Medication Management Follow-Up Note Cheat Sheet

Reviewed by the BastionGPT Clinical Advisory Board · July 2026

A medication management follow-up note is a prescriber's record of an established-patient psychiatric visit centered on medications: response, adherence, side effects, monitoring, and the plan. Billed in the US as an E/M visit (99212 to 99215). The E/M rules are payer policy and convention; no statute prescribes the format.

Reason for visit condition + purpose, not an interval
Do: state the condition and today's purpose: "6-week follow-up of sertraline titration for MDD", never a bare "follow-up".
Pitfall: medical-necessity denials (CO-50) start at a one-word first line.

Interval history what changed since last visit
Do: record course, response to the dose, adherence with specifics, side effects asked and answered, sleep, substances, stressors.
Pitfall: history copied forward until it contradicts the plan; auditors read consecutive notes side by side.

Current medications & monitoring name, dose, frequency, reviewed data
Do: reconcile the full list and note the monitoring you reviewed: levels, metabolic labs, AIMS, vitals, ECG where indicated.
Pitfall: results that live only in the lab module; data counts toward MDM only when the note shows review.

Exam / mental status & risk medically appropriate scope
Do: document what you examined and found; assess suicidality (and violence where pertinent) when symptoms, meds, or history make it relevant.
Pitfall: the 12-domain MSE copied forward unchanged; a shorter honest exam audits better.

Assessment & medical decision making status, severity, data, rationale
Do: give each problem a status and severity, name the data reviewed, and state why the medication decision was made.
Pitfall: "stable, continue" under a 99214; downcoding clusters on unstated severity and rationale.

Plan & prescriptions every change with its why
Do: pair changes with rationale; record scripts, labs ordered, the PDMP query where state law requires it, safety-netting, follow-up interval.
Pitfall: a PDMP check performed but never attested; the attestation is one dated line.

Billing basis & signature MDM or total time, never mixed
Do: choose MDM or total time on the encounter date; document any psychotherapy add-on separately (E/M level then by MDM); sign with credentials.
Pitfall: a stray "15 minutes" beside an MDM-based 99214 does the auditor's work.

Before you sign

- [ ] Reason for visit names the condition, not just "follow-up"
- [ ] Adherence, side effects, and response each addressed with specifics
- [ ] Medication list reconciled: name, dose, frequency, change dates
- [ ] Exam scoped to the visit; risk assessed and freshly written
- [ ] Each change carries its rationale; diagnosis at full specificity
- [ ] Billing basis clean: MDM or total time, no stray minutes

Drafting with AI

Dictate the visit or paste a transcript; keep the moving parts straight.

> *"Draft a med management follow-up note from this dictation: established patient with MDD and GAD, sertraline raised to 150 mg, PHQ-9 11 from 18, risk denied, MDM basis: …"*

Never paste patient-identifying information into consumer AI tools. BastionGPT is HIPAA-compliant with a signed BAA on every plan.

150 to 500 words	5 to 10 min by hand	Every med-focused visit	Prescriber · payers · auditors
typical length	clinical team estimate	when it's written	who reads it

Full guide, sample note, and compliance notes:
bastiongpt.com/template/medication-management-note

Medication Management Follow-Up Note Template

Copy or print for your practice · Adapt fields to your organization's, payer's and jurisdiction's documentation requirements.

Patient (initials): DOB: Visit date:

Prescriber, credentials: Total time (if billed by time):

Reason for visit

Condition and purpose of today's visit, beyond a bare "follow-up"

Interval history

Course since last visit · response · adherence · side effects · sleep · substance use · stressors

Current medications & monitoring

Name, dose, frequency, start or change date · levels, labs, AIMS, vitals reviewed

Exam / mental status & risk

Medically appropriate scope · suicidality addressed · violence risk where pertinent

Assessment / medical decision making

Each problem with status and severity · data reviewed · rationale and risk of medication decisions

Plan & prescriptions

Changes with rationale · scripts · labs ordered · PDMP where required · safety-netting · follow-up interval

Billing basis

MDM, or total time on the date of encounter · psychotherapy add-on documented separately (E/M level by MDM)

Prescriber signature / credentials: Date signed: