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Prepared by:  
APPROVED BY:

## Patient Progress Note & Dictation Standard

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**Objective:** The *patient progress note* serves as a basis for planning patient care, documenting communication between the health care provider and any other health professional contributing to the patient's care, assisting in protecting the legal interest of the patient and the health care providers responsible for the patient's care, and documenting the care and services provided to the patient.

An accurate *patient progress note* is essential in providing adequate documentation for correct billing and reimbursement. A *patient progress note* is required for each patient seen at (**Facility Name**) within 48 hours of the encounter.

**Responsibility:** All (**Facility Name**) Providers are responsible for providing an accurate detailed patient progress note for each patient seen on a daily basis.

### Protocol:

Providers are required to dictate a *patient progress note* for each patient seen on a daily basis. All dictation must be completed within 48 hours and reviewed and initialed by the provider for accuracy.

The *patient progress note* begins with the identification of the Patient:

- Patient Name
- Medical Record Number
- Patient Date of Birth
- Date of Service

The four components of a SOAP note are Subjective, Objective, Assessment, and Plan. It is the provider's responsibility to make sure that all four of these components are addressed in each patient progress SOAP note.

### Subjective Component

This describes the patient's current condition in narrative form. ***The Chief Complaint is a required element.*** The history or state of experienced symptoms is recorded in the patient's own words. It will include all pertinent and negative symptoms under review of body systems (ROS). Pertinent Medical History, Surgical History, Family History, Social History along with current medications and allergies are also recorded.

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### Chief Complaint

- *The Chief Complaint is a concise statement describing the symptom, problem, condition, diagnosis, physician recommended return or other factor that is reason for encounters.*
- *This is a statement in the patient's own words.*

### A Chief Complaint is not the following:

- *A one word symptom*
- *FU*
- *Follow-up*
- *OV*
- *Office Visit*
- *EST*
- *Establish care*
- *Medication Recheck or Refill*
- *Lab or X-ray Results*
- *A diagnosis or chronic condition*
- *Fill out patient note/ paperwork*
- *Sick*

*The statements highlighted in red are not reasons for a visit under the CMS guidelines that became effective in 1995.*

### Some Samples of acceptable Chief Complaints:

Patient Presents today for Diabetic recheck

Patient presents today for Hypertension recheck

Patient presents today for physician ordered return

Patient presents today for review of abnormal lab results – (documentation required)

Patient presents today for pre-operative required physical

Patient presents today to establish care and complete health physical

Patient complains of cold, fever and chills

Patient complains of dizziness and headache

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Patient complains of chest pain when coughing

Patient complains of sore throat, cough and cold symptoms

Parent reports child has been ill with flu like symptoms for the last two days.

Parent reports child has had fever and sore throat for three days

Parent report child has decreased appetite and is just not feeling well

The history or state of experienced symptoms of the patients is recorded in the patient's own words.

### *History of Present Illness –HPI*

- *The HPI is chronological description of the development of the patient's present illness including the following elements*
  - *Location:*
  - *Quality*
  - *Severity*
  - *Duration*
  - *Timing*
  - *Context*
  - *Modifying factors*
  - *Associated signs and symptoms*
- *Brief and Extended HPI's are distinguished by the amount of detail needed to accurately characterize the clinical problem or problems:*
  - ***Brief** – consist of 1 to 3 elements.*
  - ***Extended** - consists of 4 or more element*

### **Review of Systems - ROS**

- *A Review of Systems is an inventory of body systems obtained through a series of question seeking to identify signs and/or symptoms which the patient may be experiencing or has experienced.*

*The following are the recognized systems:*

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- *Constitutional data (height and weight are required on all adult patients, BMI)*
- *HEENT*
- *Neck*
- *Cardiovascular*
- *Respiratory*
- *Gastrointestinal*
- *Genitourinary*
- *Musculoskeletal*
- *Integumentary (skin and/or breast)*
- *Neurological*
- *Psychiatric*
- *Endocrine*
- *Hematologic/Lymphatic*
- *Allergic/Immunologic*

*There are three levels used for recording ROS.*

- ***Problem Pertinent:*** *ROS inquires about the system directly related to the problem(s) identified in the HPI.*
- ***Extended:*** *ROS inquires about the system directly related to problem(s) identified in the HPI and a limited number of additional systems.*
- ***Complete:*** *ROS inquires about the system(s) directly related to the problem(s) identified in the HPI plus all additional body systems.*

### ***PFSH - Past, Family and Social History***

*The PFSH consists of review of three areas:*

- *Past History: Patient's past experiences with illnesses, operations, injuries and treatments.*
- *Family History: A review of medical events in the patient's family, including diseases which maybe hereditary or place the patient at risk.*
- *Social History: An age appropriate review of past and current activities.*

