OPTUM360®

DESK REFERENCE

# Auditors` Desk Reference

A comprehensive resource for code selection and validation



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# Contents





 

# Chapter 1.
# Auditing Processes and Protocols

Many years ago getting reimbursed for a service was simple, requiring only a handwritten or typed claim form that included the procedure performed, the fee, and the diagnosis. CPT® and ICD-10-CM codes were not necessary. Life was easy. Now the entire process has evolved and everything is much more complicated. Processes have been streamlined, requiring a uniform process for all providers to follow. This chapter discusses some of these processes, and includes information as to why it is necessary to include audits as a part of each practice.

## Claims Reimbursement

Receiving appropriate reimbursement for professional services can sometimes be difficult due to the complexity of rules involved. There are a number of things that are important to consider. The following section discusses some of the various requirements for getting a claim paid promptly and correctly.

### Coverage Issues

Covered services are services payable by the insurer in accordance with the terms of the benefit-plan contract. Such services must be properly documented and medically necessary in order for payment to be made.

Medical necessity has been defined by CMS as "services or supplies that are proper and needed for the diagnosis or treatment of [a] medical condition; are provided for the diagnosis, direct care, and treatment of [a] medical condition; meet the standards of good medical practice in the local area; and aren't mainly for the convenience of [a patient] or doctor."

Section 1862 (a)(1) of the Social Security Act prohibits Medicare from covering items and services that "are not reasonable and necessary for the diagnosis or treatment of illness or injury, or to improve the function of a malformed body member."

Typically, most payers define medically necessary services or supplies as:

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

**DENIAL ALERT**

Medical necessity denial decisions must be based on a detailed and thorough analysis of the patient's condition, need for care, safety and effectiveness of the service, and coverage policies.



 

# Chapter 2.
# 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 2021,* 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.



 

## CPT Modifiers and Applicable Sections

### Table 1

| Modifier | Brief Description | Applicable Sections |
|---|---|---|
| 22 | Increased procedural services | Anesthesia, Surgery, Radiology, Pathology and Laboratory, Medicine |
| 23 | Unusual anesthesia | Anesthesia |
| 24 | Unrelated evaluation and management service by the same physician or other qualified health care professional during a postoperative period | E/M |
| 25 | Significant, separately identifiable evaluation and management service by the same physician or other qualified health care professional on the same day of the procedure or other service | E/M |
| 26 | Professional component | Surgery, Radiology, Pathology and Laboratory, Medicine |
| 32 | Mandated services | E/M, Anesthesia, Surgery, Radiology, Pathology and Laboratory, Medicine |
| 33 | Preventive service | E/M, Surgery, Radiology, Pathology & Laboratory, Medicine (Services rated "A" or "B" by the USPSTF, Preventive care and screenings) |
| 47 | Anesthesia by surgeon | Surgery |
| 50 | Bilateral procedure | Surgery, Radiology, Medicine |
| 51 | Multiple procedures | Anesthesia, Surgery, Radiology, Medicine |
| 52 | Reduced services | Surgery, Radiology, Pathology and Laboratory, Medicine |
| 53 | Discontinued procedure | Anesthesia, Surgery, Radiology, Pathology and Laboratory, Medicine |
| 54 | Surgical care only | Surgery |
| 55 | Postoperative management only | Surgery, Medicine |
| 56 | Preoperative management only | Surgery, Medicine |
| 57 | Decision for surgery | E/M, Medicine |
| 58 | Staged or related procedure or service by the same physician or other qualified health care professional during the postoperative period | Surgery, Radiology, Medicine |
| 59 | Distinct procedural service | Anesthesia, Surgery, Radiology, Pathology and Laboratory, Medicine |
| 62 | Two surgeons | Surgery |
| 63 | Procedure performed on infants less than 4kg | Surgery |
| 66 | Surgical team | Surgery |



 

*Observation or Inpatient Care Services (Including Admission and Discharge Services)*

| E/M Code | History[1] | Exam[1] | Medical Decision Making[1] | Problem Severity | Coordination of Care; Counseling | Time |
|---|---|---|---|---|---|---|
| 99234 | Detailed or comprehensive | Detailed or comprehensive | Straight-forward or low complexity | Low | Consistent with problem(s) and patient's needs | 40 min. |
| 99235 | Comprehensive | Comprehensive | Moderate | Moderate | Consistent with problem(s) and patient's needs | 50 min. |
| 99236 | Comprehensive | Comprehensive | High | High | Consistent with problem(s) and patient's needs | 55 min. |

1 Key component. All three components (history, exam, and medical decision making) are crucial for selecting the correct code.

