Codify
BY AAPC

Part B Insider (Multispecialty) Coding Alert

Reader Question: E/M Format Shouldn't Matter

Question: My physician reported established patient office visit code 99213, but the only note in the chart is a letter back to the referring doctor detailing the patient's condition. He insists that this is the way he has always done things, and there has never been a problem before. Is this wrong? It doesn't seem right to report a code without a standard progress note format.

Answer: The answer depends on what information you can find in that letter. Is there a chief complaint, review of systems, medication reconciliation, and other similar documentation in the letter that supports 99213? If so, then it should hold up as documentation of the patient's visit.

If, however, the letter simply states, "Thank you for referring Mr. Smith. I concur with your assessment of arthritis and have recommended medication," then you won't meet the criteria for 99213 because you don't have enough information to support the code.