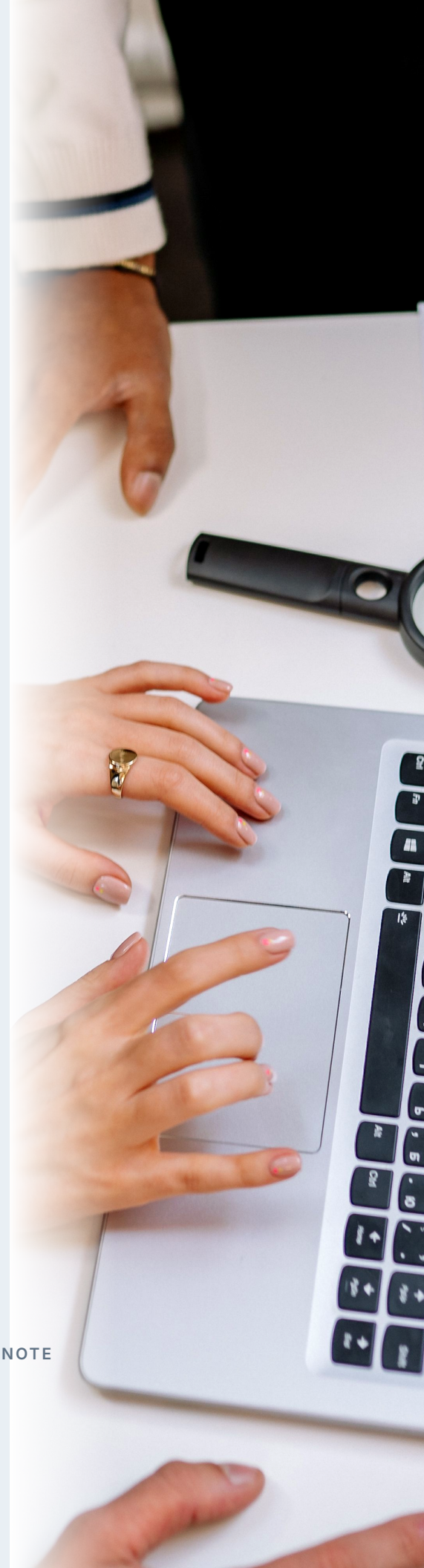
NATREVMD

The E/M Documentation Toolkit

Five physician-first tools for writing the note you already write, faster and more defensibly.



5
WORKFLOW TOOLS

12
ANNOTATED CASES

90s
PER COMPLEX NOTE

Companion resource · E/M Coding and Downcoding Webinar · natrevmd.com

Leave with a better way to write the note you already write.

Not longer. Not more templated. Not more coding-driven. For most office and outpatient E/M services, code selection is based on medical decision making or total practitioner time, and documentation volume should not drive the level of service.

COMMON MISTAKE

What this toolkit is not

It is not an audit form, an appeal template, or a code grid. No diagnosis, template phrase, or single action automatically determines a code level.

KEY INSIGHT

What it is

A clinical-thinking-to-note system. Each tool turns reasoning you already perform into a concise, individualized narrative a reviewer can follow.

THE QUESTION EVERY NOTE HAS TO ANSWER

Could a clinician who did not see this patient understand exactly what made this visit medically necessary, and why this specific plan was chosen?

If the answer is no, the fix is missing clinical reasoning, not more templated text.

WHERE IT COMES FROM

Medical decision making, or total time

Built from Problems, Data, and Risk, or total practitioner time on the date of the encounter.

WHERE IT DOES NOT

History and exam

Both are required when medically appropriate, but neither determines the level of service.

CONTENTS

Five tools, built for the moments you are actually in.

Your first week

1

Install two phrases

Build two SmartPhrases from tool 03 in your EHR and test them in a practice chart.

2

Run the check

Use the before-sign question from tool 01 on your next five complex notes.

3

Keep two in reach

Print tools 01 and 04 and keep them where you close charts.

Tool 01 / Point-of-care template

The 90-Second MDM Note Builder

A four-step structure that turns the clinical reasoning you already perform into a concise, defensible narrative, without adding length to the note.

