Optum

Desk Reference

Auditors' Desk Reference

A comprehensive resource for code selection and validation

2024

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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

Documentation must be provided to support the medical necessity of a service, procedure, and/or other item. Remember, payers may request the medical record documentation to determine medical necessity. 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

Services, procedures, and/or other items that may not be considered medically necessary are:

- Services that are not typically accepted as safe and effective in the setting where they are provided
- Services that are not generally accepted as safe and effective for the condition being treated
- Services that are not proven to be safe and effective based on peer review or scientific literature
- Experimental or investigational services
- Services that are furnished at a duration, intensity, or frequency that is not medically appropriate
- Services that are not furnished in accordance with accepted standards of medical practice
- Services that are not furnished in a setting appropriate to the patient's medical needs and condition

If a service rendered is not deemed to be medically necessary, that service will be denied. For Medicare, unless the patient was previously notified of this fact and an Advance Beneficiary Notice (ABN, also referred to as a Waiver of Liability Statement) has been completed, the patient may not be billed for these services.

> **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 create a policy stating that a prospective review is performed on a specified number of claims as part of a compliance plan. The basic coding audit should include, at minimum, validation of CPT® code use, including the level of E/M visit assigned; undocumented or underdocumented services; correct use of modifiers; and accuracy of diagnosis codes and whether the source document supports medical necessity. Additional areas of review may include verifying that the correct place of service was billed, the correct category of service was billed, and whether there were services documented but not billed.

Step 4. Request necessary medical record, billing, and reporting documentation. To verify the accuracy of the services reported, request the patient chart to review the documentation. Also obtain copies of the superbill or charge ticket, along with a copy of the claim form. By examining these documents, problematic areas may be identified, such as data entry errors, use of outdated code sets, incorrect or missing modifier usage, or improperly sequenced surgery CPT codes, which can result in incorrect reimbursement.

Step 5. Assemble reference materials. Reference materials, such as current editions of coding manuals, NCCI edits, and CMS or other third-party policies pertinent to the services being reviewed, should be collected. When auditing evaluation and management (E/M) services, determine which set of CMS documentation guidelines and, if applicable, which exam guidelines (1995 or 1997) are appropriate for the review and have the corresponding E/M audit worksheet available.

> ✓ **Quick Tip**
>
> Keep current with weekly CMS updates by signing up for CMS e-news at https://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Electronic-Mailing-Lists. These notifications are published every Thursday and include Medicare updates and information about CMS national provider calls.

Step 6. Develop customized data capture tools. Use an audit worksheet. Audit worksheets (available in the appendix of this book) can aid in the audit process. They help verify that signatures were obtained, that patient identifying information (such as complete name, date of birth) is correct, that the practice is in compliance with "incident-to" guidelines, and that time-based codes are documented and reported appropriately.

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 2022,* 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.

Types of Modifiers

There are basically two types of modifiers: informational modifiers (those that do not affect payment) and payment modifiers (modifiers that affect reimbursement).

Informational Modifiers

Although informational modifiers may not have a direct impact on reimbursement, it should be noted that the improper use of an informational modifier may affect coverage of a service or procedure. Failure to use or to apply informational modifiers correctly may result in claim denial or can affect balance billing.

For example, a patient receives a service that is unlikely to be covered by Medicare. The office fails to complete an advance beneficiary notice (ABN); however, the claim is submitted with modifier GA Waiver of liability statement on file, appended to the procedure code. The Medicare contractor contacts the office and requests that the completed waiver be faxed as proof that it was obtained.

Since the office cannot comply, the service is denied and the Medicare remittance advice (RA) indicates that the patient cannot be billed for the noncovered service.

Payment Modifiers

Other modifiers have a direct impact on the amount a provider may be paid for a service or procedure. For example, a physician provides only the postoperative care following a laparoscopic cholecystectomy. In this instance, CPT code 47562 Laparoscopy, surgical; cholecystectomy, is submitted with modifier 55 Postoperative management only, appended to the code. The payer reimburses the physician the postoperative care portion of the procedure fee only.

Using Modifiers

There are two levels of modifiers within the HCPCS coding system. Level I (CPT) and Level II (HCPCS Level II) modifiers are applicable nationally for many third-party payers and all Medicare Part B claims. Level I or CPT modifiers are developed by the American Medical Association (AMA). HCPCS Level II modifiers are developed by the Centers for Medicare and Medicaid Services (CMS).

