Data Drought: How Under-Documentation Drains Your Revenue

The era of meticulously counting elements in evaluation and management notes is behind us. We no longer need to dissect each note—from the patient's history to the physical examination and Medical Decision Making (MDM)—to avoid "double-dipping," as if a provider's note were a large container of dip and each section represented a chip being carefully removed. Although the coding criteria for evaluation and management services have changed, documentation requirements remain unchanged. In this whitepaper, we will break down the **Amount and/or Complexity of Data to Be Reviewed and Analyzed**, and how the under-documentation of this information could cost you money.

The **Amount and/or Complexity of Data to Be Reviewed and Analyzed** is broken down into three categories:

- **Category 1:** Tests, documents, or an independent historian
  - Tests are imaging, laboratory, psychometric, or physiologic data.
  - Documents are external notes/records from an appropriate source.
  - An independent historian is an individual, other than the patient, who provides a history in addition to that which the patient has provided.
- **Category 2:** Independent interpretation of tests
  - An independent interpretation means the provider personally reviews and assesses a diagnostic test that typically comes with its own CPT code and is expected to include a formal report. This isn't just glancing at results; it's a complete clinical interpretation that would ordinarily be documented and billed as a separate service.

- **Category 3:** Discussion of management or test interpretation
  - To count as a valid discussion, there must be a two-way exchange with a qualified individual who plays a role in the patient's care or management, even if they're not a healthcare provider. This could include professionals like attorneys, parole officers, case managers, or educators. Conversations with family members or informal caregivers, however, don't meet the criteria for this type of discussion.

In the case of MDM, data elements are inherent—not necessarily because of their individual analysis, but because of their effect on the provider's clinical judgment. An example would be a laboratory value such as glucose, which may not be segmented alone, but certainly affects the treatment or diagnostic process. Documenting data is not as difficult as it may seem. We will dive into how to obtain data points.

Awkward pause.

Here comes the exclamation:

“WAIT! I thought we weren’t counting elements anymore!”

Can you believe we were misled? Just when you thought you were done with The Fundamentals of Evaluation and Management Math, that is just not the case. We are still “counting” but in a different way. Let’s dive in.

Clues, Charts, and the Chatty Historian: Where Data Meets Dialogue

The items in category one are straightforward - order and/or review tests, review documents, and obtain information from an independent historian. There is nothing complicated about that; however, the under-documentation of tests, documents, and the independent historian is leaving money on the table. The level 3 visit can become a level 4 visit for work that is **already being done** but is not adequately documented. Money talks. Currently, the difference between 99213 and 99214 on the Medicare National Fee Schedule is approximately $36, or 0.62 RVUs. Imagine if your level 3 visit is a level 5 visit, with a difference of over $86.50, or 1.5 RVUs. The chances of a 2-level increase may be few and far between, but think of the impact this could have on your revenue. This is the category that has the greatest potential to gain those data points.

Tests ordered and/or reviewed are an area where we have seen the most under-documentation. It is essential to understand how to count the data points for tests ordered and/or reviewed. A test ordered during a patient encounter is assumed to be reviewed once the results are available, so they are counted toward that same encounter. In lay terms, if you order it, you are responsible for delivering the results, and it can only be counted at the encounter where it was initially ordered. However, if a test is ordered outside of the visit but its results are reviewed during a subsequent encounter, it can be counted at that later time. There are also cases where a recurring order is entered, like monthly prothrombin times; each new result may be counted in the encounter where it’s actually reviewed. So, if a provider orders a prothrombin time and reviews the result during the visit, that counts as one data point. Future results from that same recurring order can be counted individually, but only in the encounters where they’re actively analyzed.

Documentation Review Example 1

Scenario: The provider orders CBC, CMP, A1c, a lipid panel, and INR labs.

Documentation: “Labs ordered.” This is insufficient for the consideration of data points.

Documentation Improvement:

The patient is complaining of increased fatigue and unintentional weight loss. Orders placed for CBC.

The patient has type 2 diabetes and chronic kidney failure. Orders placed for CMP and A1c.

The patient's last cholesterol screening was borderline; orders were placed for a lipid panel to assess if a prescription will be needed.

The patient is on anticoagulation therapy, warfarin, and new orders have been placed for monthly INR checks.

Reviewing a prior external note or notes can be painstakingly time-consuming to include in your documentation. To receive credit for this data element, the documentation review must be from an external, unique source (more on this later) and include the source, date of the note being reviewed, and a summarization of pertinent information.

Documentation Review Example 2

Scenario: The provider reviews the ED discharge summary note to determine the conditions for which the patient is now being seen in the office.

