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Progress note with chart mechanics

Documentation guidance: Ensure patient full name, date of service (DOS) and date of birth (DOB) are identified 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]

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

Medically appropriate 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]

Medical decision making/Time: Medical decision making **OR** total time spent on the date of service can be used to determine the level of service.[3]

Progress note (example for codes 99202–99215)

Patient: Full name **DOS: 01/08/24** **DOB: 12/05/40**

Reason for visit: Follow-up for complicated diabetes following left great toe amputation.

CC: Patient notes progressive loss of sensation in her feet.

Medication list: Glyburide 10 mg PO q.d.; Pregabalin 50 mg PO t.i.d. Atenolol 10 mg q.h.s,, Gabapentin 300 mg q.h.s.

S: States she is able to get around, including bathroom and kitchen, with the aid of her walker. She tries to follow her diet, but does not check her fingerstick blood sugars. She has not been taking her blood pressure medications regularly because she said it makes her feel dizzy.

O: Morbidly obese

Vital signs: T 98.2; BP 154/95; HR 63; Wt. 238 lbs.; Ht. 64"; BMI 40.8; In office fingerstick blood glucose 275

Neck: Supple. Carotid pulses 2+. No bruits. No jugular venous distention. Thyroid normal and palpable. Trachea in midline. No masses or lymphadenopathy noted.

Skin: Warm, dry, intact, no rashes, no abnormal lesions, no cyanosis or diaphoresis.

Chest: Lungs clear to auscultation. No rales, rhonchi or crepitation. No shortness of breath or cough.

Cardiovascular: RRR, normal S1 and S2, no extra heart sounds, no murmur, gallop, rub or extrasystole. 1+ nonpitting peripheral edema. Peripheral pulses barely palpable, unchanged from prior exam. No clubbing or cyanosis.

GI/GU: Round, soft. Nontender. Bowel sounds normoactive in all 4 quad. No guarding, rigidity or rebound tenderness. Spleen, liver and kidneys are not palpable. No ascites present. No hernias noted. Colostomy intact with surrounding pink red stoma, liquid brown feces. No CVA tenderness.

Assessment that documents the diagnosis, its status and any causal relationships (for example, 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]

Document and report coexisting conditions – any that require or affect the care, treatment or management of the patient that day.[4]

- Do not document "history of" for an active condition, and do not assign an active code when the condition no longer exists.[4]
- Use only standard abbreviations (acronyms and symbols).
- It is not appropriate to code a condition that is represented only by an up or down arrow in combination with a chemical symbol or lab abbreviation, such as "↑ chol" for "hypercholesterolemia".
- Proper documentation should show monitoring, evaluation, assessment or treatment (M.E.A.T.) of the conditions documented.

Authentication
Paper record: Authentication by the provider author of the progress note, which includes a legible name and credential, a handwritten 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 (for example, authenticated by, approved by), including typed name and credential and the date authenticated.[2,3]

Please note that CMS requires that the date of the electronic signature must be within 180 days of the date of service.[2]

Neurological: Cranial nerves II-XII grossly intact. She is alert, oriented to place, person, time and purpose. Able to follow commands. Able to move all four extremities. No gross motor, fine motor or sensory deficits noted except for diminished vibratory sensation at right great toe DIP (5 seconds). DTRs 2+ and equal. Sharp and dull sensations noted normally bilaterally in both upper but diminished in lower extremities with diabetic neuropathy.

Musculoskeletal system: Strength 5/5 bilaterally both upper and lower extremities. No muscle asymmetry, atrophy or involuntary movements. No structural deformity, effusion, periarticular swelling or tenderness of any joint except as noted with left great toe amputation, healing incision and no drainage.

