

DESK REFERENCE

2019

Auditors' Desk Reference

A comprehensive resource for code selection and validation



Power up your coding
optum360coding.com



Contents

Chapter 1. Auditing Processes and Protocols	1
Claims Reimbursement	1
Role of Audits	5
Medical Record Documentation	8
Chapter 2. Focusing and Performing Audits	19
Ten Steps To Audits	19
Identifying Potential Problem Areas	21
Clean Claims	21
Remittance Advice Review	39
Non-medical Code Sets	40
Common Reasons for Denial for Medicare	41
General Coding Principles That Influence Payment	55
Correspondence	75
Resubmission	75
Chapter 3. Modifiers	77
What is a modifier?	77
Types of Modifiers	78
OIG Reports and Payer Review of Modifiers	80
Modifiers and Modifier Indicators	81
Auditing Modifiers	86
Chapter 4. Auditing Evaluation and Management Services	169
Evaluation and Management Codes	169
E/M Levels of Service	170
Location of Service	170
Status of Patient	171
Documentation	171
Contributory Components	187
Correct Coding Policies for Evaluation and Management Services	190
Office or Other Outpatient Medical Services (99201–99215)	195
Observation Hospital Services	199
Inpatient Services	201
Consultations (99241–99255, 99446–99449)	203
Other Types of E/M Service	210
Chapter 5. Auditing Anesthesia Services	235
The Reimbursement Process	235
Code Selection	237
Modifier Selection	237
Qualifying Circumstance Codes	245
Correct Coding Policies for Anesthesia Services	245
Anesthesia for Endoscopic Procedures	247
Anesthesia for Radiological Procedures	248
Monitored Anesthesia Care	249
Units of Service Indicated	250
General Anesthesia	253
Monitored Anesthesia Care General Guidelines	254
Regional Anesthesia	255

Epidural Analgesia	255
Nerve Block Anesthetics	256
Patient-Controlled Anesthesia	258
Postoperative Pain Management	258
Anesthesia-Specific Documentation Recommendations	259
Chapter 6. Auditing Surgical Procedures	263
Date of Service	263
Medical Necessity	263
Complications and Unusual Services	263
Number of Units	264
Documentation	264
Global Surgical Package Definition	265
Supplies and Materials Supplied by Physician	268
Assistants at Surgery	270
Separate Procedures	270
Multiple Procedures	271
Add-on Codes	271
Moderate (Conscious) Sedation	271
Unlisted Procedures	271
Modifiers for Surgical Procedures	272
Procedures Performed on the Integumentary System	273
Procedures Performed on the Musculoskeletal System	294
Procedures Performed on the Respiratory System	308
Procedures Performed on the Cardiovascular System	323
Procedures Performed on the Digestive System	362
Procedures Performed on the Urinary System	410
Procedures Performed on the Male Genital System	422
Procedures Performed on the Female Genital System	430
Pregnancy, Delivery, and the Puerperium	460
Procedures Performed on the Nervous System	468
Procedures Performed on the Eye and Ocular Adnexa	474
Procedures Performed on the Auditory System	484
Chapter 7. Auditing Radiology Services	489
Date of Service	489
Medical Necessity	489
Procedure Coding	490
Auditing Supplies	503
Radiological Procedures	506
Diagnostic Radiology/Imaging Procedures: By Specific Area (70010–76499) ...	507
Diagnostic Ultrasound Procedures: By Specific Area (76506–76999)	508
Radiologic Guidance: By Technique/Specific Area (77001–77022)	509
Radiography: Breast (77053–77067)	510
Additional Evaluations of Bones and Joints (77071–77086)	510
Radiation Oncology Procedures: By Technique/Specific Area (77261–77799) ..	510
Nuclear Radiology Procedures (78012–78999)	513
Interventional Procedures	514
Special Report	515
Chapter 8. Auditing Pathology and Laboratory Procedures	517
Laboratory and Pathology Coding and Billing Considerations	517
Modifier Assignment	520
Billing Guidelines	521
Medical Necessity	523

