Model progress note

Documentation guidance

Patient name, date of service (DOS) and an additional patient identifer (e.g., date of birth [DOB]) is required on every page.[1,2]

Chief complaint (CC): "Follow-up" alone is not a valid CC. The documentation must describe why the patient is presenting for follow-up.[3]

History: History of present illness (HPI) driven by the CC and review of systems (ROS) driven by the HPI.[3]

Exam: Exam driven by the patient history, describing in detail any pertinent positive findings and any chronic findings that affect the care and treatment of the patient.[3,4]

Medical decision making:
Assessment that documents the diagnosis, its status and any causal relationships (e.g., diabetic, due to diabetes). Assessment that documents not only conditions being treated, but any chronic conditions that affect the care and treatment of the patient.[3,4]

Plan that specifies treatment for each condition listed in the assessment, including, but not limited to, diet, medications, referrals, laboratory orders, patient education and return visits.[3]

Authentication:
Paper record: Authentication by the provider author of the progress note which includes a legible name and credential, a hand-written signature and the date signed.

EMR: Authentication by the provider author of the progress note, password-protected to that provider only, at the end of the note (i.e., Authenticated by, Approved by), including typed name and credential and the date authenticated.[1]

Sample progress note

Patient: Name **DOS:** 01/02/2014 **DOB:** 08/01/48

Reason for visit: Follow-up for diabetes

Medications list: glyburide 10mg PO q.d.; pregabulin 50mg PO t.i.d.

S: States she is able to get around, including bathroom and kitchen with aid of her walker. Denies any pain or shortness of breath. No change in bowel or bladder habits. She states she takes her glyburide regularly. She tries to follow her diet but does not check her fingerstick blood sugars.

O: Patient alert, oriented to person, place and time. No acute distress.
Vital signs: T 98.2; BP 163/92; HR 63; Wt 203 lbs; Ht 68"; BMI 31.57
Cardiac: RRR no rubs, gallops or murmurs noted.
Lungs: Clear to auscultation.
Abd: Soft non-tender to palpation with colostomy intact, skin dry and intact surrounding pink-red stoma, liquid brown feces.
Feet: Peripheral pulses barely palpable, unchanged from prior exam. Left great toe amputation with healing incision. Monofilament testing shows increased loss of sensation bilaterally with absent ankle reflexes.

A:
1. Worsening diabetic polyneuropathy (**250.60** and **357.2**)
2. Progressing PAD due to diabetes (**250.70** and **443.81**)
3. Functioning colostomy (**V44.3**)
4. Status post left great toe amputation, healing (**V49.71**)

P:
1. Continue current diabetic diet; continue current dosage of glyburide; refer for diabetic eye exam and education; lab testing for fasting CMP and A1C; increase pregabulin 100mg PO t.i.d. for worsening neuropathy.
2. Refer to vascular surgeon for surgical evaluation.
3. Continue monitoring of functional colostomy.
4. Instructed and demonstrated proper wound care.

RTC 1 month.

Authenticated by: Joseph A. Williams MD, 01/02/14

Due to the updated, clinically revised CMS-HCC Medicare Advantage risk adjustment model for Payment Year 2015, the bolding of ICD-9-CM codes has been revised to reflect:

- **Black = Risk adjusts *in both* the 2013 CMS-HCC model and the 2014 CMS-HCC model**

Note: The 2015 Payment Year model is a blend of the 2013 CMS-HCC model (67%) and the 2014 CMS-HCC model (33%).

1. Centers for Medicare & Medicaid Services, "2008 Risk Adjustment Data Technical Assistance For Medicare Advantage Organizations Participant Guide." Leading Through Change, Inc. 2008 1-49.
2. The Joint Commission, Standards. The Joint Commission, 01 2012. Web. 30 Nov 2012. <jointcommission.org/mobile/standards_information/national_patient_safety_goals.aspx>.
3. Centers for Medicaid & Medicare Services. "1995 Documentation Guidelines for Evaluation & Management Services." (1999). Medicare Learning Network. Web.
4. World Health Organization. "International Classification of Diseases, Ninth Revision, Clinical Modification, 6th Ed." *National Center for Health Statistics 2011 1-107. Web. 22 Oct. 2012.* <cdc.gov/nchs/icd/icd9cm_addenda_guidelines.htm>.

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