Medicare Note For Daily Visit

Medicare wants daily notes to be CONCISE yet COMPLETE.

This means that you must update the patient’s subjective complaints and objective findings. Report any changes since the last visit. Also document what treatment that has been rendered to the patient and their response to care that day.

NOTE: Medicare will not reimburse for notes that contain subjective complaints only. You must document a LOSS or CHANGE in FUNCTION.

Also, Medicare will NOT pay for “canned” notes. Your notes must be specific to that patient and meet Medicare’s requirements.

So, if a patient presents with neck pain, ask them what they are unable to do as a result of the neck pain. The SUBJECTIVE may look like this:

S: Mr. Smith is complaining of continued neck pain that appears to be getting better. He states that he has some difficulty turning his head to the right and tilting to the left.

Next, the OBJECTIVE must address the fixation or subluxation, muscle spasm, tenderness or decreased motion. Here is an example:

O: There is a loss of joint mobility in the cervical spine with paraspinal muscle spasm on the right.

Your ASSESSMENT is simply your opinion as to how the patient is progressing. It may look like this:

A: The patient is progressing as expected but still has some functional limitations.

Your PLAN is what treatment was rendered and what you plan on doing in the future. Here is an example:

P: I performed a diversified maneuver to the cervical spine today. There was an increase in joint mobility after treatment and the patient reported a slight increase in motion and less tightness. He is to return in 2 days. We will perform a re-evaluation (Neck Disability Index) in 2 weeks.

So, there you have it! As you can see, Medicare notes must be WRITTEN, DICTATED or IMPORTED INTO EMR SOFTWARE.

Just be sure that your EMR software is “tweaked” to Medicare standards.