Documentation: “ED discharge summary reviewed.” This is insufficient for the consideration of data points.

Documentation Improvement:

I reviewed the discharge summary from this patient's visit to the emergency department at ABC Hospital on August 1, 2025. The patient presented to the ED for dizziness and facial droop. The workup revealed high blood sugar levels, which were stabilized and attributed to a new diagnosis of Type 2 Diabetes. A CT scan and MRI were performed, and stroke was ruled out as the cause of the facial droop. Differential diagnoses were listed as Bell’s palsy, Lyme disease, and MS.

We are frequently asked if the review of the Prescription Drug Monitoring Program (PDMP) can be counted as an external document. This is something you are already doing, but there is often a lack of documentation stating that this review was conducted to reconcile medications or to review the patient’s controlled substance history, which would assist a provider in their prescribing decisions. The bottom line is that if you consider it for your medical decision-making regarding the management of the patient's condition(s) and document it appropriately, then you can and should count it.

The assessment requiring an independent historian is an essential part of your documentation, providing clarity, continuity of care, and/or when the patient is unable to advocate for themselves. When a patient is unable to provide a complete or reliable medical history, whether due to age, cognitive impairment, or a medical condition, it's essential to document the use of an independent historian in the clinical note, this means clearly stating that someone else provided the history, explaining why the patient couldn't do so themselves, and identifying the historian's relationship to the patient. For example, you might note that the patient is a toddler, intubated, or experiencing confusion and, therefore, unable to communicate effectively.

Equally important is specifying who the historian is, such as a parent, guardian, or caregiver, and detailing the information they shared. This could include symptoms, recent changes in condition, or relevant medical background. Including these details not only supports accurate coding and billing but also strengthens the clarity and defensibility of the documentation. It ensures that other providers understand both the source and the substance of the patient’s history, reducing the risk of misinterpretation and improving continuity of care.

Documentation Review Example 3

Scenario: The provider sees a patient with dementia, but is not seeing them for this condition; instead, the patient is being seen for a recent rash due to exposure to poison ivy. The patient presents with their daughter, who provides the context of how the exposure occurred, because the patient is unable to remember how it happened.

Documentation: “Patient seen today for a rash, daughter present in the room.” This is insufficient for the consideration of data points.

Documentation Improvement:

This patient presents today with a rash after being exposed to poison ivy while on a walk in the park with their daughter. The patient is unable to recall the details of this exposure due to worsening dementia. The daughter informed me that they were going for a walk in the park when the patient lost balance and fell into a brush of poison ivy. This incident occurred yesterday, around 5 pm, after dinner. The daughter, a nursing student, marked where the rash began to monitor for spreading.

Documentation Review Example 4

Scenario: The provider sees a 5-month-old infant who has developed a worsening, barky-type cough. The patient is brought in by mom.

Documentation: “The patient is a 5-month-old infant and presents with a worsening barky-type cough.” This is insufficient for the consideration of data points.

Documentation Improvement:

The patient is a 5-month-old infant, presenting with a worsening barky-type cough. Mom reports the baby has been fussy and febrile for the past day and a half. She has tried to give Tylenol to bring the fever down, without success.

Even when it seems obvious, such as in the case of a young child who cannot communicate beyond basic words, it should never be assumed that the history was provided by a parent or caregiver unless explicitly documented. While clinical intuition might suggest that stating the source is unnecessary, documentation requires precision, not presumption. The medical record must clearly identify who provided the history and why the patient was unable to do so.

