Codify
BY AAPC

Optometry Coding & Billing Alert

Office Visits: Boost Your E/M Bottom Line With These Quick Tips

Chief complaint shouldn't be 'follow-up.'

E/M coding might be part of your everyday routine, but that doesn't mean you have to fall into a coding rut. The following four tips can help ensure that you don't miss out on optimal E/M best practices.

Step 1: Change the Documentation Wording

Although you might think of "cloned documentation" as only existing when using electronic health records (EHRs), the truth is that even paper records can be considered "cloned," if they are all worded exactly alike. The answer? Help providers remember to document things differently, so they don't look like carbon copies.

Whether the cloned documentation is handwritten, the result of a pre-printed template, or involves electronic health records, cloning of documentation will be considered misrepresentation of the medical necessity requirement for coverage of services by most payers.

Even if the physician sees seven patients with otitis media on the same date of service, they won't all have the same history, symptoms, treatment recommendation, or prognosis, so copying documentation from one patient to the next is inappropriate. The notes should be tailored to each patient's individual case.

Step 2: Verify That Provider Signatures Are Legible

Optometrists who are signing documentation by hand should ensure that they include both their first and last names, and that the signature is legible. In addition, most experts recommend that practitioners include their credentials (such as OD) after their signature.

If a signature is illegible, auditors will require a signature log or attestation statement to determine who authored a medical record entry. If a signature is missing from an order for other services, the order will be disregarded as if it didn't exist.

Step 3: Grab the Billing Provider's Signature for Some

Ancillary Services

If ancillary staff members perform a service and write documentation, you may need to have the record signed by the practitioner who is billing for the service. This is state-specific, as some payers do not require the physician to sign incident-to documentation. The medical record only needs to be signed if the state requires the NP, PA, or other practitioner's notes to be counter-signed by the optometrist.

Step 4: Avoid 'Follow-Up' as a Catch-All Complaint

All E/M documentation must include a chief complaint, but what your physician lists as the chief complaint may not fit your insurer's requirements.

The chief complaint is a concise statement that describes the symptom, problem, condition, diagnosis, or reason for the E/M encounter. It is typically stated in the patient's own words. An example would be a "sore throat," or "ear pain." Just

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stating "follow-up" is not appropriate.

Find it: Although some coders were trained to only look for a chief complaint in one particular section of the documentation, that is inaccurate. The chief complaint may actually be listed as a separate element of the history, or it may be included in the history of present illness (HPI).

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