Coding tips for:

PROGRESS NOTE CONTENTS

PREFERRED FORMAT, PER CMS, IS THE S.O.A.P. FORMAT:

SUBJECTIVE:

This section should be utilized to report subjective information of clinical significance. The chief complaint of the patient belongs in this section.

OBJECTIVE:

This section is where you will report the measurable and observable information that you obtain during the visit. Review of systems, physical examination, any test results, outside communications with specialists should be noted in this section.

ASSESSMENT:

List all diagnoses and conditions assessed during the visit. Include any conditions for which prescriptions were given/renewed, tests were ordered, referrals were given. Also include any conditions in which affected decision-making for treatment.

PLAN:

The final section of your SOAP notes is where you outline the course of treatment, after considering the information you gathered during the visit.
Coding tips for:

**ASSURE PROGRESS NOTE COMPLIANCE**

- The physician’s *signature* must be on all progress notes.
- If the physician does not include his/her credentials as part of their signature, the *full name and credentials* must be printed clearly on the note.
- The *patient’s name, date of birth and DOS* must be on each page of the patient’s progress note/chart.
- Electronic Medical Records *must clearly be “authenticated”, “digitally signed”, “electronically signed by”* the provider.
- The medical record *must be legible/complete*.
- Only standard medical abbreviations should be used.
- Late entries can be made to clarify confirmed diagnoses. Date and time the late entry.