Multi-test Laboratory Panels (80047–80076 and 80081)	524
Pap Smear Screening (88141–88155, 88164–88167, 88174–88175)	536
Surgical Pathology (88300–88399)	538
Other Pathology Services (89049–89240)	538
Infertility Treatment Services (89250–89398)	538
Proprietary Laboratory Analyses (PLA) Codes (0001U–0017U)	538
Chapter 9. Auditing Medical Services	539
Date of Service	540
Immune Globulins Serum or Recombinant Products (90281–90399)	540
Administration and Vaccine Products (90460–90749)	541
Psychiatric Treatment (90785–90899)	544
Diagnostic Gastroenterology Procedures (91010–91299)	547
Ophthalmology Examinations and Other Services (92002–92499)	550
Diagnostic Otorhinolaryngologic Services (92502–92700)	552
Cardiography and Cardiovascular Monitoring (93000–93278)	556
Monitoring of Cardiovascular Devices (93279–93299)	561
Echocardiography (93303–93355)	562
Heart Catheterization (93451–93572)	567
INR Monitoring (93792–93793)	578
Respiratory Services: Diagnostic and Therapeutic (94002–94799)	578
Allergy Tests and Immunology (95004–95199)	582
Hydration, Therapeutic, Prophylactic, and Diagnostic Injections and Infusions (Nonchemotherapy) (96360–96379)	586
Chemotherapy and Other Complex Drugs, Biologicals (96401–96549)	592
Chapter 10. After the Audit	597
Developing the Audit Report	597
Developing an Executive Summary	599
Calculate Potential Risks to Lost Revenue or Revenue at Risk	600
Determine the Root Cause of the Error	601
Develop Recommendations for a Corrective Action	601
Implement Action Plan	609
Reevaluation	609
Appendix 1. Audit Worksheets	611
Modifier Worksheet	611
Evaluation and Management Services Worksheets	613
1997 General Multisystem—Audit Worksheet	618
1997 Evaluation and Management Worksheet	623
Critical Care Audit Worksheet	625
Transitional Care Management (TCM) Auditing Worksheet	627
Surgical Auditing Worksheet	631
Radiology Auditing Worksheet	632
Laboratory Auditing Worksheet	633
Medicine Auditing Worksheet	634
Heart Catheterization Auditing Worksheet	636
Non-Chemotherapy Injections and Infusion Auditing Worksheet	638
Fracture Care Audit Worksheet	640
Wound Repair Audit Worksheet	642
Lower Endoscopy Auditing Tool	644
Facet Joint Injection Audit Tool	648
Appendix 2. Place-of-Service Codes	649

Focusing and Performing Audits

Conducting an effective chart audit requires careful planning. A well thought out plan is essential to completing a chart audit that yields useable data.

Some questions to consider before starting the audit are:

- What is the topic/focus of the audit (e.g., evaluation and management, surgery, etc.)?
- Is the topic/focus too narrow or too broad?
- Is there a measure for the topic/focus (e.g., level for established patient visits)?
- Is the measure available in the medical record (e.g., recorded by the provider in review of systems)?
- Has the topic/focus been measured before?
 - If yes, then a benchmark or standard exists.
 - If no, then a standard for comparison may not exist.

Once the answers to the above questions have been determined, the practice must decide which steps are necessary to perform a complete and accurate audit.

Ten Steps To Audits

Step 1. Determine who will perform the audit. An internal audit is typically performed by coding staff within the practice that are proficient in coding and interpreting payer guidelines. Depending upon the size of the practice and the number of services provided annually, a compliance department with full-time auditors may be established. If not, the person performing the audit should not audit claims that he or she completed.

Step 2. Define the scope of the audit. Determine what types of services to include in the review. Utilize the most recent Office of Inspector General (OIG) work plan, Recovery Audit Contractor (RAC) issues, and third-party payer provider bulletins, which will help identify areas that can be targeted for upcoming audits. Review the OIG work plan to determine if there are issues of concern that apply to the practice. Determine specific coding issues or claim denials that are experienced by the practice. The frequency and potential effect to reimbursement or potential risk can help prioritize which areas should be reviewed. Services that are frequently performed or have complex coding and billing issues should also be reviewed, as the potential for mistakes or impact to revenue could be substantial.

Step 3. Determine the type of audit to be performed and the areas to be reviewed. Once the area of review is identified, careful consideration should be given to the type of audit performed. Reviews can be prospective or retrospective. If a service is new to the practice, or if coding and billing guidelines have recently been revised, it may be advisable to

Chapter 3. Modifiers

Over the last 20 years, physicians and hospitals have learned that coding and billing are closely connected processes. Coding provides the universal language through which providers and hospitals can communicate—or bill—their services to third-party payers, including managed care organizations, the federal Medicare program, and state Medicaid programs.