The Health Insurance Portability and Accountability Act (HIPAA) guidelines indicate that all codes and modifiers are to be standardized. Some coding and modifier information issued by CMS differs from the AMA's coding advice in the CPT book; a clear understanding of each payer's rules is necessary to assign such modifiers correctly.

Generally speaking, modifiers are specific to certain sections of the CPT book. The following table contains a list of CPT modifiers and the CPT section to which they can be applied.

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

- Clinical psychologists
- Clinical social workers
- Nurse-midwives
- Registered dietitians or nutrition professional

Telehealth services are reimbursed when they are provided using technology that is designated as a real-time interactive audio and video telecommunications system. To demonstrate that the telehealth services furnished have been provided with this specific technology, CMS established two HCPCS Level II modifiers to be appended the CPT code of the service provided. The modifiers are GT Via interactive audio and video telecommunication systems, and GQ Via asynchronous telecommunications system.

When services are performed using asynchronous telecommunication, HCPCS Level II modifier GQ should be appended to the CPT code of the service provided. The use of asynchronous telecommunication is restricted to demonstration programs in Alaska and Hawaii. When using modifier GQ, the provider is certifying the asynchronous medical file was collected and transmitted to the distant site from a federal telemedicine demonstration project conducted in Alaska or Hawaii.

> **Auditor's Alert**
>
> Providers submitting codes for telehealth services to Medicare administrative contractors (MAC) should use telehealth POS code 02 to certify that the service performed was furnished as a professional telehealth service from a distant site.

For payers that do not recognize these HCPCS Level II modifiers, CPT modifier 95 Synchronous Telemedicine Service Rendered Via a Real-Time Interactive Audio and Video Telecommunications System, should be appended to the service provided. A list of applicable CPT codes for reporting real time telehealth services with modifier 95 can be found in Appendix P of the CPT book.

> **Auditor's Alert**
>
> The current list of Medicare's approved telehealth can be found at: https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes. This list includes temporary codes that are valid during the remainder of the PHE for the COVID-19 pandemic and codes that qualify for audio-only services.

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Temporary Expansion of Telehealth Services Due to Covid-19 Public Health Emergency

On March 17, 2020, the Centers for Medicare and Medicaid Services (CMS) announced the emergent and temporary expansion of telehealth services. CMS is expanding the telehealth benefit on a temporary and emergency basis under the 1135 waiver authority and Coronavirus Preparedness and Response Supplemental Appropriations Act. Beginning March 6, 2020 and through the duration of the Public Health Emergency (PHE), Medicare can reimburse telehealth services, including office, hospital, and other visits furnished by physicians and other practitioners to patients anywhere in the United States, including the patient's place of residence. Many services have been temporarily added to the Medicare list of eligible telehealth services, and some frequency limitations and other requirements have been removed. These changes have been made to encourage the substitution of in-person services, thus reducing exposure risks for patients, practitioners, and the community at large. These telehealth services are not limited to patients with COVID-19 but must be considered reasonable and necessary.

> **Key Point**
>
> For additional guidance regarding telehealth services during the public health emergency (PHE) due to COVID-19, refer to the Medicare FAQ, Section P, at: https://www.cms.gov/files/document/03092020-covid-19-faqs-508.pdf.

All health care practitioners who are authorized to bill Medicare for their services may also furnish and bill for telehealth services during the PHE including physical therapists, occupational therapists, speech language pathologists, licensed clinical social workers, and clinical psychologists. Telehealth services should include the same level of documentation that would ordinarily be provided if the services were furnished in person.

The following areas have been revised for the duration of the PHE Site of service:

- Originating site
  - Telehealth services can be provided to patients wherever they are located, including their home.

Medical Necessity
Multiple indications for these services exist for them to be performed; verify coverage with the payer.

Key Documentation Terms
Medical record documentation must indicate that a section of the lesion was removed for the sole purpose of examination and not as a means of removing the entire lesion. Key terms include single or multiple lesions as well as the type of biopsy performed.

A common documentation error is one in which the provider fails to document the exact number of lesions biopsied when performed on more than one lesion. When this occurs, the claim should indicate only the number of lesions clearly documented or, in some cases, only one lesion. Provider education should be performed to prevent this from occurring.

Coding Tips
- As "add-on" codes, 11103, 11105, and 11107 are not subject to multiple procedure rules. No reimbursement reduction or modifier 51 is applied. The following table provides additional information for these codes as found in the Medicare Physician Fee Schedule Database.