WHEN YOU USE IT

While closing a complex office note, before you sign.

TOOL 01

The four-step MDM workflow

KEY INSIGHT

The core principle

Code selection for most office and outpatient E/M services is based on Medical Decision Making or Total Time. While a medically appropriate history and exam are required when performed, they do not determine the level of service. Documentation volume should not drive the code; the documented clinical narrative must support the service reported. **[1] [2]**

Complete this mental workflow while closing your note. It replaces extensive, templated paragraphs with a concise, individualized narrative that supports the AAPC focus on Problems, Data, and Risk. **[2]**

THE SEQUENCE

1. **Status**
   What is the current state of the problem?
2. **Data**
   What information informed my decision?
3. **Decision & Risk**
   What action did I take, and what is the risk?
4. **Next Steps**
   What happens next?

WHAT EACH STEP PROVES TO A REVIEWER

1. Status
Establishes the complexity of the problem addressed during the encounter.

2. Data
Proves the cognitive work of reviewing or analyzing data, moving beyond a generic “records reviewed” statement.

3. Decision & Risk
Links the management decision directly to the patient's specific risk of complications, morbidity, or mortality.

4. Next Steps
Demonstrates active management and safety-netting.

TOOL 01

The documentation prompts

Say it in your own words. The bracketed parts are what a reviewer cannot infer.

STEP	WHAT YOU WRITE
1. Status	"I addressed [condition/problem], which was [new / worsening / not at goal / stable with side effects / of uncertain cause]."
2. Data	"I reviewed/ordered/discussed [specific relevant data, prior record, test, or collateral history] because [clinical reason]."
3. Decision & Risk	"Given [finding/context], I [started / changed / continued / deferred / referred / escalated] [specific plan]; the key risk or consideration was [patient-specific rationale]."
4. Next Steps	"The patient will [follow up / monitor / seek urgent care] for [specific trigger or timeline]."

CLINICAL PEARL

Could a clinician who did not see this patient understand exactly what made this visit medically necessary, and why this specific plan was chosen?

If the answer is no, add the missing clinical reasoning, not more templated text or imported lab results.

Tool 02 / Annotated reference guide

Is This Really a Level 4?

What the note needs to show. Twelve everyday outpatient encounters, each contrasting a thin note that is vulnerable to reduction with a defensible, individualized one.

WHEN YOU USE IT

Before clinic, after a disputed note, or when you want a realistic comparison.

TOOL 02

How to read a case

Diagnosis codes alone do not guarantee a specific E/M level. A note with a complex diagnosis but a thin narrative can be vulnerable to a reduction upon review. Each case below contrasts a typical thin note with a defensible, individualized one built on the 90-Second MDM Note Builder. **[1]**

Every case follows the same five steps

STEP 01

The problem

The clinical situation, in one line.

STEP 02

The thin note

Clinically accurate, but it hides the reasoning. This is what gets reduced on review.

STEP 03

The defensible note

Same encounter, same length range, with status, data, risk and plan made explicit.

STEP 04

Why it matters

What makes the stronger version defensible, and which MDM element it speaks to.

STEP 05

What changes the result

The change in fact pattern that would alter the outcome. The case teaches judgment, not a formula.

COMPLIANCE REMINDER

Important

This is not a “Level 4 checklist.” No diagnosis, template phrase, or single action automatically determines a code level. Apply the current MDM framework or total-time rules to the full encounter, and report only the service supported by the work actually performed and documented. **[1] [2]**

01

ANNOTATED CASE

The Worsening Chronic Condition

1 THE PROBLEM

Established patient with hypertension, currently uncontrolled on Lisinopril.

2 THIN NOTE VERSUS DEFENSIBLE NOTE

VULNERABLE

Hypertension. BP elevated today at 150/90. Add Amlodipine 5mg. Return in 4 weeks.

DEFENSIBLE

Status: Essential hypertension, currently not at goal (BP 150/90) despite adherence to Lisinopril 10mg.

Data: Reviewed home BP log; consistently elevated in the 140s/90s over the past two weeks.

Decision & Risk: Added Amlodipine 5mg daily. Discussed risk of hypotension and peripheral edema.

Next Steps: RTC in 4 weeks for BP check and basic metabolic panel.

3 WHY IT MATTERS, AND WHAT CHANGES IT

THE WHY

The defensible note clearly establishes a worsening or uncontrolled problem, documents the patient-specific information that informed management, and explicitly states the risks associated with the medication change. Not every clinically useful item of information independently counts toward the technical Data element; use the current MDM framework for final analysis.

THE WHAT IF

If the BP was at goal and the medication was simply continued without side effects, the MDM complexity would be lower; the final level would depend on the complete MDM analysis or, when used, total practitioner time.

BUILT WITH THE 90-SECOND MDM NOTE BUILDER

1 Status → 2 Data → 3 Decision & Risk → 4 Next Steps

02

ANNOTATED CASE

Diagnostic Uncertainty

1 THE PROBLEM

New patient with atypical chest pain; EKG normal in office.

2 THIN NOTE VERSUS DEFENSIBLE NOTE

VULNERABLE

Chest pain. EKG normal. Rule out GERD vs musculoskeletal. Start trial of Omeprazole.

DEFENSIBLE

Status: Atypical chest pain, new onset.

Data: In-office EKG reviewed; normal sinus rhythm, no acute ischemic changes.

Decision & Risk: Working assessment is GERD versus musculoskeletal pain, but cannot entirely rule out atypical cardiac etiology given age. Initiating Omeprazole trial.

Next Steps: Patient instructed to go to ER immediately if pain worsens, radiates, or is associated with shortness of breath.

3 WHY IT MATTERS, AND WHAT CHANGES IT

THE WHY

The defensible note captures the cognitive work of managing an undiagnosed new problem with an uncertain prognosis and documents the safety-netting necessary for a potentially high-risk symptom.

THE WHAT IF

If the pain was clearly reproducible by palpation (musculoskeletal) with no cardiac risk factors, the risk element would be lower.

BUILT WITH THE 90-SECOND MDM NOTE BUILDER

1 Status → 2 Data → 3 Decision & Risk → 4 Next Steps

03

ANNOTATED CASE

Medication Side Effects

1 THE PROBLEM

Established patient on Lisinopril, reporting a persistent dry cough.

2 THIN NOTE VERSUS DEFENSIBLE NOTE

VULNERABLE

Cough likely related to Lisinopril. Stop Lisinopril. Start Losartan.

DEFENSIBLE

Status: Hypertension, currently at goal, but patient reports a persistent dry cough that is likely an adverse effect of Lisinopril.

Data: Reviewed recent basic metabolic panel; renal function and potassium are normal.

Decision & Risk: Discontinued Lisinopril due to suspected adverse effect. Initiated Losartan 50mg. Discussed risk of hyperkalemia and hypotension.

Next Steps: RTC in 2 weeks for BP check and repeat potassium level.

3 WHY IT MATTERS, AND WHAT CHANGES IT

THE WHY

It documents the management of a treatment-related complication and the specific risks associated with the alternative treatment plan.

THE WHAT IF

If the cough was deemed unrelated (for example, a viral URI) and Lisinopril was continued, the risk profile and management decision would be different.

BUILT WITH THE 90-SECOND MDM NOTE BUILDER

1 Status → 2 Data → 3 Decision & Risk → 4 Next Steps

04

ANNOTATED CASE

Review of Outside Records

1 THE PROBLEM

Established patient following up after an ER visit for a minor laceration.

2 THIN NOTE VERSUS DEFENSIBLE NOTE

VULNERABLE

ER follow-up for laceration. Healing well. Suture removal today.

DEFENSIBLE

Status: Follow-up for right forearm laceration. Wound is clean, well-approximated, with no signs of infection.

Data: Reviewed ER note from 10/12; confirmed tetanus was updated in the ER and no deeper structures were involved.

Decision & Risk: Sutures removed today. Discussed signs of delayed infection and scar care.

Next Steps: Return as needed.

3 WHY IT MATTERS, AND WHAT CHANGES IT

THE WHY

The defensible note makes the cognitive work of reviewing the external ER record and extracting clinically relevant information visible. Apply the current MDM data rules to determine whether the record review contributes to the final Data element.

THE WHAT IF

If the ER record was not reviewed and the physician relied solely on the patient's history, that specific external-record review would not be part of the MDM analysis.

BUILT WITH THE 90-SECOND MDM NOTE BUILDER

1 Status → 2 Data → 3 Decision & Risk → 4 Next Steps

05

ANNOTATED CASE

The Multi-Morbidity Visit

1 THE PROBLEM

Established patient with stable diabetes and stable hyperlipidemia.

2 THIN NOTE VERSUS DEFENSIBLE NOTE

VULNERABLE

Type 2 DM, stable. Hyperlipidemia, stable. Continue current meds.

DEFENSIBLE

Status: Type 2 Diabetes (A1c 6.8%) and Hyperlipidemia (LDL 85), both currently at goal on current regimen.

Data: Reviewed in-house labs from yesterday.

Decision & Risk: Continuing Metformin and Atorvastatin. Discussed importance of continued adherence and diet to maintain current stability and prevent microvascular complications.

Next Steps: RTC in 6 months with repeat labs.

3 WHY IT MATTERS, AND WHAT CHANGES IT

THE WHY

Even when stable, addressing two or more stable chronic illnesses supports moderate complexity in the Problems column of the MDM table. The defensible note explicitly names the conditions and their status.

THE WHAT IF

If only one stable chronic condition was addressed, the Problem element would be lower; the final level would still depend on the remaining MDM elements and the work documented.

BUILT WITH THE 90-SECOND MDM NOTE BUILDER

1 Status → 2 Data → 3 Decision & Risk → 4 Next Steps

06

ANNOTATED CASE

Decision to Refer

1 THE PROBLEM

Established patient with worsening osteoarthritis of the knee, failing conservative therapy.

2 THIN NOTE VERSUS DEFENSIBLE NOTE

VULNERABLE

Knee OA. Still hurts. Refer to Ortho.

DEFENSIBLE

Status: Right knee osteoarthritis, worsening pain and decreased mobility despite NSAIDs and physical therapy.

Data: Reviewed recent weight-bearing X-rays showing severe joint space narrowing.

Decision & Risk: Conservative management has failed. Discussed surgical risks versus benefits. Referring to Orthopedics for evaluation for total knee arthroplasty.

Next Steps: Await Ortho consultation. Continue Meloxicam for symptomatic relief.

3 WHY IT MATTERS, AND WHAT CHANGES IT

THE WHY

The note documents the failure of current therapy and the cognitive work involved in deciding to escalate care to a surgical specialist.

THE WHAT IF

If the patient was just starting physical therapy and NSAIDs, the management risk would be lower than considering surgical escalation.

BUILT WITH THE 90-SECOND MDM NOTE BUILDER

1 Status → 2 Data → 3 Decision & Risk → 4 Next Steps

07

ANNOTATED CASE

Independent Historian

1 THE PROBLEM

Pediatric patient with a fever, history provided by the mother.

2 THIN NOTE VERSUS DEFENSIBLE NOTE

VULNERABLE

Fever x 2 days. Ear exam shows OM. Prescribe Amoxicillin.

DEFENSIBLE

Status: Acute otitis media, right ear.

Data: History of 2-day fever and poor feeding obtained from mother, as patient is pre-verbal.

Decision & Risk: Initiating Amoxicillin 90mg/kg/day. Discussed risk of GI upset and allergic reaction.

Next Steps: Mother to call if fever persists beyond 48 hours or if patient develops a rash.

3 WHY IT MATTERS, AND WHAT CHANGES IT

THE WHY

Explicitly noting that the history was obtained from an independent historian (the mother) may contribute to the Data element when an independent historian is required for the assessment under current guidelines.

THE WHAT IF

If the patient was a teenager who provided their own history, that independent-historian consideration would not apply.

BUILT WITH THE 90-SECOND MDM NOTE BUILDER

1 Status → 2 Data → 3 Decision & Risk → 4 Next Steps

08

ANNOTATED CASE

Discussion with Another Provider

1 THE PROBLEM

Established patient with abnormal thyroid labs, physician calls endocrinologist.

