



July 1, 2009

Re: Progress Note documentation guidelines

Dear Provider/Office Manager,

Universal Health Care Group is a Medicare Advantage organization contracted with the Centers for Medicare & Medicaid Services (“CMS”) to offer coverage plans to Medicare beneficiaries. As such, we are obligated to conduct certain activities to administer this Medicare Advantage program. CMS requires us to report certain medical diagnoses for all of its Medicare Advantage members (and former members) in accordance with ICD-9–CM coding guidelines. CMS will use these diagnoses to compute payments to the Medicare Advantage organization that more accurately reflect their members’ medical conditions.

**We have developed the below guidelines to help ensure your Progress Notes meet CMS requirements for the submission of encounter data:**

** Patient information requirements on the Progress Note:**

- Progress Note must contain patient name and DOS on each page.
- A unique identifier, either patient DOB, plan ID, or medical record #, should be on the first page of the Progress Note.
- If the Progress Note is more than one page or two-sided, the pages must be numbered (i.e. page 1 of 2). If pages are not numbered, then the provider must sign each page of the Progress Note.
- Progress Note should follow the standard S.O.A.P. format.

** Provider signature requirements on the Progress Note:**

- All Progress Notes must be signed by the provider rendering services. If needed, each state has requirements for physician’s co-signature on Progress Notes for Physician Assistants. In Florida, as of July 1, 2009 a physician does not need to cosign PA notes.
- All provider credentials must either be pre-printed on the Progress Note as part of the stationary or the provider must sign the Progress Notes with his/her credentials as part of the signature.
- Dictated notes and consults must be signed by the provider. The provider’s credentials must either follow the signature or be pre-printed on the stationary.
- Provider signature must be legible, i.e. “John Smith Dow, M.D.” or “JSD, MD”. If a provider’s signature is illegible, a Signature Log must be completed – the original should be dated and stored at your practice for future audits or requests. An example of a Signature Log is attached for your reference use.
- Stamped signatures are no longer acceptable as of January 1, 2009, as stated by the Centers for Medicare & Medicaid Services (“CMS”).

- Electronic Medical Record (“EMR”) Progress Notes must have the following wording as part of the signature line: “*Electronically signed*”, “*Authenticated by*”, “*Signed by*”, “*Validated by*”, “*Approved by*”, or “*Sealed by*”. The signed EMR record must be closed to all changes.
- Any additional information or updates can be added as a separate addendum to the DOS, i.e. lab result returned which confirms diagnosis.

**🌀 Use of abbreviations in the Progress Note:**

- Please use standard medical abbreviations, acronyms, or symbols. If your office chooses to use abbreviations specific to your practice, create a list of definitions with a statement by the provider that these abbreviations mean a specific diagnosis in the medical record. This document should be stored along with the Signature Log for future audits or requests.
- Do not use arrows up or down in place of “hyper-“ and “hypo-“, as they could be interpreted as an elevated condition, unless you have previously defined the symbols in the above mentioned list.

**🌀 Diagnosis documentation requirements on the Progress Note:**

- CMS is also looking for an evaluation of each diagnosis on the Progress Note, not just the listing of chronic conditions, i.e.: DM w/Neuropathy - meds adjusted, CHF - compensated, COPD - test ordered, HTN - uncontrolled, Hyperlipidemia - stable on meds. CMS considers diagnoses listed on the Progress Note without an evaluation or assessment as a “problem list”, which is unacceptable for encounter data submission.
- Each Progress Note must be able to “**stand alone**”. Do not refer to diagnoses from a prior Progress Note, problem list, etc.
- Progress Notes can be revised within 30 days of a visit by adding additional information, along with a supporting explanation, signature, and date. You may need to bring the patient back in the office if the condition needs to be documented and it is past the 30 days to revise the Progress Note.

We appreciate you taking the time out of your busy schedule to review the above recommendations. It is more important than ever that you follow them in order to stay compliant with CMS requirements. Failure to follow these guidelines may result in non-compliance during risk adjustment data validation audits conducted by CMS. If you have any questions regarding this memo or would like to schedule a more detailed presentation on any aspect of Medicare Risk Adjustment, please feel free to contact Olga Marytcheva, Senior Manager of MRA at 727-456-6503.

Thank you for your time, effort, and cooperation.



Edward Lowenstein, M.D.  
Medical Director, Universal Health Care Group