Codify
BY AAPC

Optometry Coding & Billing Alert

Don't Rule Out Billing if Documentation Is Missing

3 steps ensure you're using compliant documentation.

Every biller comes across this situation at least once: Your optometrist documents a visit with a patient, but leaves out critical information about the services he or she provided. Now you're unable to bill using the appropriate codes for the visit.

What can you do? In many cases, your optometrist can simply write an addendum to the medical record -- but be sure that this addendum meets the requirements.

Warning: Frequent amendments to chart notes will raise a red flag. If the optometrist cannot get the documentation right the first time, often third-party payers may question the validity and quality of the physician notes. If there are frequent amendments, the third-party payers may question the motives of the amendments.

Step 1: Ensure Clarity

"The critical issue when amending a patient's medical record is that the physician needs to ensure that any subsequent treating provider reviewing the patient's medical record can determine precisely what the amendment is and when it was made," says **Mark. C. Rogers, Esq.**, with The Rogers Law Firm in Boston.

Step 2: Amend for the Right Reasons

"My first question to the physician is, 'Why are you amending it?'" says **Margaret T. Atkinson, BS, CPC, RMC,** business manager at Centennial Surgery Center in Vorhees, N.J. "You should never consider whether the patient has coverage when making your decision on how to treat the patient, and you can't change the record to reflect information that will help get the claim paid if it's not true to what the doctor performed."

Step 3: Make Sure Addendum Is Signed and Dated

When you add information to the medical record, the optometrist should initial or sign the addendum and include the date and time that he made the revision, Rogers says. Remember that the caregiver who performed the service should personally make the change to the record, Atkinson says: "The signature and date can't be performed by a representative or the coder."

EMR tip: "If the physician is making entries on an electronic medical record, this approach may not be possible depending upon the software that is being used," Rogers says. "Nevertheless, every effort possible should be made to link the revision to the incorrect entry."

Potential pitfall: "I am aware of certain electronic medical record software that 'locks' entries and does not allow a direct amendment to the entry," Rogers says. "The physician is required to revise the entry through an addendum; the addendum, however, is not available for review on future patient visits. Such a process absolutely creates a potential liability exposure to the physician and the institution in which he is practicing."