Best Practice: Documentation for Evaluation and Management Services

American Medical Association's CPT® Evaluation and Management (E/M) Code and Guideline Changes
CMS Evaluation and Management Services Guide (HHS/CMS)

The Value of Clear Documentation:

Purpose

Reflect the care provided in the medical record
Support quality, continuity, and compliance
Ensure accurate coding for reimbursement

Billing Essentials

Documentation must justify the level of service reported
Capture medical necessity, complexity, and scope of the encounter
Select the E/M code that best represents the services rendered

"Clear and concise medical record documentation is critical to providing patients with quality care…"

Key Takeaway: Clear, concise documentation supports accurate payment and demonstrates the quality and integrity of care delivered

E/M Documentation Elements:

Medical Decision Making (MDM)

Reflects the complexity of diagnosing and management of the patient's condition

Based on 2 out of 3 components must meet requirements: number/severity of problems, amount/complexity of data reviewed, and risk of complications

Time

May be used as the determining factor for E/M level when counseling, coordination, or total encounter time dominates the visit

Includes both face-to-face and qualifying non–face-to-face activities

Documentation should…

Reflect patient-specific details, not generic templates

Clearly link medical necessity to the services provided

Capture the clinical reasoning that supports the MDM level

Accurate documentation protects against audit risk and ensures the record tells the full story of the patient's care.

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Pitfalls & Best Practices

Common Pitfalls

🚫Overdocumentation – Adding excessive, non-relevant details that obscure the medical necessity

🚫Cloned Notes – Copy/paste text without updating for the current encounter

🚫Incomplete Justification – Level of service not supported by MDM or time

🚫Missing Linkage – Diagnoses not clearly tied to assessment, plan, or orders

🚫Inconsistent Information – Mismatch between chief complaint, exam, and plan

Best Practices

✅Document the "why" — show the thought process behind decisions

✅Reflect only what's medically necessary for that visit

✅Use specific, patient-focused language (avoid generic templates)

✅Ensure documentation supports coding level and medical necessity

✅Review notes for consistency before signing

Strong documentation tells the patient's story clearly, supports accurate coding, and demonstrates the value of clinical care.

Before Signing Your Note, Double Check:

1. Confirm Patient Information
2. Verify Chief Complaint & History
3. Examination / Assessment
4. Medical Decision Making (MDM)
5. Time (if applicable)
6. Plan of Care
7. Documentation Integrity Check
8. Link Diagnoses to Services