

# Auditors` Desk Reference

A comprehensive resource for code  
selection and validation

**2022**

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## 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.

# 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.

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## 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 <sup>1</sup>	Exam <sup>1</sup>	Medical Decision Making <sup>1</sup>	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.

<sup>1</sup> 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.

### 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.



#### DENIAL ALERT

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



**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.

**DEFINITIONS**

**currettage.** Removal of tissue by scraping.

**distal.** Located farther away from a specified reference point or the trunk.

**frostbite.** Damage to skin, subcutaneous, and possibly deeper tissue caused by exposure to low temperatures, resulting in ischemia, thrombosis, even gangrene, and the loss of affected body parts.

**onychauxis.** Congenital condition in which the nails are hypertrophied.

**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.

**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 nails are shortened and shaped. For one to five nails, see 11720; six or more nails, see 11721.


**Medical Necessity**

The following conditions may warrant nail debridement (this list is not all inclusive):

- Crushing injury
- Frostbite
- Infection
- Ingrown toenail
- Mycosis of the toenail
- Onychauxis
- Onychogryphosis

**Coding Tip**

- Correct Coding Initiative (CCI) edits prohibit separate reporting of code 11720 Nail debridement by any method, one to five nails, with code 11719 Trimming of nondystrophic nails. This edit is often bypassed by using modifier 59. According to CMS, the use of modifier 59 to bypass this edit is only appropriate when the trimming and debridement of the nails are performed on different nails or if the two procedures are performed at separate patient encounters.
- Correct Coding Initiative (CCI) edits prohibit reporting codes 11055-11057 for removal of hyperkeratotic skin on the same digit a nail is also debrided (11720-11721).

 **DENIAL ALERT**

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

Type of Colorectal Screening	HCPCS Code(s)	Type of Payment	Deductible/Coinsurance
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.

**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.
- Procedure code and diagnosis code do not match (i.e., diagnosis indicates a screening examination; however, procedure code indicates a diagnostic examination)
- Provider does not indicate that the procedure is screening by reporting Z12.11.

**Procedures Performed on the Anus (46020–46999)**

***Surgical Incision of the Anus (46020–46083)***

Incision codes include placement of a seton (46020). The physician makes an incision in the anal opening. A suture is passed and the seton is securely tied using a rubber band, or similar technique. A nylon suture is threaded around the sphincter and tied loosely. An elastic band is secured to the suture and a safety pin is attached. The pin is taped to the patient's thigh and the patient is instructed to adjust the amount of pull to produce minimal discomfort until the seton cuts through. Code 46030 reports the removal of a seton.

Treatment of an abscess by incision and drainage is reported with 46040–46060 according to the site and extent of the repair. Incision into the anal sphincter (sphincterotomy) is reported with 46080. In this procedure, the physician divides the anal sphincter. The patient is placed in jackknife or lithotomy position. The physician performs digital and instrumental dilation of the anus with exposure of the patient's anal canal. A small incision is made between the

 **DEFINITIONS**

**seton.** Finely spun thread or other fine material for leading the passage of wider instruments through a fistula, canal, or sinus tract.

**sphincter.** Ring-like band of muscle that surrounds a bodily opening, constricting and relaxing as required for normal physiological functioning.

**thrombosed hemorrhoid.** Dilated, varicose vein in the anal region that has clotted blood within it.

Tests that are not usually performed using the automated testing methodology can be billed separately. For example, if in addition to the tests indicated above the physician also orders an A1C (by chromatography) (83036), the Medicare contractor would pay for 80047 and 83036.

### Nonpatient Testing

Nonpatient testing is when the hospital performs testing on patients who are not being treated in the facility—the specimen is obtained by personnel other than one employed by the hospital. In these instances, the hospital is acting as a reference laboratory. Claims for nonpatient testing are reported using a bill type of 0141 on the UB-04 claim.

### Payment for Review of Laboratory Test Results by Physician

Reviewing results of laboratory tests, phoning results to patients, filing such results, etc., while considered a Medicare-covered service, are not separately billable. Payment for these services are included in the physician fee schedule payment for the evaluation and management (E/M) service.

Clinical pathology consultation services (80500–80502) include a written report with medical interpretation of the results. More information regarding these codes can be found elsewhere in this chapter.

### Billing for Noncovered Tests

Medicare does not allow a provider to bill for services that are denied as not medically necessary unless the provider has had a patient sign a completed Advance Beneficiary Notice (ABN) of noncoverage.

It is very important that the ABN is completed before the patient signs. A common error that physician practices make is to have the patient sign a blank ABN or one that does not indicate the reason a laboratory test is likely to be denied as noncovered.

### 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)



#### KEY POINT

The ABN must be completed BEFORE obtaining a patient's signature.



#### SPECIAL ALERT

A revised Advance Beneficiary Notice of Noncoverage (ABN), Form CMS-R-131, has been approved. Use will be mandatory starting 8/31/20. More information can be found at: <https://www.cms.gov/Medicare/Medicare-General-Information/BNI/ABN>



#### FOR MORE INFO

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

# 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.

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							