2 THIN NOTE VERSUS DEFENSIBLE NOTE

VULNERABLE

Abnormal TSH. Called Endo. Adjust Synthroid.

DEFENSIBLE

Status: Hypothyroidism, currently not at goal with elevated TSH.

Data: Discussed case directly with Dr. Jones (Endocrinology) regarding appropriate dose adjustment given patient's concurrent cardiac history.

Decision & Risk: Increasing Levothyroxine to 100mcg based on discussion. Discussed risk of palpitations and anxiety with dose increase.

Next Steps: Repeat TSH in 6 weeks.

3 WHY IT MATTERS, AND WHAT CHANGES IT

THE WHY

Documenting the direct discussion with an external physician may contribute to the Data element under the current MDM framework and makes the cognitive work of care coordination visible.

THE WHAT IF

If the physician simply adjusted the dose without the consultation, that specific documented external discussion would be absent.

BUILT WITH THE 90-SECOND MDM NOTE BUILDER

1 Status → 2 Data → 3 Decision & Risk → 4 Next Steps

09

ANNOTATED CASE

Social Determinants of Health

1 THE PROBLEM

Patient with asthma, unable to afford inhalers.

2 THIN NOTE VERSUS DEFENSIBLE NOTE

VULNERABLE

Asthma exacerbation. Out of meds. Give samples.

DEFENSIBLE

Status: Asthma exacerbation, moderate. Patient reports running out of Albuterol 2 weeks ago.

Data: Patient states they lost their insurance and cannot afford refills (SDOH: economic instability).

Decision & Risk: Provided Albuterol samples today to manage acute symptoms. Risk of severe exacerbation if untreated.

Next Steps: Social work consult placed to assist with medication assistance programs. RTC in 1 week.

3 WHY IT MATTERS, AND WHAT CHANGES IT

THE WHY

Documenting that diagnosis or treatment is significantly limited by social determinants of health elevates the Risk element of MDM to moderate.

THE WHAT IF

If the patient simply forgot to pick up the refill but had no barrier to access, the SDOH risk modifier would not apply.

BUILT WITH THE 90-SECOND MDM NOTE BUILDER

1 Status → 2 Data → 3 Decision & Risk → 4 Next Steps

10

ANNOTATED CASE

The Acute Uncomplicated Illness

1 THE PROBLEM

Healthy adult with a simple urinary tract infection.

2 THIN NOTE VERSUS DEFENSIBLE NOTE

VULNERABLE

UTI. Macrobid.

DEFENSIBLE

Status: Acute uncomplicated cystitis.

Data: In-office urinalysis positive for leukocytes and nitrites.

Decision & Risk: Initiated Nitrofurantoin 100mg BID x 5 days. Discussed risk of GI upset.

Next Steps: Patient to call if symptoms do not improve in 48 hours or if flank pain or fever develops.

3 WHY IT MATTERS, AND WHAT CHANGES IT

THE WHY

This demonstrates appropriate documentation for a lower-complexity visit. It clearly outlines the problem, the data (point-of-care test), and the low-risk management plan. The final code selection depends on the full MDM analysis or, when used, total practitioner time.

THE WHAT IF

If the patient was pregnant or had a history of recurrent, resistant UTIs, the problem complexity and management risk could increase.

BUILT WITH THE 90-SECOND MDM NOTE BUILDER

1 Status → 2 Data → 3 Decision & Risk → 4 Next Steps

11

ANNOTATED CASE

Minor Surgery in Office

1 THE PROBLEM

Incision and drainage of a simple abscess.

2 THIN NOTE VERSUS DEFENSIBLE NOTE

VULNERABLE

Abscess on back. I&D performed.

DEFENSIBLE

Status: Acute abscess, left upper back.

Data: Clinical exam confirms fluctuance.

Decision & Risk: Discussed risks of bleeding, infection, and scarring. Patient consented. Performed simple I&D (see separate procedure note).

Next Steps: Wound care instructions provided. RTC in 2 days for packing removal.