# Inpatient Services

In the inpatient setting, there are several types of services provided to patients, including:

- Initial inpatient hospital care
- Subsequent inpatient hospital care
- Hospital discharge
- Inpatient consultation

There are specific guidelines for reporting each type of inpatient service. These guidelines are covered in more detail below. Although these services are not outpatient, they rely on the same key and contributory components for code selection as those previously discussed. A few codes use time or other criteria that will be explained.

**DENIAL ALERT**

Inpatient services must report place of service code 21 for the inpatient setting to prevent claim denial.

## Initial Inpatient Hospital Care (99221–99223)

Initial inpatient care can be reported only for services provided by the admitting physician. Other physicians or other qualified health care providers providing initial inpatient E/M services should use consultation or subsequent hospital care codes, as appropriate. Combine all E/M services performed on the same date by the same provider that are related to the admission, regardless of where they were provided (e.g., emergency department, observation status, office, or nursing facility), and report the appropriate initial hospital care code.

The lowest level of initial hospital care should be reported when the admitting physician performed a detailed or comprehensive history and physical several days prior to admission and a lesser history and physical on the day of admission.

If a patient is admitted late in the evening on the first day and the physician does not see the patient until the next day, the admission history and physical (H&P), or initial inpatient service, is reported on the second day if that is when the service was performed. This E/M service is used to report the first face-to-face encounter between the patient and the provider in the inpatient setting.



 

### Coding Tips

- When a biopsy is performed as part of a lesion removal, the biopsy is a component of the overall procedure and is not reported separately.
- After lesion excision, the defect may require simple, intermediate, or complex closure and, in unusual circumstances, tissue transfer procedures. Bandaging, strip closure, or simple closure is considered to be a component of the excision and should not be reported separately. Intermediate, complex, or other types of complicated repair services must be thoroughly documented in the medical record to be reported separately.
- When a malignant lesion has been excised and a re-excision is performed to ensure that the entire lesion has been removed, the malignant lesion excision code is assigned to the second procedure, even though the pathology report may indicate no further evidence of malignancy at the margins. According to the AMA, because the patient had a previous malignancy at this site, the procedure should be coded as excision of a malignancy.
- Removal of a lesion from a previous mastectomy site would be assigned to the anatomic site "trunk," not "breast," since the breast is no longer present.
- For destruction of premalignant lesions, by any method, including laser, see 17000–17004; benign, see 17106–17111.
- For excision of a cicatricial lesion that is full thickness, see 11400-11406.
- For removal of skin tags, see 11200–11201.
- For destruction of extensive cutaneous neurofibroma lesions, see 0419T for more than 50 lesions of the face, head, and neck and 0420T for more than 100 lesions of the trunk and extremities.

## Nail Trimming (11719)

Code 11719 describes fingernail or toenail trimming, usually with scissors, nail cutters, or other instruments. This code is reported when the nails are not defective from nutritional or metabolic abnormalities and can be used for one or more nails.

### Coding Tips

- This code is reported only once regardless of the number of nails that are trimmed.
- Some non-Medicare payers may require that HCPCS Level II code S0390 be reported for this service when provided as routine foot care or as preventive maintenance in specific medical conditions.
- For diabetic patients with diabetic sensory neuropathy resulting in a loss of protective sensation (LOPS), see G0247.
- For trimming of nondystrophic nails, see 11719. For trimming of dystrophic nails, see G0127.

**YIELD DENIAL ALERT**

Medicare requires the use of specific HCPCS Level II modifiers Q7–Q9 to report clinical findings indicative of severe peripheral involvement, warranting the medical necessity of a podiatrist providing foot care, such as nail debridement or trimming, that would usually be considered routine and for which benefits would not be provided.