The use of modifiers is an important part of coding and billing for health care services. Modifier use has increased as various commercial payers, who in the past did not incorporate modifiers into their reimbursement protocol, recognize and accept HCPCS codes appended with these specialized billing flags.

Correct modifier use is also an important part of avoiding fraud and abuse or noncompliance issues, especially in coding and billing processes involving the federal and state governments. One of the top 10 billing errors determined by federal, state, and private payers involves the incorrect use of modifiers. With that being said, modifier use should also be incorporated into a practice's audit plan.

What is a modifier?

A modifier is a two-digit numeric alpha or alphanumeric code appended to a CPT® or HCPCS code to indicate that a service or procedure has been altered by some special circumstance, but for which the basic code description itself has not changed. A modifier can also indicate that an administrative requirement, such as completion of a waiver of liability statement, has been performed. Both the CPT and HCPCS Level II coding systems contain modifiers.

The CPT code book, *CPT 2018*, lists the following examples of when a modifier may be appropriate (this list does not include all of the applications for modifiers).

- A service or procedure has both a professional and technical component, but both components are not applicable
- A service or procedure was performed by more than one physician or other health care professional and/or in more than one location
- A service or procedure has been increased or reduced
- Only part of a service was performed
- An adjunctive service was performed
- A bilateral procedure was performed
- A service or procedure was performed more than once
- Unusual events occurred
- The physical status of a patient for the administration of anesthesia must be defined

Modifiers from either level may be applied to a procedure code. In other words, a CPT or HCPCS Level II modifier may be applied to a CPT or HCPCS Level II code.

47 Anesthesia by Surgeon

Regional or general anesthesia provided by the surgeon may be reported by adding modifier 47 to the basic service. (This does not include local anesthesia.)

Note: Modifier 47 would not be used as a modifier for the anesthesia procedures.

When to use this modifier:

Modifier 47 is used to indicate that the surgeon performing a procedure also provided regional or general anesthesia.

Note: Modifier 47 is not commonly reported and is not a covered benefit under Medicare and many state Medicaid programs. In addition, many third-party payers will deny any additional payment for anesthesia services not performed by an anesthesiologist or certified registered nurse anesthetist (CRNA). Check with specific payers for coverage details.

Correct usage of this modifier:

- Modifier 47 is used when the anesthesia is administered by the surgeon. It denotes the use of regional or general anesthesia.

Incorrect usage of this modifier:

- Use of the modifier by the anesthesiologist.
- Attaching the modifier to anesthesia codes (00100–01999).
- Using modifier 47 to bill for payment of local anesthesia a surgeon has administered.
- Reporting modifier 47 on services submitted to Medicare and other payers who do not cover this service.
- Reporting modifier 47 with the surgical procedure code when the surgeon provides moderate sedation. See codes 99151–99153.

