Optum

Desk Reference

Auditors' Desk Reference

A comprehensive resource for code selection and validation

2026

optumcoding.com

Contents

Introduction

Auditor's Desk Reference is a reference guide that helps providers or auditors to select or validate the correct code and staff and compliance personnel to ensure that the medical record documentation substantiates the code selected.

The guide provides:

- Exploration of auditing processes and protocols with key areas that readers must be familiar with before proceeding with an audit
- In-depth discussion of setting parameters for an audit
- Detailed explanation of CPT® and HCPCS modifiers with modifier decision flow charts
- American Medical Association (AMA) guidelines for accurate evaluation and management (E/M) code selection and the documentation criteria necessary to support each E/M code
- Code selection and validation guidelines for anesthesia, surgical procedures, radiology services, and pathology and laboratory procedures
- Guidance for developing an auditing report and tips for corrective action

In addition to being a resource for solving day-to-day coding and documentation problems, the *Auditor's Desk Reference* can be used as a teaching tool for inservice education and as a source book for seminars, coding and documentation training programs, and college and university courses.

Auditor's Desk Reference does not replace the CPT code book, nor does it contain all the coding guidelines created by the AMA. Rather, it is to be used to understand proper code selection and the linkage to medical record documentation.

This manual includes coding and documentation guidance that is derived from official government source information and the AMA. This manual provides the most current information that was available at the time of publication. This publication went to press before the official Medicare Physician Fee Schedule (MPFS) release; therefore, the October 2024 MPFS information, including the global days and status indicators, are referenced in the tables in chapter 6, "Auditing Surgical Procedures" and chapter 9, "Auditing Medical Services." Any pertinent changes to source information in this manual will be posted to the following website address:

https://www.optumcoding.com/Product/Updates/

This website is available only to customers who purchase the *Auditor's Desk Reference*, using the following password: **XXXXXX**

The Physician's Role

The AMA's CPT book advises coders that the procedures and services listed throughout the book are for use by any qualified physician or other qualified health care professional or entity (e.g., hospitals, laboratories, or home health agencies).

Other qualified health care professional: The use of the phrase "other qualified health care professional" was adopted to acknowledge the contributions from a health care provider other than a physician. This type of provider is further described in the CPT book as an individual "qualified by education, training, licensure/regulation (when applicable), and facility privileging (when applicable) who performs a professional service within his/her scope of practice and independently reports that professional service." The professionals within this definition are separate from "clinical staff." The CPT book defines clinical staff as "a person who works under the supervision of a physician or other qualified health care professional and who is allowed by law, regulation, and facility policy to perform or assist in the performance of a specified professional service but who does not individually report that professional service." Keep in mind that other policies or professional guidance can affect who may report a specific service.

How to Use *Auditor's Desk Reference*

This manual walks you through auditing protocols, including how to manage denials and appeals, provides guidance on how to create and maintain appropriate audit activities, and defines modifiers and appropriate usage, as well as steps to take post audit. Six chapters are dedicated to auditing practices related to:

- Evaluation and management services
- Anesthesia services
- Surgical procedures
- Radiology services
- Pathology and laboratory procedures
- Medical services

Two appendixes supplement the content of this manual. Appendix 1 provides auditing worksheets that medical practices can use to audit different areas of CPT codes. Appendix 2 provides a list of place-of-service codes reported on professional claims.

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 functioning 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. In addition, encoder software can be an efficient tool with multiple coding resources in one place.

For More Info

Keep current with weekly CMS updates by signing up for CMS e-news at https://www.cms.gov/training-education/Medicare-learning-network/newsletter. 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.

General Coding Principles That Influence Payment

This section addresses general coding principles, issues, and policies that should be applied when reporting services or procedures performed. They should also be used as a guide when auditing services and procedures to make sure that they have been adhered to. The principles in this section are taken from the Medicare NCCI Policy Manual and are strictly enforced by Medicare. As always, other payers tend to follow suit. Examples within the text are often utilized to clarify principles, issues, or policies and do not represent the only codes to which the principles, issues, or policies apply.