Parent Code	Add-On	GLOB DAYS	MULT PROC	BILAT SURG	ASST SURG	COSURG	TEAM SURG
11102		000	2	0	1	0	0
	11103	ZZZ	0	0	1	0	0
11104		000	2	0	1	0	0
	11105	ZZZ	0	0	1	0	0
11106		000	2	0	1	0	0
	11107	ZZZ	0	0	1	0	0

- To report the removal of a lesion by shave technique, see 11300–11313.
- To report the complete removal of a lesion (including margins), see 11400–11646.
- To report the biopsy of the lip see, 40490.
- To report the biopsy of the vestibule of mouth, see 40808.
- To report the biopsy of a nail unit, see 11755.

Skin Lesion Removal: Shaving (11300–11313)
These codes are used to report the sharp removal of epidermal or dermal lesions by a transverse or horizontal slicing method (shaving).

Procedure Differentiation
Appropriate code selection is determined by the location and size of the lesion. Shaving is a method of removal that would not require a suture closure. The codes include chemical or electrocauterization. When measuring the size of the lesion, the borders around the area are not considered part of the lesion diameter.

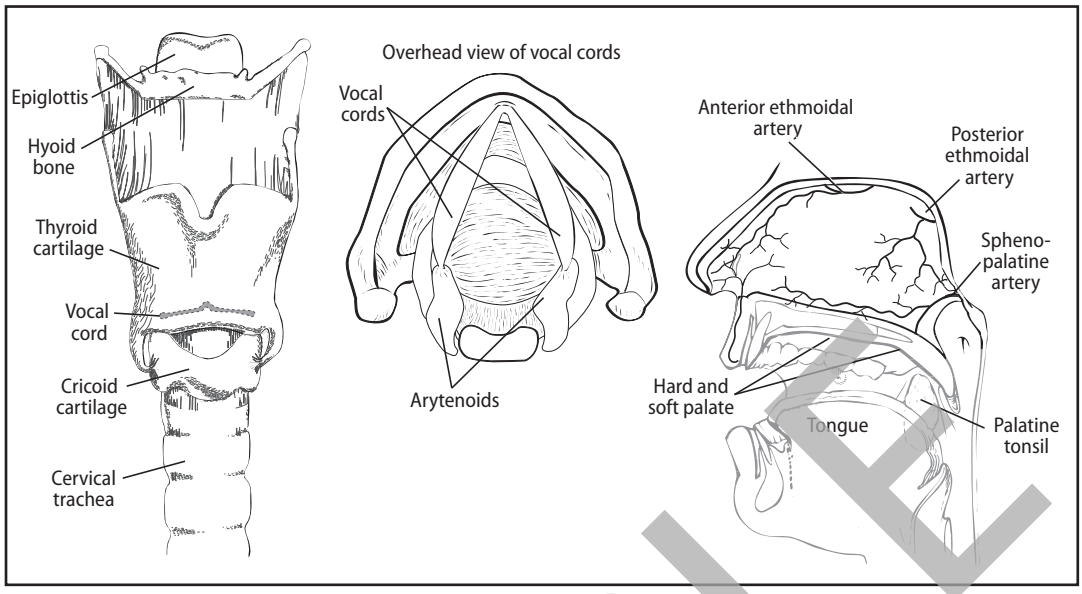
Medical Necessity
The following conditions may warrant these procedures (this list is not all inclusive):

- Actinic keratosis
- Inflamed seborrheic keratosis
- Molluscum contagiosum
- Viral and plantar warts

Definitions
actinic keratosis. Flat, scaly precancerous lesions appearing on dry, sun-aged, and overexposed skin, including the eyelids.

seborrheic keratosis. Common, benign, noninvasive, lightly pigmented, warty growth composed of basaloid cells that usually appear at middle age as soft, easily crumbling plaques on the face, trunk, and extremities.

Endoscopy of the Larynx (31505–31579)



Very simply, a laryngoscopy visualizes the interior of the tongue base, larynx, and hypopharynx; it can be done for diagnostic purposes or surgical purposes. Within the structures examined, there are midline (single anatomic sites) and paired structures. When reporting procedures, if one side of a paired structure is involved then a unilateral code is reported. The structures are identified below.

Midline	Paired
Epiglottis	Arytenoids
Posterior pharyngeal wall	Aryepiglottic folds
Subglottis	False vocal cords
Tongue base	Pyriform sinuses
Vallecula	True vocal cords
	Ventricles

There are different approaches that may be used, including indirect, direct, and direct operative. Each is explained briefly below.