3 WHY IT MATTERS, AND WHAT CHANGES IT

THE WHY

The E/M note must establish the medical necessity for the procedure. If an E/M service is reported on the same date as a procedure, the documentation must support a separate, significant E/M service, and current modifier and payer rules must be followed. The procedure note should stand on its own.

THE WHAT IF

If the abscess was merely observed and warm compresses recommended, the management risk would generally be lower.

BUILT WITH THE 90-SECOND MDM NOTE BUILDER

1 Status → 2 Data → 3 Decision & Risk → 4 Next Steps

12

ANNOTATED CASE

Time-Based Coding, Counseling Heavy

1 THE PROBLEM

New diagnosis of Type 2 Diabetes requiring extensive education.

2 THIN NOTE VERSUS DEFENSIBLE NOTE

VULNERABLE

New onset diabetes. Discussed diet and exercise. Started Metformin.

DEFENSIBLE

Status: Type 2 Diabetes, new diagnosis.

Data: Reviewed recent A1c of 8.2%.

Decision & Risk: Initiated Metformin. Total time: 45 minutes spent on the date of the encounter. Time included face-to-face evaluation, extensive counseling on disease process, dietary modifications, exercise expectations, and medication side effects, plus care coordination with a diabetes educator.

Next Steps: Follow up with educator next week; RTC in 1 month.

3 WHY IT MATTERS, AND WHAT CHANGES IT

THE WHY

The extensive counseling required 45 minutes of the billing practitioner's time on the date of the encounter. Documenting the total time and summarizing the activities permits code selection based on time when that route is allowed and better represents the visit; verify the applicable current CPT® and payer requirements.

THE WHAT IF

If the time statement was omitted, code selection would need to rely on MDM rather than total time.

BUILT WITH THE 90-SECOND MDM NOTE BUILDER

1 Status → 2 Data → 3 Decision & Risk → 4 Next Steps

Tool 03 / EHR implementation tool

The EHR SmartPhrase Starter Pack

Prompt-driven macros that make individualized MDM documentation easier to complete in real time.

WHEN YOU USE IT

Once, at your desk. Then every time you document, without thinking about it.

TOOL 03

Build it once, use it every day

KEY INSIGHT

Moving beyond note bloat

Traditional phrase banks encourage note bloat, importing paragraphs of generic text that obscure the actual clinical work. These phrases are different. They are built as **prompt-driven macros**, so they structure your documentation while forcing you to enter the patient-specific detail reviewers look for when assessing MDM complexity. **[1]**

Implementation, four steps

1

Create the macro

Open your EHR's phrase or macro manager. SmartPhrase in Epic, Dot Phrase in Cerner, and equivalents.

2

Copy and paste

Copy the text of the phrase from the block on the following pages.

3

Insert prompts

Replace bracketed text with your EHR's prompt or drop-down function, such as *** in Epic.

4

Test

Run it in a test chart to confirm the prompts fire and force you to complete the narrative.

5
PROMPT-DRIVEN PHRASES

1
AFTERNOON TO BUILD THEM

0
CANNED PARAGRAPHS OF BOILERPLATE

COMPLIANCE REMINDER

Before you use them

Use only when true. Replace every bracket. Remove unused sections. Never rely on copied text to establish work that was not actually performed.

TOOL 03

Phrases 1 and 2

1. The Worsening Problem Phrase

USE WHEN

A chronic condition is not at goal, or an acute problem is deteriorating.

WHY IT MATTERS

Establishes higher problem complexity.

Status/Trajectory: I addressed **[condition]**, which is currently **[worsening / not at goal / experiencing side effects]** because **[clinical rationale or patient report]**.

Today's Management Decision: I decided to **[specific action: e.g. increase dose, add medication, refer]** to address this.

2. The Medication Management Phrase

USE WHEN

Starting, stopping, or significantly changing a prescription medication.

WHY IT MATTERS

Links the management decision directly to patient risk.

Medication Management: I **[started / stopped / changed / continued] [medication name/ class]** today. The primary clinical reason for this decision is **[patient-specific benefit, lack of efficacy, or adverse effect]**. I discussed the specific risk of **[key risk, interaction, or side effect]** with the patient.