## Debridement (11720–11721)

### Procedure Differentiation

Codes from range 11720–11721 are reported for debridement of finger or toenails, including tops and exposed undersides, by any method. The cleaning is performed manually with cleaning solutions, abrasive materials, and tools. The



 

screening colorectal services, the patient is responsible for the copayment; however, the deductible is waived.

If a screening flexible sigmoidoscopy is performed in the outpatient department of a hospital or in an ambulatory surgical center, the patient is responsible for 25 percent of the Medicare approved amount.

The following table can be used to determine the reimbursement for colorectal cancer screening procedures and the patient's responsibilities.

| Type of Colorectal Screening | HCPCS Code(s) | Type of Payment | Deductible/Coinsurance |
|---|---|---|---|
| Cologuard | 81528 | Clinical Laboratory Fee Schedule (Medicare pays 100% of the Clinical Laboratory Fee Schedule amount or the provider's actual charge, whichever is lower.) | Deductible and coinsurance do not apply for this type of screening. |
| Fecal Occult Blood Tests | 82270, G0328 | Clinical Laboratory Fee Schedule (Medicare pays 100% of the Clinical Laboratory Fee Schedule amount or the provider's actual charge, whichever is lower.) | Deductible and coinsurance do not apply for this type of screening. |
| Flexible Sigmoidoscopy | G0104 | Medicare Physician Fee Schedule | Deductible and coinsurance do not apply for this type of screening. |
| Colonoscopy | G0105, G0121 | Medicare Physician Fee Schedule | Deductible and coinsurance do not apply for this type of screening. |
| Barium Enemas | G0106, G0120 | Medicare Physician Fee Schedule | Deductible does not apply. Coinsurance applies for this type of screening. |
| Screening Colonoscopy Resulting in a Surgical Procedure | Use appropriate CPT code for procedure performed | Medicare Physician Fee Schedule | Deductible applies. Payment responsible for coinsurance. Two ICD-10-CM codes should be reported, Z12.11 to indicate the screening and a second code indicating the condition found. |

**DENIAL ALERT**

When screening colonoscopy procedures are performed, be certain that the appropriate ICD-10-CM screening code is reported.

**Most Common Reasons for Claim Denial**

The following are the most common reasons for colorectal cancer screening claim denials:

- The patient does not meet the age requirements.
- The patient has exceeded the payer's frequency requirements.
- The patient does not meet the criteria for being at risk and therefore the procedure is noncovered because of the patient's age or the frequency of the service.

**FOR MORE INFO**

A list of the laboratory national coverage determinations can be found at http://www.cms.gov/Medicare/Coverage/CoverageGenInfo/LabNCDs.html.

# Medical Necessity

Payers cover laboratory services only when considered reasonable and necessary. Medicare has developed a set of Laboratory National Coverage Determinations (NCD). These NCDs differ from other Medicare NCDs in that ICD-10-CM codes are included. All codes are included on one of three lists: covered codes, noncovered codes, and codes that do not support medical necessity. The laboratory NCDs may be useful in determining when an ABN should be completed and signed by the patient in addition to determining coverage guidelines.

## Laboratory-Specific Documentation

Laboratory accrediting agencies, federal law (CLIA and OSHA), and state laws dictate specific documentation requirements for all phases of the analytic process and mandate the retention of:

- Test requisition
- Test records
- Test procedures
- Patient test reports (preliminary and final)
- Immunology test reports
- Pathology test reports
- Bone marrow reports
- Histopathology stained slides and blocks
- Cytology slides
- Accession log records
- Quality control activity records
- Blood and blood products quality control records
- Instrument maintenance records
- Personnel records
- Proficiency testing records
- OSHA training, inspection, and exposure records

Documentation must show that all tests were ordered by an authorized individual, correctly performed on the correct patient by qualified personnel, and timely reported to the ordering provider. Test results must be interpretable and accurate. Documentation must also be maintained to substantiate that test systems are operating correctly.

Regulatory agencies have indicated that records do not need to be in hard copy form. Records may be stored in computers, on tapes or disks, compact disks, microfilm, or microfiches as long as they can be retrieved within a reasonable period of time.

# 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: AUDR19

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 | | | | | | | |
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