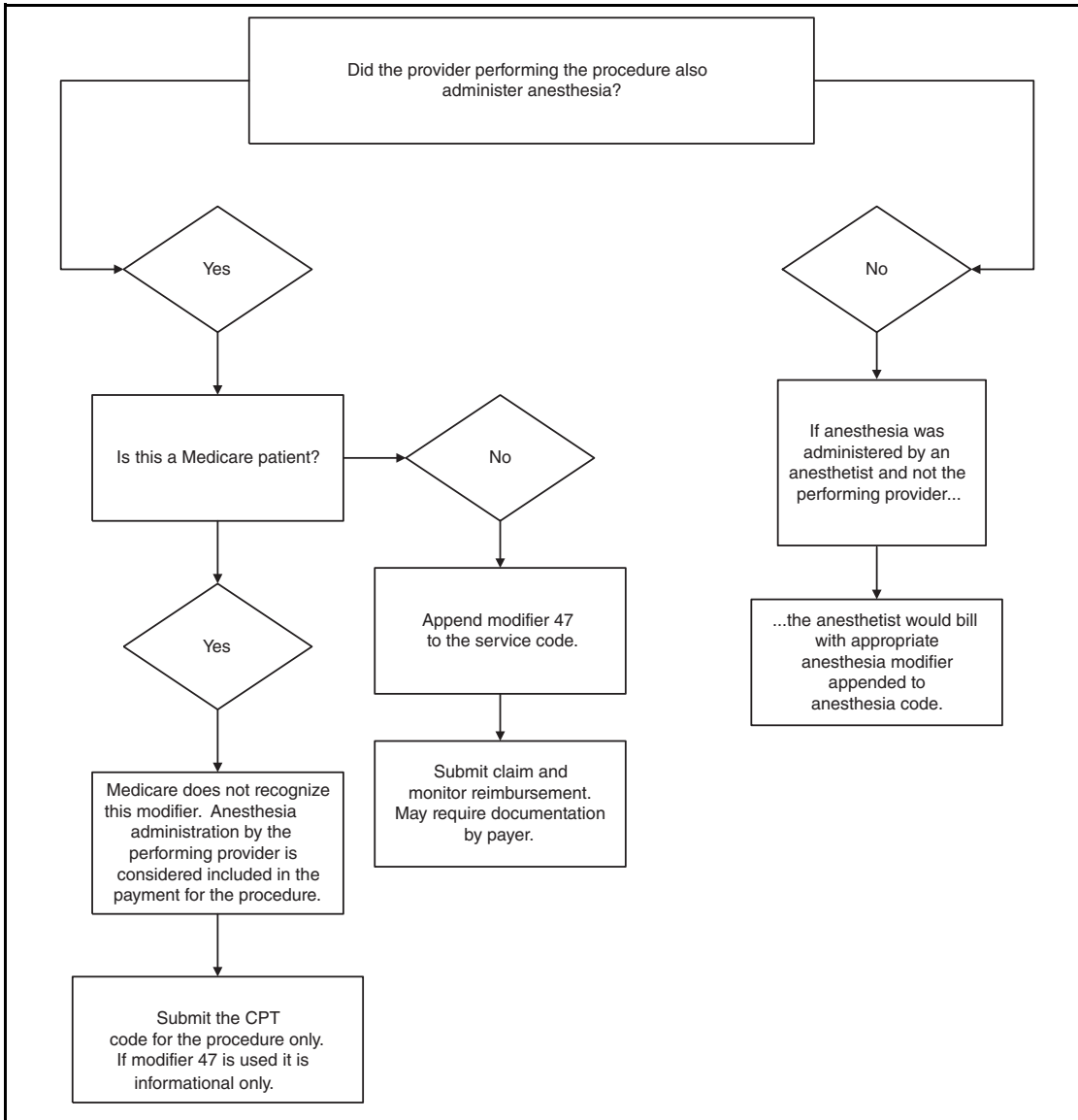


SPECIAL ALERT

Modifier 47 Anesthesia by surgeon, should not be used with anesthesia procedure codes (00100–01999). Rather, this modifier is reserved for use by the provider performing the surgery. The modifier should be appended to the procedure code to indicate the use of regional or general anesthesia administered by the surgeon.

The following flow chart can aid in an audit by helping determine if modifier 47 is being used correctly and whether additional documentation might be required.

Modifier 47



Chapter 4. Auditing Evaluation and Management Services

Evaluation and Management Codes

To make certain that evaluation and management (E/M) coding is reported correctly, it is essential to document the complete clinical picture in the medical record. Higher levels of service require more advanced documentation that supports not only the components of E/M codes but also the medical necessity of a higher level of service. In spite of years of examination and refining, E/M claims reviews remain a subjective endeavor. In simulated situations where documentation is borderline, justification to downcode the claim is as likely to be based on the time of day as it is the complexity of the medical decision. To be fair, recent studies show wide discrepancies when the same documentation was submitted to professional coders for code assignment as well. The physician specialty also has a bearing on code selection. A normal head and neck exam may involve something entirely different to an otolaryngologist than to an orthopedic surgeon.

From a coder's perspective, one of the most difficult instincts to curb is the desire to fill in missing information in the medical record to justify a code selection that seems intuitively or historically correct. As an auditor, determining that the documentation meets or exceeds the key components of the E/M code is imperative. Clearly, coders and auditors can never fill in, extrapolate, or assume that elements belong in the medical records that, in fact, do not appear there. If the documentation for a key E/M component does not meet or exceed the specified requirements for coding and reimbursement purposes, it should be viewed as if it was not performed.