Correct Coding Initiative

The Health Insurance Portability and Accountability Act established standard code sets that must be used for reporting procedures and services. The regulation identifies the HCPCS/CPT coding systems as the required code sets. Providers utilize these code sets to report medical services and procedures to most third-party payers.

HCPCS (Healthcare Common Procedure Coding System) consists of Level I CPT (Current Procedural Terminology) codes and Level II codes. CPT codes are defined in the American Medical Association's (AMA) CPT book, which is updated and published annually. HCPCS Level II codes are defined by CMS and are updated throughout the year as necessary. Changes in CPT codes are approved by the AMA CPT Editorial Panel, which meets three times per year.

CPT and HCPCS Level II codes define medical and surgical procedures performed on patients. Some procedure codes are very specific defining a single service (e.g., code 93000 Electrocardiogram) while other codes define procedures consisting of many services (e.g., code 58263 Vaginal hysterectomy, for uterus 250 g or less; with removal of tube(s) and/or ovary(s), with repair of enterocele). Because many procedures can be performed by different approaches, different methods, or in combination with other procedures, there are often multiple HCPCS/CPT codes defining similar or related procedures. CPT and HCPCS Level II code descriptors usually do not define all services included in a procedure. There are often services inherent in a procedure or group of procedures. For example, anesthesia services include certain preparation and monitoring services.

CMS developed the NCCI program to prevent inappropriate payment of services. Prior to April 1, 2012, there were two tables, NCCI "Column One/Column Two Correct Coding Edit Table" or the "Mutually Exclusive Edit Table." However, on April 1, 2012, the edits in the "Mutually Exclusive Edit Table" were moved to the "Column One/Column Two Correct Coding Edit Table" to simplify researching NCCI edits. The NCCI table contains edits that are pairs of HCPCS/CPT codes that, in general, should not be reported together. Each edit has a column one and column two HCPCS/CPT code. If a provider reports the two codes of an edit pair, the column two code is denied, and the column one code is eligible for payment. However, if it is clinically appropriate to utilize an NCCI-associated modifier, both the column one and column two codes are eligible for payment.

When the NCCI program was established and during its early years, the "Column One/Column Two Correct Coding Edit Table" was termed the "Comprehensive/Component Edit Table." This latter terminology was a misnomer. Although the column two code is often a component of a more comprehensive column one code, this relationship is not true for many edits. In the latter type of edit, the code pair edit simply represents two codes that should not be reported together. For example, a provider should not report a vaginal hysterectomy code and total abdominal hysterectomy code together.

Use of the term "physician" does not restrict the policies to physicians only, but applies to all providers eligible to bill the relevant HCPCS/CPT codes pursuant to applicable portions of the Social Security Act (SSA) of 1965, the Code of Federal Regulations (CFR), and Medicare rules.

Procedures shall be reported with the most comprehensive CPT code that describes the services performed. Physicians must not unbundle the services described by a HCPCS/CPT code. Some examples follow:

- A physician should not report multiple HCPCS/CPT codes when a single comprehensive HCPCS/CPT code describes these services. For example, if a physician performs a vaginal hysterectomy on a uterus weighing less than 250 grams with bilateral salpingo-oophorectomy, the physician shall report code 58262 Vaginal hysterectomy, for uterus 250 g or less; with removal of tube(s), and/or ovary(s). The physician should not report code 58260 Vaginal hysterectomy, for uterus 250 g or less; in addition to code 58720 Salpingo-oophorectomy, complete or partial, unilateral or bilateral (separate procedure).
- A physician should not fragment a procedure into component parts. For example, if a physician performs an anal endoscopy with biopsy, the physician shall report code 46606 Anoscopy; with biopsy, single or multiple. It is improper to unbundle this procedure and report code 46600 Anoscopy; diagnostic,..., in addition to code 45100 Biopsy of anorectal wall, anal approach.... Code 45100 is not intended to be used with an endoscopic procedure code.
- A physician should not unbundle a bilateral procedure code and report the procedure with two unilateral procedure codes. For example, if a physician performs bilateral mammography, the physician shall report code 77066 Diagnostic mammography... bilateral. The physician shall not report code 77065 Diagnostic mammography... unilateral, with 2 units of service or 77065-LT plus 77065-RT.
- A physician should not unbundle services that are integral to a more comprehensive procedure. For example, surgical access is integral to a surgical procedure. A physician should not report code 49000 Exploratory laparotomy,..., when performing an open abdominal procedure such as a total abdominal colectomy (e.g., CPT code 44150).
- A physician should report a biopsy separately only when pathologic examination results in a decision to immediately proceed with a more extensive procedure (e.g., excision, destruction, removal) on the same lesion; or when performed on a separate lesion.

93 Synchronous Telemedicine Service Rendered Via Telephone or Other Real-Time Interactive Audio-Only Telecommunications System

Synchronous telemedicine service is defined as a real-time interaction between a physician or other qualified health care professional and a patient who is located away at a distant site from the physician or other qualified health care professional. The totality of the communication of information exchanged between the physician or other qualified health care professional and the patient during the course of the synchronous telemedicine service must be of an amount and nature that is sufficient to meet the key components and/or requirements of the same service when rendered via a face-to-face interaction.

When to use this modifier:

This modifier should be reported only when real-time interaction is provided by a physician or other qualified health care professional. The documentation for the services provided with this modifier must be provided as if it was a face-to-face visit and include the required components or key components. A complete list of codes that modifier 93 can be appended is in appendix T of the CPT book.

Example

A patient receives 60 minutes of psychotherapy via telephone while residing in a group home environment. The physician rendering the treatment is in an offsite inpatient psychiatric facility office. Report 90837 (a ◀ icon identifies this code as an audio-only service) and append modifier 93. The total amount of communication exchanged between the provider and the patient must be commensurate with the same requirements that would be in place had the service been provided in the more traditional face-to-face setting.

Correct use of this modifier:

