American Occupational Therapy Association

Maximizing Your Clinical Documentation

Evaluation/Plan of Care

- **Link objective information and test scores to functional performance and participation.** Example: *The child's assessment results indicate a primary challenge with bilateral coordination and motor planning, resulting in the inability to complete desktop activities in the classroom at the level of his peers and to perform developmentally appropriate play activities such as a throwing, catching, and kicking a ball, in addition to other key activities of daily life. Many assessments also provide scoring interpretations.*

- **Add pertinent medical and/or family history that could have an impact on the plan of care.** Example: *In addition to her painful arthritis, this client has significant vision loss due to macular degeneration, affecting her ability to safely perform household activities, such as cooking hot meals for her family.*

- **Address cognitive level if it has an effect on the intervention.** Example: *This client's performance is affected by his stroke, affecting his ability to understand concepts of directionality in dressing.*

- **Identify why the specific skills of an occupational therapy practitioner is required.** Example: *Skilled therapy is necessary to design and fabricate a specialty hand splint to enable the client to write legibly while protecting joints.*

- **Include an adequate baselines of functional deficits and underlying impairments to measure change and support treatment interventions.**

- **Clearly state the frequency and duration of necessary therapy treatment.** The frequency and duration should be considered with other factors such as condition, progress, and treatment type to provide the most effective and efficient means to achieve the client's goals.

- **Goals must be client-centered and measurable.**

Intervention

- **Document current client status by identifying the specific outcome/goal being addressed and how the client is responding at present.** Example: *The client is working on independent lower-extremity dressing skills and has improved in this session from minimal physical assistance needed for putting on socks to verbal cues only.*

- **Use action verbs such as evaluate, fabricate, analyze, tailor, grade, develop, design, optimize, stabilize, facilitate, inhibit, and educate** to describe skilled service in notes. A practitioner's presence alone does not justify skilled services. Articulate how your skills and clinical judgment were used throughout the session. Avoid repetitive notes that do not clearly demonstrate skill and change due to client response.

- **Be sure the coding, intervention descriptions, and dates within the intervention notes are accurate and consistent.** CPT codes selected should match the intervention delivered, based on the description of the CPT code and intention of intervention.

- **Indicate whether group or concurrent therapy is being furnished.** Check payer guidelines to comply with coverage and documentation policies.

Progress Notes

- **Indicate why the frequency or duration of treatment has changed.** Example: *The client's frequency of treatment is reduced from two to one session per week this period, as progress has been good. Further monitoring of the client's progress will determine future frequency.*
- **Use approved abbreviations, and spell out the full abbreviation at the outset in your documentation.** Example: *The abbreviation xfer to mean "transfer" may not be understood by anyone outside of the facility.*
- **Indicate how your interventions achieve functional performance, participation, or other outcome, rather than just describing the activities themselves.** Example: *The client's progress in sequencing, standing balance, and gross motor coordination have improved her ability to perform simple meal prep independently while standing.*
- **Address each original goal in the progress report.** Identify why any goals are modified or discontinued.
- **Address any lack of progress** with explanation of why progress was not achieved and how the treatment plan will be adapted to address the lack of progress.
- **Summarize skilled services provided during the intervention period** to further justify why the specific skill set of an occupational therapy practitioner was required. Avoid listing only therapy modalities (E.g. therapeutic exercise, self-care re-training). Summarize how your skills were utilized throughout the period by using action verbs.
- **Explain why continued services are needed to reach the goals in the plan of care.**
- **Document when OTA notes have been reviewed by an OT.** OTA supervision should be documented in accordance with each state's practice act. Examples of topics for supervision could include how often OTA supervision has occurred and if the client's goals or interventions will change or remain the same.

Discharge Summary

- **Identify appropriate carryover training for the caregiver.**
- **Summarize the client's progress from the start of care to the end of the episode.** Paint a picture of the client's functional status at the start and end of care.
- **Summarize skilled intervention delivered over the course of the episode.** This is the last opportunity to support why skilled occupational therapy services were needed for this client.

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Adapted from "The Do's and Don'ts of Documentation: Pitfalls to Avoid," by C. Brennan, 2015, OT Practice, 20(14), pp. 8–11.

Disclaimer: This information is for general guidance only. Practitioners should consult with their payer source for specific documentation requirements and refer to their state practice act when documenting OTA supervision.

For more information, go to https://www.aota.org/practice/practice-essentials/payment-policy.