Each E/M service is evaluated on the documentation for that service only; referring to information obtained from a prior history or exam is unacceptable grounds upon which to make a code assignment. The range of codes more accurately reflects the content and context of a visit than was ever remotely possible under the old levels of service codes.

As a result of these discrepancies and difficulties, E/M coding has ushered in an era of greater provider involvement in the coding process and increased clinical and technical demands on coding professionals.

Because evaluation and management (E/M) codes represent the most frequently reported services and comprise 70 to 80 percent of all billed services, they are the target of many payer audits and are also cited in the Office of the Inspector General (OIG) work plan every year. This chapter contains an overview of E/M services and includes guidance for auditing provider services.

Chapter 5. Auditing Anesthesia Services

Anesthesia services are distinctive in the manner in which they are billed; therefore, when the need arises to audit anesthesia services, it must be conducted in a unique way.

While most payers, including Medicare, reimburse anesthesia services under a fee schedule, the calculation used is different because anesthesia services are paid on a base unit and the amount of time spent providing the service. Additionally, the geographically specific conversion factor or dollar value used to convert the total relative value (base and time unit together) is different from that used to compute payment for other types of services. Since anesthesia codes are based on time units, documentation must include the start and stop time of the service and who provided the anesthesia. Other factors such as the type of anesthesia provided (general, monitored anesthesia care, conscious sedation), if the anesthesia service was personally performed or medically directed, type of provider, modifiers assigned, and code selection also affect anesthesia coding, billing, and payments.

The Reimbursement Process

Appropriate reimbursement for anesthesia services can sometimes be difficult because of the myriad of rules and paperwork involved. The following guidelines outline the various requirements utilized in these types of claims.

Coverage Issues

First, it is important to know which services are covered. Covered services are those payable by the insurer in accordance with the terms of the benefit-plan contract. Such services must be documented and medically necessary for payment to be made.

When in doubt, providers should consult with the specific payer or refer to national policies, national coverage determinations (NCD), and local coverage determinations (LCD) that address the reasonable and necessary provisions of a service.

Typically, payers define medically necessary services or supplies as:

- Services established as safe and effective
- Services consistent with the symptoms or diagnosis
- Services necessary and consistent with generally accepted medical standards
- Services furnished at the most appropriate, safe, and effective level

Documentation must be provided to support the medical necessity of a service, procedure, and/or other item. This documentation should show:

- What service or procedure was rendered
- To what extent the service or procedure was rendered
- Why the service, procedure, or other item was medically warranted

Chapter 6. Auditing Surgical Procedures

Auditing surgical services requires a unique approach. There are a number of coding, reporting, and payment guidelines that must be considered before determining if the claim is correct and supported by the medical record documentation.

When auditing surgical services, not only must the reviewer determine if the date of service, place of service, number of units, modifier application, and code selection is correct, the reviewer must also determine if the coder:

- Was in compliance with the global surgical package definition (items that are included in the surgical package, and should not be reported separately).
- Reported follow-up care unrelated to the surgical procedure, when applicable.
- Submitted additional, separately identifiable services with the appropriate modifier appended.
- Followed separate procedure guidelines.
- Billed supplies over and above the usual, when appropriate.
- Identified whether the provider was the surgeon, cosurgeon, or member of a surgical team.

Date of Service

The date of service on the claim must correspond with the date of service in the medical record. For services that extend beyond a single calendar day, such as an emergency appendectomy started at 11:45 p.m. and completed at 1:15 a.m. the next day, the date the procedure was started is usually indicated on the claim.

Medical Necessity

Medical necessity dictates that one would never do more than is necessary. The medical record documentation should describe the patient's condition and complaints; thereby, indicating the need for the service. These conditions are then translated into ICD-10-CM codes and reported on the claim form. It is the responsibility of the auditor to determine that what the clinician has documented as the patient's condition has been appropriately reported on the claim. ICD-10-CM codes should never be selected simply to ensure payment. See chapter 1 for more information on medical necessity and ICD-10-CM codes.