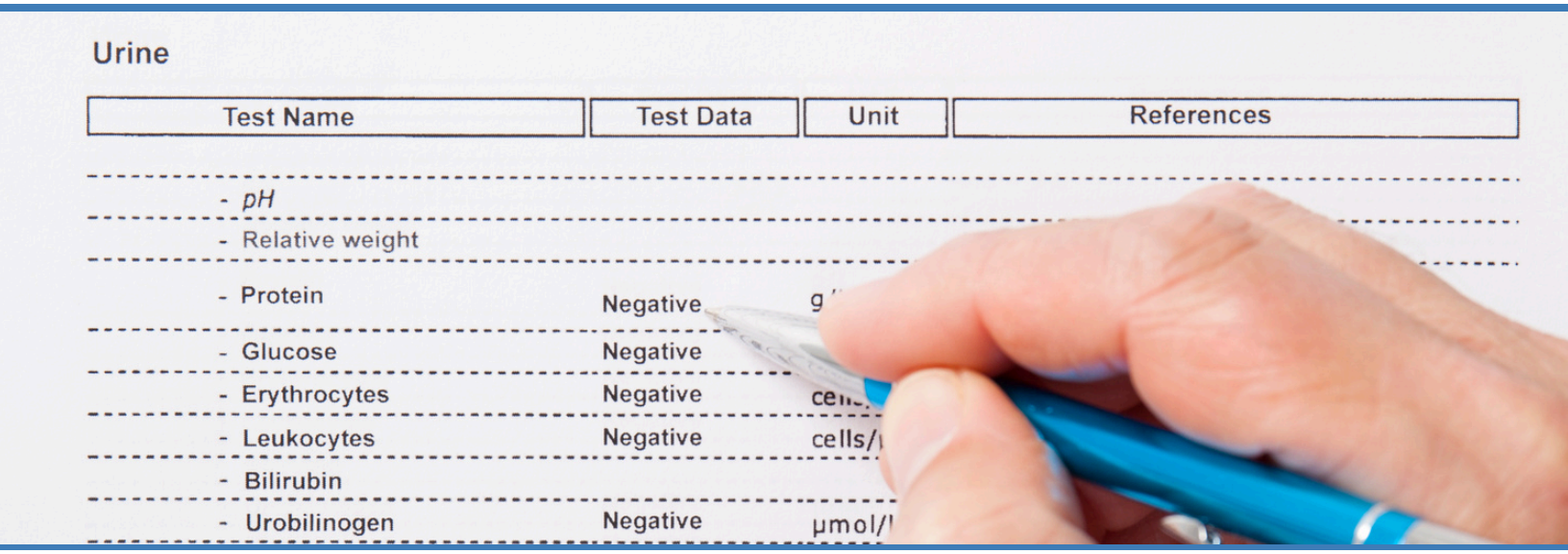
In short: if it's relevant and you thought it, write it down. Documentation is not the place for assumptions.

We would be remiss not to highlight a crucial term in this discussion: unique.

A "unique test" is determined by how it's defined in the CPT code set. If you're reviewing multiple results from the same test, like several blood glucose readings during an E/M visit, it still counts as just one unique test. Even if different CPT codes are used, tests that share overlapping components aren't considered unique; for instance, a CBC with differential already includes hemoglobin, a standard CBC, and platelet count.

A "unique source" refers to a provider or healthcare professional from a different group, specialty, or subspecialty, or a distinct entity altogether.

Reviewing information from any one unique source contributes a single element toward MDM.



Read Between the Lines—Because You're the One Reading Them

Category two references the independent interpretation of tests; there could be some confusion with this concept, so let's dive in. An independent interpretation of a test is when a provider is physically analyzing and interpreting tests performed by another provider and is not reporting the professional (or global) component on their claim(s). When a provider reviews a diagnostic test that is billed by a CPT code and generally includes a customary interpretation or report, some form of documentation should be included in the medical record. While a comprehensive, standalone report isn't required, the documentation should clearly reflect that the provider personally reviewed and interpreted the diagnostic images. This interpretation should be distinct from the findings provided by the reading specialist and serve to support the provider's own clinical judgment and decision-making. However, this requirement doesn't apply if the provider who is billing the E/M service is also the one who performed or previously reported the test. In such cases, the interpretation is already taken into account.

Documentation Review Example 5

Scenario: The provider performs an independent review of an MRI of the neck with findings consistent with spinal cord compression.

Documentation: “MRI Reviewed.” This is insufficient for the consideration of data points.

Documentation Improvement:

MRI of the cervical spine was reviewed independently. Imaging reveals a significant narrowing of the spinal canal at the C5-C6 level, with associated signal changes within the spinal cord suggestive of myelomalacia. There is evidence of a disc osteophyte complex contributing to anterior cord compression. Findings are consistent with cervical spinal cord compression. Final read pending.

Clinical correlation with the patient’s symptoms of upper extremity weakness and gait instability is recommended. Neurosurgical consultation may be warranted based on the degree of cord involvement.

The documentation of the review does not need to be this in-depth; however, it should evidence that there was an independent review performed, and the findings of the documenting provider should be documented.

Talk It Out, Think It Through: When Collaboration Counts Toward Complexity

Category three is inclusive of the discussion of management or test interpretation with an external physician/other qualified healthcare professional/appropriate source. An external provider refers to a licensed physician or qualified healthcare professional who operates outside the patient's current group practice or specializes in a different field. This can include independent practitioners as well as professionals affiliated with hospitals, skilled nursing facilities, or home health agencies. The key is that they're not part of the same practice and bring a distinct clinical perspective to the case. When documenting the discussion of management or test interpretation as part of MDM, it's important to note that relevant sources can include professionals outside of healthcare, such as attorneys, parole officers, case managers, or educators, if they play a role in the patient's care or coordination. However, conversations with family members or informal caregivers don't meet the criteria for this element.

