid and Medicare, FLR G-codes with their corresponding severity and therapy modifiers may be required.
- C. *Recommendations*—Recommendations pertaining to the client's future needs; specific follow-up plans, if applicable; and referrals to other professionals and agencies, if applicable.

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