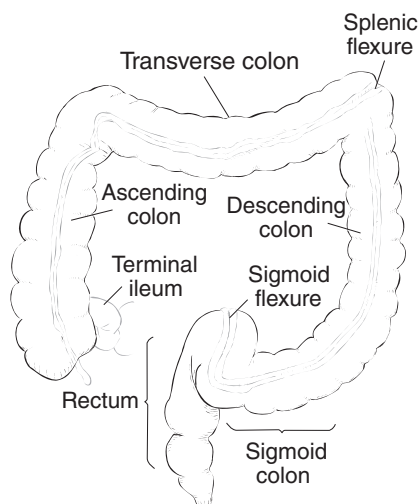
Complications and Unusual Services

Any intraoperative misadventure should be summarized in the complications section of the operative report. Specific information about the complication and the steps taken to remedy it are to be thoroughly documented in the procedure section of the medical report. Examine the medical record documentation to

Coding Traps

- If an endoscopy or enteroscopy is performed as a common standard of practice when performing another service, the endoscopy or enteroscopy is not separately reportable. For example, if a small intestinal endoscopy or enteroscopy is performed during the creation or revision of an enterostomy, the small intestinal endoscopy or enteroscopy is not reported separately.
- Control of bleeding that is the result of a surgical procedure is not reported separately. In the case of endoscopy, if it is necessary to repeat the endoscopy at a later time during the same day to control bleeding, a procedure code for endoscopic control of bleeding may be reported with modifier 78, indicating that this service represents a return to the endoscopy suite or operating room for a related procedure during the postoperative period.
- When biopsy of a lesion is performed followed by excision or destruction of the same lesion, the biopsy is not reported separately.
- If the same surgical endoscopy service is performed repeatedly (e.g., multiple polyps are removed through the scope), the service is reported only once.
- Services such as venous access (36000), infusions and injections (96360–96379), noninvasive oximetry (94760–94761), and anesthesia provided by the surgeon are considered an integral part of the endoscopy and should not be billed separately.
- When a surgical colonoscopy is performed, the diagnostic colonoscopy should not be reported separately.

Endoscopy of the Large Intestines and Anus (45300–45398, 46600–46615)



Procedure Differentiation

Proctosigmoidoscopy performed with a rigid scope is reported with 45300–45327. Code selection is based on the specific surgical treatment performed. Sigmoidoscopy performed with a flexible scope is reported with 45330–45350. Specific codes in this range identify the surgical procedures performed. Colonoscopy using a flexible scope is reported with 45378–45398. As with the other endoscopy procedures, the anatomical structures examined as well as any surgical service determine the actual code reported.

Colonoscopy is an examination from the rectum to the cecum, or the entire colon. It may also include the terminal ileum. Sigmoidoscopy examines the entire sigmoid colon and the entire rectum and may also include the descending colon. A proctosigmoidoscopy examines the rectum and sigmoid colon. These are performed to determine if blood, tumors, erosions, ulcers, or other abnormalities are present.

The CPT book has guidelines at the beginning of this endoscopy section for patients with altered anatomy due to prior surgical procedures. Below is a brief description of the guidelines:

For a patient with colon resection proximal to sigmoid with an anastomosis (ileo-sigmoid or ileo-rectal), report codes 45330–45347.

For a patient with colon resection with an anastomosis (ileo-anal or J-pouch), report codes 45385–45386.

For a patient with segmental colon resection, report codes 45378–45398.

Some endoscopic procedures are performed through an existing stoma or opening. The first step in choosing a code is to determine the access used to perform the procedure. The most common procedures are colostomies (44388-44408).

Anoscopies are reported with 46600-46615. In 46600, a diagnostic anoscopy is performed. The physician inserts the anoscope into the anus and advances the scope. The anal canal and distal rectal mucosa are visualized and brushings or washings may be obtained. Within this section, codes are further divided by the procedures performed (e.g., biopsy, dilation, removal of foreign body, and removal of tumor). Anoscopies may also be performed with high resolution magnification (HRA) as in codes 46601 and 46607.

Colorectal Cancer Screening

Regulatory Issues

Colorectal cancer is the third leading cause of cancer deaths in the United States. These types of cancers primarily affect people age 50 or older, with the risk of developing the disease increasing with age.

Colorectal cancers rarely display any symptoms, and the cancer can progress undiagnosed until it becomes fatal. The most common symptom of colorectal cancer is bleeding from the rectum. Other symptoms include cramping, abdominal pain, intestinal obstruction, or a change in bowel habits.

Colorectal cancer is largely preventable through screening since this allows a physician to identify and remove precancerous polyps. Screening can also detect malignancies early allowing for a good treatment outcome.