*There are two levels used for recording PFSH.*

#### ***The first level***

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- *Pertinent PFSH is a review of the history area(s) directly related to the problem(s) identified in HPI.*
  - **Documentation Requirements:**
- *At least one specific item from any of the three history areas must be documented.*

### *The second level*

- *Complete PFSH is a review of two of the three of the PFSH history areas.*
  - **Required Documentation**
- *Established patients – at least one specific item from two of the three history areas must be documented in the progress note.*
- *New patients – at least one specific item from each of the three history areas must be documented in the progress note.*

### Objective Component

The objective component includes:

- Constitutional data
- 
- Findings from the **physical examination** of patient which consists of:
  - A comprehensive exam that consist of a review of all organ systems: *HEENT, Cardiovascular, Respiratory, Gastrointestinal, Genitourinary, Musculoskeletal, Integumentary (skin and/or breast), Neurological, Psychiatric, Endocrine, Hematologic/Lymphatic, and Allergic/Immunologic Systems, and any other symptomatic or related body areas. **The Constitutional data including (height and weight are required on all adult patients; BMI can be used only if it has not been used in the ROS)**. This is considered a **comprehensive exam** by all payor sources.*
  - An extended exam of the affected body area and 5 to 7 related organ systems. This is considered an **intermediate exam** by all payor sources.

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- A limited examination of the affected system pertinent to the presenting complaint and any other symptomatic or 2 to 4 related body areas. This is considered a ***limited exam*** by all payor sources.
- A brief limited examination of the body area or major symptom (system of complaint). This is considered a ***brief exam*** by all payor sources.

- ***Review of Laboratory all completed results***
- ***Review of consultant reports***

### Assessment Component

This is a summary of the patient's diagnosis. *For patients with chronic disease diagnoses it is important to include them at every visit*

**It is required that the diagnoses used in the dictation of the patient progress note are identical to those used on the patient encounter form.**

### Plan Component

This is what the provider will do to treat the patient's concerns. This should address each item of the differential diagnosis. A note of what was discussed or advised with the patient as well as timings for further review or follow-up may also be included. Providers need to make sure that all referrals are included in the plan along with all labs that is ordered in the patient visit.

This will include a review of ***all medications*** that the patient is currently taking, adding any new medications that will be prescribed from the current visit, and removing medications that are no longer needed or not to be refilled.

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### Complexity of Medical Decision Making

<b>Number of Diagnoses or Management options</b>	<b>Amount and/or Complexity of data to be reviewed</b>	<b>Risk of complications and/or morbidity or mortality</b>	<b>Type of Decision Making</b>
Minimal	Minimal or None	Minimal	<i>Straightforward</i>
Limited	Limited	Low	<i>Low Complexity</i>
Multiple	Moderate	Moderate	<i>Moderate Complexity</i>
Extensive	Extensive	High	<i>High Complexity</i>

*All patient progress notes are completed on a daily basis. Medicare has passed a new documentation rule that indicates all notes must be completed within 48 hours of the face-to-face encounter.*

*“No Charge Visits”*

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**“No charge” visits are prohibited if they are part of a fraudulent scheme. For example, a no charge visit is still a patient care encounter and must be fully documented.**

Assume that a patient has severe asthma and is waiting out a one year preexisting illness exclusion in a health insurance policy. If that patient requires treatment a month before the end of the year waiting period, you have to fully document the treatment even if you do not charge the insurance company for it. *You cannot use “no charge” to hide medical information.*

You may also deliver non-reimbursable care as part of an otherwise justified office visit and bill the company for the authorized part of the visit. For example, if the insurance doesn't cover immunizations, then you could do the immunizations at the time you do an authorized well-child checkup, or when the child is in for some other medical condition that is not a contraindication for immunizations. You cannot, however, bill for an office visit when the only reason the patient is being seen is to deliver care that is not authorized under the policy.

### **“No Charge Waiver of Co-Pay”**

It would also be improper to “no charge” as a way to waive a co-pay in order to generate ancillary business for the physician's office lab or other health services business. In other words, you cannot “no charge” for the visit and bill the insurance company for \$100 worth of lab work that it would not have approved as part of a reimbursed visit.

### **Auditing**

A random selection of all provider progress notes will be audited on a quarterly basis. This audit will review key health center indicators, Title X indicators, chronic disease management requirements (see protocols) and accuracy of coding and documentation.

Providers will be provided one-on-one review and coaching to eliminate any deficiencies found during the audit. Audits will be used during annual review for each provider.

### **References:**

Medicare E&M Guidelines Compliance Handbook versions: 1995, 1997, and 2007.

Medical and Public Health Policy Law Center: Compliance: No Charge Health Information, 2009 Archive