Optometry Coding & Billing Alert

You Be the Expert: Does A Letter Count as A 'Medical Record?'

Question: Our optometrist circled 99213 on his chart, but the only note in the records is a letter back to the referring doctor explaining the patient's condition and the doctor's ultimate diagnosis. When we asked him about it, he said that he's never had a problem documenting this way before. Is he correct that we can bill this claim without using the standard progress note, or should we have him convert the letter into a standard E/M documentation format?

Texas Subscriber

Answer: Depending on what type of information is included in the letter, it may pass muster with your insurer as acceptable documentation. The letter should include the patient's chief complaint, review of systems, medication reconciliation, physical examination, and other similar information that supports 99213 if you're expecting it to hold up as documentation of the patient's visit.

If, however, the letter simply states, "Thank you for referring Thomas Jones. I concur with your assessment of blepharitis and have recommended Restasis and daily eye washes," then you won't meet the criteria for 99213 because you don't have enough information (history, exam, and medical decision-making) to support the code. It's possible that the doctor's EHR will have this information in it, but you'll have to cross-reference that against the letter to see if you're missing any information that would support the use of 99213 before you bill the code.