Procedure Differentiation

An indirect laryngoscopy involves the visualization of the larynx using a warm laryngeal mirror positioned at the back of the throat and a head mirror held in front of the mouth containing a light source. This method should be attempted prior to considering a flexible or rigid laryngoscopy.

Direct laryngoscopy involves the visualization of the tongue base, larynx, and hypopharynx by passing a rigid or flexible fiberoptic endoscope through the mouth and pharynx to the larynx. If the laryngoscopy was direct, ascertain whether the procedure was performed with an operating microscope (microsurgery), telescope, or flexible fiberoptic scope. A flexible laryngoscopy is often used when gagging limits the mirror used in an indirect exam, as well as to obtain a more clear view of laryngeal structures when the diagnostic need arises.

Operative direct laryngoscopy involves an examination of the tongue base, larynx, and hypopharynx by the passing of a rigid or fiberoptic endoscope through the mouth and pharynx to the larynx with the patient under general anesthesia.

Separate endoscopic codes are provided for direct and indirect procedures; procedures on newborns; and diagnostic, biopsy, foreign body removal, and injection procedures. Review each code description carefully and review the provider's documentation before assigning the code.

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?

> **Auditor's Alert**
> See appendix 1 for the audit worksheet for radiology procedures.

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 building. On the request for the service, the primary care physician should indicate the reason the service is being ordered.

When completing the claim form, ICD-10-CM coding guidelines indicate that the radiologist should identify the reason the service was requested unless another definitive diagnosis was established as a result of the service. In other words, if after interpreting the chest x-ray in the scenario above the radiologist notes that the patient has pneumonia, the diagnosis reported should be pneumonia.

There will be times, however, that the request does not contain a reason for the service. In this instance, the medical record should include documentation that the requesting provider was contacted, and that a reason for the service was provided. Additionally, there may be times when the radiology practice may contact the referring provider to obtain additional information regarding the patient's condition to further substantiate the medical necessity of the service. This, too, should be well documented.

Medical record documentation must also necessitate the need for certain screening services. When a service such as a screening mammography is performed, it is imperative that the claim indicates the appropriate Z code to identify the screening nature of the service. Failure to do so can result in claim denial, inappropriate payment, or inappropriate costs to the patient.

Chapter 8. **Auditing Pathology and Laboratory Procedures**

The pathology and laboratory CPT® codes (80047–89398 and 0001U–0354U) are used for those services provided by a reference, hospital, or physician laboratory. **Note:** A draw station is not a laboratory. It is a place where a specimen is collected but no laboratory testing is performed on the specimen.

Laboratory and Pathology Coding and Billing Considerations

A laboratory is defined as any facility that performs laboratory testing on specimens derived from humans for the purpose of providing information for the diagnosis, prevention, and treatment of disease or impairment, or assessment of health. A diagnostic laboratory test is considered a laboratory service for billing purposes, regardless of where it is performed.

Some factors that can influence billing and payment of laboratory services include:

- Clinical Laboratory Improvement Amendment (CLIA) status
- Point of service
- Billing authority
- Code selection
- Modifier assignment
- Units of service
- Qualifying circumstances

> **Auditor's Alert**
> See appendix 1 for the audit worksheet for laboratory procedures.

Clinical Laboratory Improvement Amendments Status

CMS regulates all laboratory testing (except research) performed on humans in the U.S. through the Clinical Laboratory Improvement Amendments (CLIA). The objective of the CLIA program is to ensure quality laboratory testing. All clinical laboratories must enroll in CLIA and they must be certified to test in order to receive Medicare or Medicaid payments. The type of certification is dependent upon the complexity of the test being performed. There are three basic levels of CLIA tests: waived, moderate, and high-complexity. Each level of complexity has a set of personnel requirements, as well as proficiency standards that must be met in order for that entity to be certified. This information can be found on the Center for Disease Control website at http://www.cdc.gov/CLIA/default.aspx. CLIA certified laboratories are able to bill for laboratory procedures that fall within their certification level. The CLIA number must be entered on the claim as a condition for payment. Medicare contractors deny claims for diagnostic clinical laboratory tests performed if the laboratory CLIA certificate is expired or the laboratory performs a testing outside the scope of their certificate.

There are five types of certification that a laboratory can receive:

- **Certificate of Waiver:** Permits the laboratory or physician practice to perform only waived tests. Waived tests have been deemed simple and accurate and have little risk of error. Examples of waived tests include fecal occult blood tests and some types of urinalysis. A list of CLIA waived tests can be found at https://www.cms.gov/Regulations-and-Guidance/Legislation/CLIA/downloads/waivetbl.pdf.