TOOL 03

Phrases 3 and 4

3. The Data Review Phrase

USE WHEN

You review outside records, consult with another provider, or analyze a test result that changes your management.

WHY IT MATTERS

Proves the cognitive work of data analysis, moving beyond a generic “records reviewed.”

Information Used Today: To answer the clinical question regarding **[specific concern]**, I **[reviewed / ordered / discussed]** the **[specific test, prior record, or name of consulting provider]**. This information confirmed **[finding]**, which led me to **[specific change or support for the management plan]**.

4. The Diagnostic Uncertainty Phrase

USE WHEN

A definitive diagnosis cannot be made today, and further workup is required.

WHY IT MATTERS

Captures the complexity of managing an undiagnosed problem with an uncertain prognosis.

Working Assessment: The diagnosis remains uncertain. The differential includes **[potential diagnoses]**, but I cannot rule out **[highest risk concern]** because of **[pertinent clinical finding]**.

Workup Plan: I will **[targeted evaluation, monitoring, or referral]** to clarify this concern.

TOOL 03

Phrase 5

5. The Risk and Follow-Up Phrase

USE WHEN

Establishing the safety net for the patient's discharge.

WHY IT MATTERS

Demonstrates active management and awareness of potential complications.

Risk/Safety Plan: The key risk we are managing today is **[specific risk]**. The patient was instructed to **[specific escalation trigger, e.g. go to ER if...]** or follow up in **[timeframe]** for **[specific re-evaluation]**.

COMPLIANCE REMINDER

Compliance warning

Use only when true. Replace all bracketed prompts. Remove any unused sections. Never rely on copied text to establish work that was not actually performed.

Documentation must always accurately reflect the specific encounter and support the level of service reported. **[1]**

Tool 04 / Point-of-care decision card

MDM or Time?

A two-route decision card for choosing the coding path your documentation supports most clearly, at the end of an unusually complex or time-intensive encounter.

WHEN YOU USE IT

At the end of an unusually complex or time-intensive encounter.

TOOL 04

Two routes, one encounter

KEY INSIGHT

The core rule

For most office and outpatient E/M visits, you may select your code level based on **either** Medical Decision Making **or** Total Practitioner Time spent on the date of the encounter. **[1] [2]**

You no longer need to meet a counseling threshold to bill based on time. Choose the route that best reflects the work performed and is most clearly supported by your documentation.

ROUTE A

Choose MDM when...

- The visit required high cognitive effort, but the total time spent was standard or brief.
- You managed high-risk medications or navigated complex diagnostic uncertainty.
- You addressed multiple chronic conditions, even if the face-to-face portion was highly efficient.
- The complexity of the patient's problems, data reviewed, and management risk clearly support a higher level than the time spent.

ROUTE B

Choose total time when...

- Extensive counseling, education, or coordination of care dominated the visit.
- You spent significant time reviewing records or coordinating care *on the same day*, before or after seeing the patient.
- The clinical narrative is relatively simple, but the time required to manage the patient was unusually high.
- The time spent clearly meets the threshold for a higher level, but the MDM elements (Problems, Data, Risk) are borderline.

Documenting total time

If you select the E/M level based on total time, your documentation must explicitly support it. Do not rely on automated EHR time stamps alone. Your note must include all three of the following.

REQUIRED 1 OF 3

The specific total time

spent by the billing practitioner on the date of the encounter. For example: "Total time spent: 45 minutes."

REQUIRED 2 OF 3

The date

the time was spent, which must be the date of the encounter.

REQUIRED 3 OF 3

A summary of the activities

that comprised that time. For example: "Time included face-to-face evaluation, review of extensive outside records prior to the visit, and care coordination with the specialist following the visit."

WARNING

Do not count

Time spent on separately billable services, such as an EKG interpretation billed separately, or time spent by clinical staff.

CLINICAL PEARL

What a time statement looks like

"Total time spent: 45 minutes on the date of the encounter. Time included face-to-face evaluation, review of extensive outside records prior to the visit, and care coordination with the specialist following the visit."