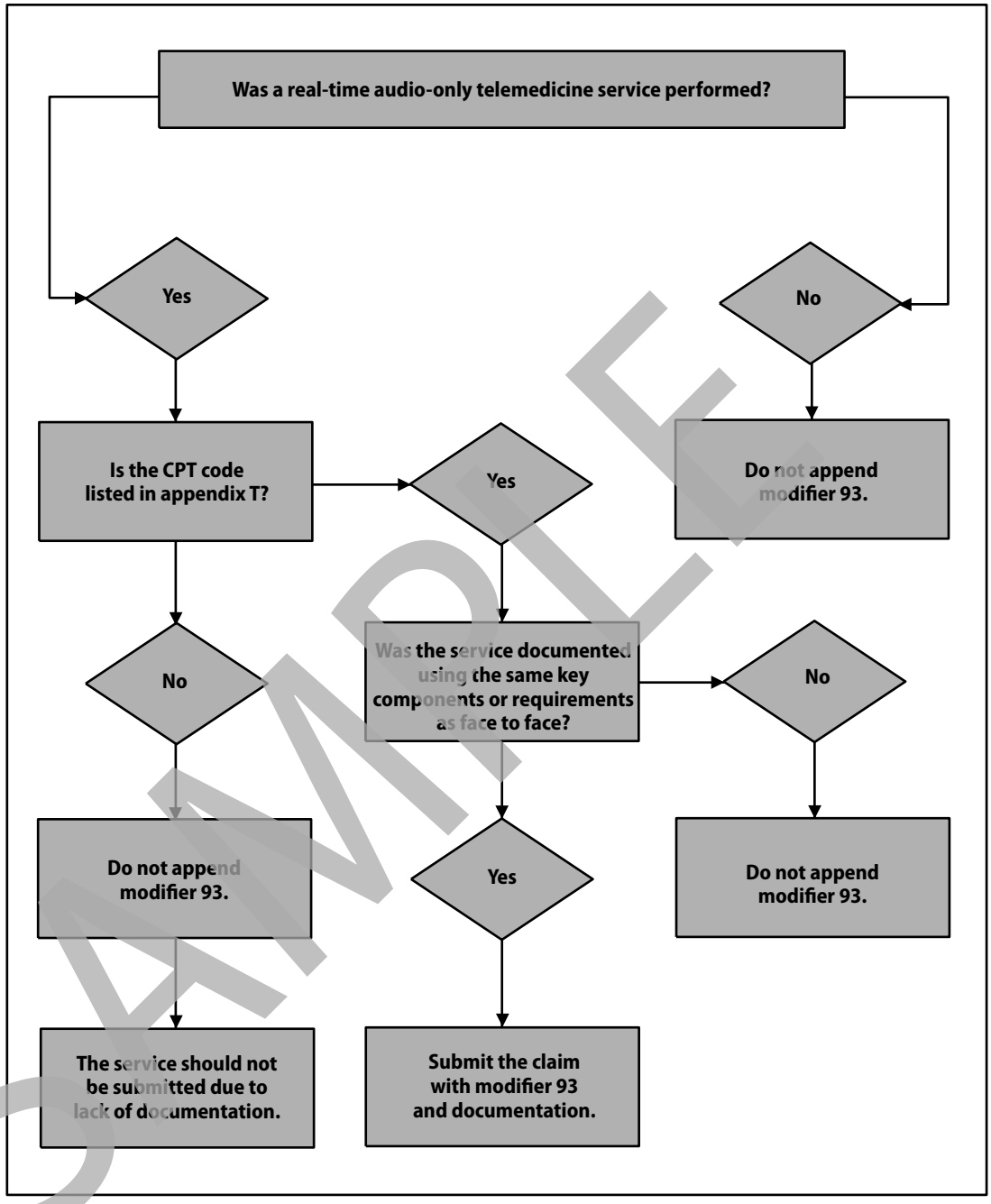
- Appending this modifier to services listed in appendix T. These codes are identified in the CPT book with a ◀ icon.
- Beginning January 1, 2023, Medicare requires modifier 93 for eligible mental health services provided using audio-only technology.

Incorrect use of this modifier:

- Appending this modifier to services other than those listed in appendix T.
- Appending this modifier to codes for services not provided using the telephone or other real-time interactive audio-only telecommunications system.

The following flow chart can aid in an audit by helping determine if modifier 93 is being used correctly and whether additional documentation might be required.

Modifier 93



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.

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 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 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 encounter is unacceptable grounds upon which to make a code assignment.

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 Inspector General (OIG) work plan regularly. This chapter contains an overview of E/M services and includes guidance for auditing provider services.

E/M Levels of Service

The levels of E/M services define the wide variations in skill, effort, time, and medical knowledge required for preventing or diagnosing and treating illness or injury. They also include services promoting optimal health and prevention of health conditions. These codes are intended to denote provider work, including cognitive work. Because much of this work revolves around the thought process of the provider, and involves a large amount of provider training, experience, expertise, and knowledge, the true indications of the level of work may be difficult to recognize without some explanation.

Auditor's Alert

Each E/M category and section has guidelines specific to that type of service. Read the guidelines before each category in the CPT® book to determine the most appropriate code for the service performed.