To qualify as a discussion for MDM, there must be a direct, two-way exchange between a provider and an appropriate source, with no intermediaries such as clinical staff or trainees. Simply sharing chart notes or leaving written comments in progress notes doesn't count. The conversation doesn't have to happen on the same day as the patient visit, but it should clearly influence the decision-making documented in that encounter. It can be asynchronous (like a secure message or phone call), but the exchange should be timely, ideally wrapped up within a day or two to stay relevant to the clinical context.

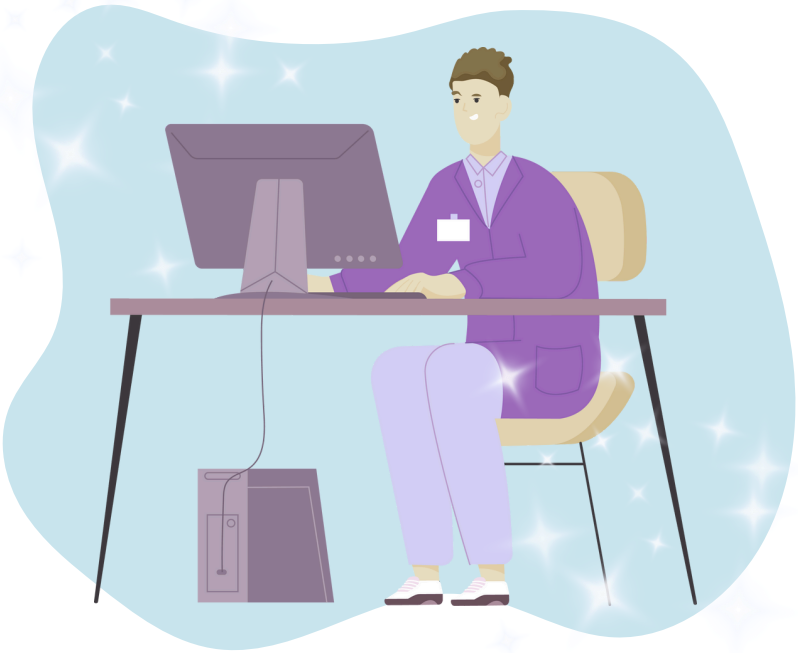
Documentation Review Example 6

> Scenario: The neurologist calls the neurosurgeon to discuss their mutual patient's recent diagnosis of pseudotumor cerebri and the next steps in the patient's treatment.
>
> Documentation: "Discussed with neurosurgeon." This is insufficient for the consideration of data points.
>
> Documentation Improvement:
>
> Called Dr. Neurosurgeon to discuss our mutual patient's recent diagnosis of pseudotumor cerebri. After discussing the patient's presentation of this condition, we agreed that the patient should have a lumbar puncture to evaluate for the necessity of a shunt. In the meantime, we decided to start the patient on Diamox 250 mg bid.

Wrap-Up: Don’t Let Easy Wins Slip Away
Most providers are already doing the work. They're ordering tests, reviewing records, talking with case managers, and gathering histories from caregivers. But if those efforts aren't documented clearly and thoroughly, they don't count. And when they don't count, you lose out on accuracy, on audit protection, and yes, on reimbursement.

The **Amount and/or Complexity of Data** isn’t some obscure coding concept; it’s a reflection of clinical effort. And when documented well, it can bump a level 3 visit to a level 4, or even higher. That’s not just good coding; that’s smart business.

So, here's the takeaway: if you're reading, interpreting, discussing, or relying on it to make decisions, write it down. Be specific. Be thorough. And above all, be intentional because the difference between a compliant note and a costly oversight might be a few well-chosen words.



How LW Consulting, Inc. Can Help
Are your providers documenting clearly and thoroughly? If your answer is “no” or “I’m not sure,” then LW Consulting, Inc. (LWCI) can help!

Our experts can audit your provider’s documentation to review if the documentation is complete and supportive of the services being billed. If we find that your provider's documentation falls short, our experts can provide education to guide your providers on the necessary improvements.

To learn more about how we can help, contact 800-320-5401.

About LW Consulting, Inc.

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Whether the goal is proactive compliance, improved clinical and financial outcomes, or navigating regulatory changes, LWCI brings deep industry expertise to support strategic decision-making and operational success.

Our experienced team delivers actionable insights that help healthcare organizations, including hospitals, long-term care, physician practices, rehabilitation and senior living providers, government programs, and payers, maintain compliance, enhance performance, and minimize risk.