A: 1. Great left toe amputation: healing (**Z89.412**)

a. Difficulty in walking. (R26.2)

2. Diabetes Type 2 with hyperglycemia (**E11.65**)

a. Worsening diabetic neuropathy (**E11.40**)

b. Worsening diabetic peripheral vascular disease (**E11.51**)

3. Morbid obesity, BMI 40.8 (**E66.01, Z68.41**)

4. Functioning colostomy (**Z93.3**)

5. Hypertension (I10)

6. Medical noncompliance (Z91.14, Z91.19)

P: 1. Great left toe amputation: Continue to monitor. She has difficulty walking. Suggested PT for ambulation – she declines. Instructed to return to clinic for any signs of infection.

2. Diabetes Type 2 with chronic complications

a. Continue current dose of Glyburide for now and check fingerstick BID and report back results.

b. Diabetic neuropathy: Increase Pregabalin to 100 mg by mouth three times daily.

c. CMP and HbA1c ordered for prior to next visit.

d. Diabetic eye examination and education class referrals ordered.

3. Morbid obesity: Patient advised on dietary changes

4. Functioning colostomy: Able to get supplies

5. Hypertension: slightly elevated. Re-check in six weeks

6. Medical non-compliance: Encouraged patient to monitor glucose levels and take medications on schedule.

A total of 25 minutes was spent caring for this patient on this date of service.

Authenticated by: Joseph A. Williams, MD, 01/08/24

The following references were used in the creation of this document at time of publication:

- Optum360. *ICD-10-CM: Professional for Physicians 2024*. Salt Lake City, UT: Optum360; 2023.
- American Medical Association. *Current Procedural Terminology Professional 2023*. Chicago, IL: AMA; 2022

1. The Joint Commission. National Patient Safety Goals® – Effective January 2024 for the Ambulatory Health Care Program. Accessed January 16, 2024.
2. Centers for Medicare & Medicaid Services. Medicare Advantage Risk Adjustment Data Validation (RADV) Program Resources. Accessed January 16, 2024.
3. Centers for Medicare & Medicaid Services. Evaluation and Management Services Guide. Accessed January 16, 2024.
4. Centers for Medicare & Medicaid Services. ICD-10-CM Official Guidelines for Coding and Reporting FY 2024. Accessed January 16, 2024.

How can we help you?

Our goal is to help health care professionals facilitate and support accurate, complete and specific documentation and coding, with an emphasis on early detection and ongoing assessment of chronic conditions. Through targeted outreach and education, we help our clients and their providers:

- Deliver a more comprehensive evaluation for their patients
- Identify patients who may be at risk for chronic conditions
- Improve patient care to enhance longevity and quality of life
- Comply with the Centers for Medicare & Medicaid Services (CMS) risk adjustment requirements

Contact your Optum representative to find out how we can help you improve outcomes for your patients.

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For the Affordable Care Act (ACA): The Department of Health & Human Services Hierarchical Condition Category (HHS-HCC) model applies to the health exchange risk adjustment program under the Affordable Care Act. This model differs significantly from the CMS-HCC model, which applies to the Medicare Advantage risk adjustment program. For more information, please visit: cms.gov/marketplace/health-plans-issuers/premium-stabilization-programs.

For Medicaid Managed Care: Risk adjustment standards, if any are applicable, are established by each state Medicaid agency and such standards often vary from state to state. For more information, please visit: medicaid.gov/medicaid/managed-care/index.html.

This tool is to be used for easy reference; however, the current ICD-10-CM code classification and the Official Guidelines for Coding and Reporting are the authoritative references for accurate and complete coding. The information presented herein is for general informational purposes only. Neither Optum nor its affiliates warrant or represent that the information contained herein is complete, accurate or free from defects. Specific documentation is reflective of the "thought process" of the provider when treating patients. All conditions affecting the care, treatment or management of the patient should be documented with their status and treatment plan and coded to the highest level of specificity. Enhanced precision and accuracy in the codes selected is the ultimate goal. Lastly, on March 31, 2023, the Centers for Medicare & Medicaid Services (CMS) announced that 2023 dates of service for the 2024 payment year model are based on the Centers for Medicare & Medicaid Services Announcement. Announcement of Calendar Year (CY) 2024 Medicare Advantage (MA) Capitation Rates and Part C and Part D Payment Policies (cms.gov).