Codify by AAPC

Part B Insider (Multispecialty) Coding Alert

Reader Question: Documentation Should Focus on Substance, Not Style

Question: My physician reported an established patient office visit code 99214, but the only note in the chart is a letter back to the referring doctor detailing the patient's condition. The doctor insists that this is the way he has always done things, and there has never been a problem before. Is this acceptable? It doesn't seem right to report a code without a standard progress note format.

Codify Subscriber

Answer: There are no specific guidelines for what a provider's documentation must look like, only what elements must be included in order to achieve a code level.

You might be able to bill 99214 (Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A detailed history; A detailed examination; Medical decision making of moderate complexity ...) based on the letter, depending on what information it contains.

Is there a documented chief complaint? Is there history review including things like history of present illness and review of systems? Does the provider explain the details of the exam he performed? Finally, does the letter clearly state your doctor's assessment and plan of care for the patient? If so, then the letter will support an E/M code which one, depends on the details of that documentation.

If, however, the letter simply states, "Thank you for referring Mr. Jones. I concur with your diagnosis of uterine fibroids and recommend surgery," then you won't meet the criteria for 99214 because you don't have enough information to support the code.

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