This tool is for educational and workflow-improvement purposes. It does not replace clinical judgment, official CPT® guidelines, or payer-specific documentation requirements. Always ensure your documentation accurately reflects the work performed.

Tool 05 / Physician reference guide

Make the Work Visible

Translate clinical reasoning already performed into concise, visible documentation. The hidden-work reference.

WHEN YOU USE IT

When a note feels clinically substantial but reads as routine.

TOOL 05

Six kinds of work that go undocumented

KEY INSIGHT

The problem with internalized decisions

Physicians make dozens of complex, high-risk decisions during a typical clinic day. Because these decisions become second nature, they are often internalized rather than documented. Under current E/M guidelines, if the cognitive work is not visible in the note, it cannot be credited toward the complexity of Medical Decision Making. **[1]**

Reviewing outside records

You read a specialist's note to ensure your plan would not conflict with theirs.

USUALLY WRITTEN

"Records reviewed."

MAKE THE WORK VISIBLE

"Reviewed Dr. Smith's cardiology note from 10/12; confirmed EF is stable, allowing us to proceed with..."

Data May contribute to the data element when it meets current unique-source and category criteria.

Deciding not to prescribe

You considered a medication but decided against it due to a potential interaction or side effect.

USUALLY WRITTEN

"Plan: continue current meds."

MAKE THE WORK VISIBLE

"Considered adding [Medication X], but deferred due to risk of interaction with the patient's current [Medication Y]. Will monitor."

Risk Documents clinically relevant management reasoning; it does not automatically establish a risk level.

Six kinds of work that go undocumented, continued

Consulting a colleague

You called a specialist or the ER to discuss the patient's presentation before deciding on a plan.

USUALLY WRITTEN

"Referred to ER."

MAKE THE WORK VISIBLE

"Discussed case directly with Dr. Jones (ER attending) regarding the patient's atypical presentation; agreed on direct admission."

Data May contribute through a documented discussion of management or test interpretation with an external physician or other qualified health professional.

Managing social barriers

You altered your ideal treatment plan because the patient could not afford the medication or lacked transportation.

USUALLY WRITTEN

"Gave samples."

MAKE THE WORK VISIBLE

"Patient unable to afford prescribed inhaler (SDOH: economic barrier). Provided samples today to prevent acute exacerbation; social work consult placed."

Risk Diagnosis or treatment significantly limited by social determinants of health.

Six kinds of work that go undocumented, continued

Using an independent historian

You had to rely on a parent, caregiver, or spouse for the history because the patient was unable to provide it.

USUALLY WRITTEN

"Patient presents with..."

MAKE THE WORK VISIBLE

"History of present illness obtained from the patient's daughter, as the patient's dementia precludes a reliable history."

Data May contribute when an independent historian is required for the assessment.

Ordering tests to clarify a concerning problem

You ordered a targeted test because the presentation requires clarification of a potentially serious condition.

USUALLY WRITTEN

"Order CT."

MAKE THE WORK VISIBLE

"Ordering CT to clarify the cause of [specific symptom] and evaluate for [clinical concern] given [pertinent finding]."

Problems / Data Documents an undiagnosed problem with uncertain prognosis when supported by the facts; test ordering itself may also contribute to the data element.

THE TAKEAWAY

You do not need to write longer notes. You need to write clearer ones.

Focus your documentation on the why behind your decisions, not just the what.

NATREVMD

Better documentation is the cheapest revenue you will ever recover.

We are a physician-led revenue cycle management company. We built this toolkit because the gap between the work physicians do and the work their notes show is one of the most expensive gaps in an independent practice.

NEXT STEP

Find out which of the five revenue leaks is costing your practice the most.

Run the RECOVER Diagnostic →
eligibility.natrevmd.com/recover-quiz-lp

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Sources: [1] CMS, Evaluation & Management Services. [2] AAPC, Evaluation and Management Coding, E/M Codes.
This tool is for educational and workflow-improvement purposes. It does not replace clinical judgment, official CPT® guidelines, or payer-specific documentation requirements. Always ensure your documentation accurately reflects the work performed.