E/M services are divided into broad categories and subcategories. The following guidelines apply to categories:

- Office or Other Outpatient Services
- Hospital Inpatient and Observation Care Services
- Consultations
- Emergency Department Services
- Nursing Facility Services
- Home or Residence Service
- Prolonged Services With or Without Direct Patient Contact on the Date of an Evaluation and Management Service

The appropriate level of E/M service is based on either the level of medical decision making as defined for each service *or* the total time for E/M services performed on the date of encounter. For each category or subcategory, there are three to five levels of services available to report. There are four types of MDM:

- Straightforward
- Low
- Moderate
- High

The MDM is defined by three elements:

- The number and complexity of problems addressed during the encounter
- The amount and/or complexity of data to be reviewed and analyzed
- The risk of complications and/or morbidity or mortality of patient management

Chapter 9. **Auditing Medical Services**

The medicine section of the CPT® book contains codes for diagnostic and therapeutic services, such as immunizations, injections, dialysis, specialty specific codes, and special services. Within the medicine section of the CPT book, there are a number of subsections for the type of service being provided (e.g., chemotherapy administration) or for the specialty area providing the service (i.e., cardiovascular). As with other sections of the CPT book, there are general guidelines at the beginning of the section. Most of the subsections have guidelines, which are specific to the codes contained in that subsection. These guidelines contain valuable information regarding the proper use of the codes and should be read carefully.

There are a number of situations that may require the assignment of a modifier to the Medicine codes in order to identify the specific services performed. Each modifier is listed below with its official definition.

22 **Increased procedural services**
26 **Professional component**
33 **Preventive service**
50 **Bilateral procedure**
51 **Multiple procedures**
52 **Reduced services**
53 **Discontinued procedure**
55 **Postoperative management only**
56 **Preoperative management only**
57 **Decision for surgery**
58 **Staged or related procedure or service by the same physician or other qualified health care professional during the postoperative period**
59 **Distinct procedural service**
76 **Repeat procedure or service by same physician or other qualified health care professional**
77 **Repeat procedure by another physician or other qualified health care professional**
78 **Unplanned return to the operating/procedure room by the same physician or other qualified health care professional following initial procedure for a related procedure during the postoperative period**
79 **Unrelated procedure or service by the same physician or other qualified health care professional during the postoperative period**
93 **Synchronous Telemedicine Service Rendered Via Telephone or Other Real-Time Interactive Audio-Only Telecommunications System**
95 **Synchronous Telemedicine Service Rendered Via a Real-Time Interactive Audio and Video Telecommunications System**
96 **Habilitative services**
97 **Rehabilitative services**
99 **Multiple modifiers**

See chapter 3 for a detailed explanation of these modifiers.

For More Info

See appendix 1 for the audit worksheet for medicine section procedures.

Date of Service

When auditing medical services it is important to pay close attention to the date of service reported. The date of service on the claim must agree with the date of service in the medical record. For those services that may extend beyond a single calendar day, such as holter monitor started at 11:45 a.m. and completed at 11:55 a.m. the next day, the date the procedure was started is usually indicated on the claim.

Definitions

Holter monitor. Device worn by the patient for long-term continuous recording of electrocardiographic signals on magnetic tape, replayed at rapid speed, for scanning and selection of significant but brief changes that might otherwise escape notice.

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 it is determined that 75 percent of claims for colonoscopy did not include all procedures performed (e.g., multiple polyps removed by different techniques), 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.

Type of Audit: _____

Focused (such as a particular provider or specific procedure), Random, Statistically Valid (an SVRS review is an in-depth audit of a provider's utilization, coding, and documentation practices), etc. If there is a specific reason for the review, such as a large number of claim denials or payer inquiries, this should be identified here.

Name of Auditor: _____

Date of Audit: _____

Span of Review: _____

Include this if the review is for a specific time frame (e.g., all level 4 E/M services for the last three months are being reviewed).

Number of Records Reviewed: _____

Number of Errors: _____

If multiple errors are discovered during the review, consider addressing each individually.

Findings: _____

_____

_____

Examples may include such items as incorrect coding, inappropriate use of modifiers, incorrect claim completion, etc.

Financial Impact: _____

_____

_____