The Balanced Budget Act (BBA) of 1997 legislated Medicare coverage of colorectal screening. Under the BBA various types of colorectal cancer screening examinations became a covered service effective January 1, 1998. There are specific coverage, frequency, and payment limitations and these coverage guidelines may vary depending on the type of colorectal screening performed and/or the level of risk to the patient. Many non-Medicare payers also have strict guidelines regarding the coverage, frequency, and payment of colorectal cancer screening.

Chapter 7. Auditing Radiology Services

Radiology services have unique components that make coding, billing, and auditing more complex than other services. Some of the unique components include:

- Radiology services consist of two components: the technical and professional component.
- Radiology services may be diagnostic, therapeutic, or interventional.
- Radiology services can be performed in a variety of settings and by more than one provider.

When auditing radiology services, the auditor must determine:

- What service was provided?
- Where was the service performed?
- Who owns the equipment used to perform the service?
- Did the provider perform both the technical and professional components?
- Was more than one procedure performed?
- Are the procedures within the same family and, therefore, should the multiple procedure reduction apply?
- How many providers performed the service, and if more than one, who did what?
- Why was the service performed?
- Was the service for screening purposes?

The CPT® book provides guidelines for radiology codes at the beginning of the radiology section. Notes providing additional instruction may also be found at the beginning of many subsections. Additional instruction is also provided at the code categories or subcategories level, as well as parenthetical notes specific to a code or group of codes.

Date of Service

When auditing radiology services, the date of service in the medical record should be compared to the date of service on the claim and any discrepancies should be noted.

Medical Necessity

The medical necessity of radiology procedures must be supported by the reason the service was rendered. However, unlike surgical or evaluation and management services, the medical necessity of the service may be established by the provider who orders the service. For example, a patient presents to his or her primary care physician complaining of a cough. The primary care physician orders a chest x-ray from the radiology group located in the same medical

Chapter 10. After the Audit

Many practices develop excellent policies and procedures for auditing medical records but fail to use the results of the audit. Before an audit can be considered complete, the practice should:

- Compile a complete report of audit findings
- Develop an executive summary
- Calculate potential risks to lost revenue or revenue at risk
- Determine the root cause of the error
- Develop recommendations for a corrective action plan
- Implement an action plan
- Reevaluate the issue

While it seems that these steps can be more difficult to accomplish than the audit itself, by creating templates and using staff input it is not as daunting as it seems.

Developing the Audit Report

An audit report should identify a number of factors:

- Number of records reviewed
- Number of potential errors
- What the errors were
- Financial impact of errors
- Extrapolated impact of errors
- Recommendations
- Corrective action plan
- Potential costs of corrective action
- Implementation time frame
- Reevaluation date

Errors that appear to be isolated do not have to be addressed in the report; however, these errors should be corrected immediately. Patterns of inappropriate coding or billing errors should be specifically addressed in the report.

For example, if upon review a code number was inadvertently transposed on a claim, the claim should be corrected and resubmitted. This does not have to be addressed in the report. However, if during the audit it is noted that 75 percent of claims for colonoscopy with both punch and hot biopsy is performed but only the code for punch biopsy is reported, this should be discussed in detail.

For consistency and to ensure that all factors are addressed, the practice should consider developing an audit report template. The following is an example of the headings that could be used and the type of information that should be included in each.

Appendix 1. Audit Worksheets

Electronic Copies of Auditing Worksheets

This edition of the *Auditors' Desk Reference* includes access to Microsoft Word formatted copies of the auditing worksheets found in this manual. To access these worksheets go to this address: <http://www.optumcoding.com/Product/Updates/AUDR>

Please use the following password to access updates: AUDR18

Customers are permitted to reproduce these worksheets for use within their own facility or medical practice. Wider licensing of this content is available. Other distribution is prohibited.

These audit worksheets can be used when auditing the different areas of CPT® codes.

Modifier Worksheet

The following worksheet may be used to collect the necessary data when auditing a medical record for modifier use.

Modifier Worksheet

Account/medical record number:

Date of service:

Date of review:

Reviewer:

Type of review:

Documentation

	Supports Modifier Assignment		Provides Necessary Detail		Authenticated		Comments
	Yes	No	Yes	No	Yes	No	
Modifier							
Modifier							
Modifier							
Modifier							
Modifier							