> **Coding Axiom**
> Modifier QW must be appended to the procedure code when billing for CLIA waived tests, unless otherwise indicated by the payer.

- **Certificate for Provider-Performed Microscopy (PPMP):** PPMP is a subset of the moderate complexity testing methodology. This certificate is required when a physician, dentist, or other mid-level provider (e.g., nurse midwife, nurse practitioner, physician assistant) performs only certain microscopy procedures, such as urine microscopic examination or KOH smear examinations. The physician, mid-level practitioner (under supervision if required by the state), or dentist must personally perform the procedure on specimens obtained during the visit. A laboratory or practice that has this type of waiver may also perform waived tests. While routine on-site surveys are not required for the PPMP Certificate, any PPMP certified entity is subject to the same moderate complexity requirements and can be surveyed by CMS as part of a routine survey for nonwaived tests or when a complaint is reported. A complete list of tests considered to be PPMP can be found at https://www.cms.gov/Regulations-and-Guidance/Legislation/CLIA/Downloads/ppmplist.pdf.

Coronavirus Disease COVID-19

The American Medical Association (AMA) continues to implement new CPT codes for the COVID-19 vaccines and administration codes for each. The codes are effective and have received emergency use authorization approval from the Food and Drug Administration (FDA).

> **Auditor's Alert**
> Medicare has created a HCPCS Level II code for the administration of the COVID-19 vaccine in the patient's home. To report the administration use code M0201.

COVID-19 codes are unusual in that they are distinct to each coronavirus vaccine manufacturer and the specific dose, making it possible to track the vaccines. To correctly report a COVID-19 vaccine, two codes are required: a code for the vaccine and the correct immunization administration code. The vaccine codes are defined by manufacturer; the administration codes are also specific to each manufacturer and are further defined by the particular dose (e.g., first, second, or booster) the patient is receiving. Manufacturer and dosing information can be found in appendix Q of the 2023 CPT book. It is important to note that each manufacturer has a different dosing interval.

The following table illustrates each manufacturer's dosing interval.

Manufacturer	Dosing interval
Pfizer	21 days
Moderna	28 days
AstraZeneca	28 days
Janssen	N/A single dose
Novavax	21 days

Boosters for Pfizer and Moderna may be administered six months after the patient receives the second dose of the vaccine.

The current COVID-19 vaccines and administration codes are as follows:

CPT	Description	Manufacturer
91300	Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, preservative free, 30 mcg/0.3mL dosage, diluent reconstituted, for intramuscular use	Pfizer
0001A	Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, preservative free, 30 mcg/0.3mL dosage, diluent reconstituted; first dose	Pfizer
0002A	Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, preservative free, 30 mcg/0.3mL dosage, diluent reconstituted; second dose	Pfizer
0003A	Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, preservative free, 30 mcg/0.3 mL dosage, diluent reconstituted; third dose	Pfizer
0004A	Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, preservative free, 30 mcg/0.3 mL dosage, diluent reconstituted; booster dose	Pfizer
91301	Severe acute respiratory syndrome coronavirus 2 (SARS-CoV2) (Coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, preservative free, 100 mcg/0.5mL dosage, for intramuscular use	Moderna
0011A	Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, preservative free, 100 mcg/0.5mL dosage; first dose	Moderna
0012A	Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, preservative free, 100 mcg/0.5mL dosage; second dose	Moderna
0013A	Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, preservative free, 100 mcg/0.5 mL dosage; third dose	Moderna

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: www.optumcoding.com/2022AUDRWorksheets. Please use the following password to access updates: o360audr22

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.

Account/medical record number: _____ Date of service: _____

Reviewer: _____ Date of review: _____

Type of review: _____

Documentation

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

Assignment

	Correct Modifier Assigned		Appended to Correct Code		Valid for Procedure		Guidelines Applied		No Code Describing Service		Comments
	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	
Modifier											
Modifier											
Modifier											

Reimbursement

	Fee Revisions Made		Comments
	Yes	No	
Modifier			
Modifier			
Modifier			

Payer Issues

	Modifier Processed		Payment Adjustment Made Correctly		Prevent Denial		Comments
	Yes	No	Yes	No	Yes	No	
Modifier							
Modifier							
Modifier							

Claim Issues

	Indicated on Claim Correctly		Claim Attachments Submitted			Payer Inquiries Responded To			Comments
	Yes	No	Yes	No	N/A	Yes	No	N/A	
Modifier									
Modifier									
Modifier									