



Are You Documenting For Comprehensive Care?

■ Brad Laymon, PA-C, CPC, CEMC

Is there an opportunity to optimize for accurate billing when more comprehensive care is delivered? Clinicians ask me this question more often than almost any other, thinking they might be leaving money on the table. The honest answer is usually yes, but not the way most people expect. The opportunity rarely sits in doing more procedures. It sits in documentation that reflects the comprehensive care that was delivered during the visit.

Most encounters involve more thinking than the note shows. A patient comes in for a sprained ankle, for example. Along the way, you notice they are on anticoagulation medication, so you factor that into your management decision and adjust your return precautions accordingly. That second problem, addressed in real time, often never makes it onto the page. The visit was comprehensive. The chart was not.

This gap matters because medical decision making is built on 3 elements: problems addressed; complexity of data reviewed; and risks associated with the management chosen.¹ When a visit genuinely touches all 3 at a meaningful level, the code should reflect that. But coding only credits what gets written down. A comorbidity that shaped your risk assessment counts only if you say so. A lab reviewed from 6 months ago that changed your differential counts only if you connect it to your decision. An independent historian who gave you history that a confused or very young patient could not provide counts only if the chart says where that information came from.

Compare 2 versions of the same encounter. The first reads, “Ankle pain, x-ray negative, splint applied, follow up as needed.” The second reads, “Ankle pain following

inversion injury, x-ray negative for fracture. Patient on warfarin for atrial fibrillation, which raised concern for occult soft tissue bleeding and informed the decision to splint rather than wrap. Discussed signs of compartment syndrome given anticoagulation status. Follow up in 1 week or sooner if swelling worsens.” Both clinicians likely thought through the same risk. Only 1 chart shows it, and only 1 supports the level of care actually delivered.

None of this is about padding a note or inflating a level. It is about closing the distance between the comprehensive thinking that already happened in the room and the comprehensive documentation meant to represent it. Clinicians who chronically undercode are likely not doing so to protect themselves from malpractice risk or audits. They are likely describing their work as simpler than it was, visit after visit, and absorbing the financial cost without realizing it.

The fix is small and specific rather than sweeping. For every secondary problem managed alongside the chief complaint, write a sentence showing you evaluated it and made a decision. For every piece of outside data reviewed, tie it directly to how it changed or confirmed your plan. For every comorbidity that raises risk, name the risk in a single line. For every follow-up plan, give it a timeframe and a reason rather than the reflexive “follow up as needed.”

These additions take seconds, not minutes, and they do not change a single decision you already made at the bedside. What they do is let the level of service finally match the level of care, which is the entire point of the coding system. The hidden value of excellent documentation is mitigation of malpractice risk. The opportunity to bill for more comprehensive care is not an opportunity to bill for more. It is an opportunity to bill accurately for what you already provide. ■



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References

1. American Medical Association. CPT Evaluation and Management (E/M) Office or Other Outpatient (99202–99215) and Prolonged Services Code and Guideline Changes. 2023. Accessed July 29, 2026. Available at: www.ama-assn.org/system/files/2023-e-m-descriptors-guidelines.pdf