Auditing and Denial Management Tool Kit

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Salt Lake City, UT 84120

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ISBN 978-1-60151-470-7

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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							

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											
Modifier											
Modifier											

Reimbursement

	Fee Revisions Made		Comments
	Yes	No	
Modifier			
Modifier			
Modifier			
Modifier			
Modifier			

Payer Issues

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

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Special Alert

Surgical procedures that require additional physician work due to complications or medical emergencies may warrant the use of modifier 22 after the surgical procedure code.

A claim with modifier 22 will be processed on a by-report basis and will cause the claim processing to be delayed. In these cases, Medicare considers the unusual nature of the service and if they believe a charge above the fee schedule is justified, approves an amount that recognizes the additional services. This in effect becomes a higher-than-usual fee schedule amount for the service. The approved amount (or higher fee schedule amount) is the basis of the limiting charge calculation for modifier 22 services. Therefore, if the billed amount exceeds Medicare's approved amount by more than 15 percent, make an adjustment or a refund to the patient in order to meet the limiting charge requirements of the law. Because the exact limiting charge on these cases is not known until an allowable amount decision is made, Medicare would not consider these cases as knowing or willful violations, provided the physician made the appropriate adjustments or refunds.

The frequent reporting of modifier 22 has prompted many payers to simply ignore it. When using modifier 22, the claim must be accompanied by documentation and a cover letter explaining the unusual circumstances.

Claims submitted to Medicare, Medicaid, and other third-party payers containing modifier 22 for unusual procedural services that do not have attached supporting documentation that demonstrate the unusual circumstances associated with the services, will generally be processed as if the modifier was not appended to the procedure code. Some third-party payers might suspend the claims and request additional information, but this is the exception rather than the rule.

Documentation includes, but is not limited to, descriptive statements identifying the unusual circumstances, operative reports (state the usual time for performing the procedure and the prolonged time due to complication, if appropriate), pathology reports, progress notes, office notes, etc.

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									
Modifier									

Modifier Tips and Traps

The following is a discussion of modifiers that are often used incorrectly. Each modifier is described along with a discussion of when the modifier is to be used, correct usage of the modifier, and incorrect usage of the modifier. Again, note that not all modifiers are included, only those that are frequently used inappropriately.

CPT Modifiers

22 Increased Procedural Services

When to use this modifier:
Modifier 22 is used to indicate that the service provided is greater than that usually required for the listed procedure. This may be identified by adding modifier 22 to the usual procedure number.

Correct usage of this modifier:

- Modifier 22 is appended to the basic CPT procedure code when the service provided is greater than usually required for the listed procedure. Use of modifier 22 allows the claim to undergo individual consideration.
- Modifier 22 is used to identify an increment of work that is infrequently encountered with a particular procedure and is not described by another code.

Incorrect usage of this modifier:

- Appending modifier 22 to a surgical code without documentation in the medical record of an unusual occurrence.
- Using modifier 22 on a routine basis.
- Using modifier 22 to indicate that the procedure was performed by a specialist. Specialty designation does not warrant use of modifier 22.

23 Unusual Anesthesia

When to use this modifier:
Modifier 23 is used to indicate a procedure that requires no anesthesia or local anesthesia.

Correct usage of this modifier:

- Use this modifier when general anesthesia is administered in situations that typically would not require this level of anesthesia, or in situations in which local anesthesia might have been required, but would not be sufficient under the circumstances.
- Incorrect usage of this modifier:
- Using modifier 23 for local anesthesia.
- Using modifier 23 to report anesthesia provided by the surgeon.

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MSP Questionnaire (Continued)

Part IV (continued)

6. Do you have group health plan (GHP) coverage based on your own or a spouse's current employment?
   - ❑ Yes.
   - ❑ No. **STOP. MEDICARE IS PRIMARY PAYER UNLESS THE PATIENT ANSWERED YES TO THE QUESTIONS IN PART I OR II.**
7. Does the employer that sponsors your GHP employ 20 or more employees?
   - ❑ Yes. **STOP. GHP IS PRIMARY. OBTAIN THE FOLLOWING INFORMATION.**

   Name and address of GHP:

   ____

   ____

   ____

   Policy identification number (this number is sometimes referred to as the health insurance benefit package number) : ____

   Group identification number: ____

   Membership number (prior to the Health Insurance Portability and Accountability Act (HIPAA), this number was frequently the individual's Social Security Number (SSN); it is the unique identifier assigned to the policyholder/patient):____

   Name of policyholder/named insured: ____

   Relationship to patient: ____
   - ❑ No.
8. If you have GHP coverage based on your spouse's current employment, does your spouse's employer that sponsors or contributes to the GHP, employ 20 or more employees?
   - ❑ Yes. **GHP IS PRIMARY. OBTAIN THE FOLLOWING INFORMATION.**

   Name and address of GHP:

   ____

   ____

   ____

   Policy identification number (this number is sometimes referred to as the health insurance benefit package number) : ____

   Group identification number: ____

   Membership number (prior HIPAA, this number was frequently the individual's SSN; it is the unique identifier assigned to the policyholder/patient):__________________________________

   Name of policyholder/named insured: ____

   Relationship to patient: ____
   - ❑ No. **STOP. MEDICARE IS PRIMARY PAYER UNLESS THE PATIENT ANSWERED "YES" TO QUESTIONS IN PART I OR II.**

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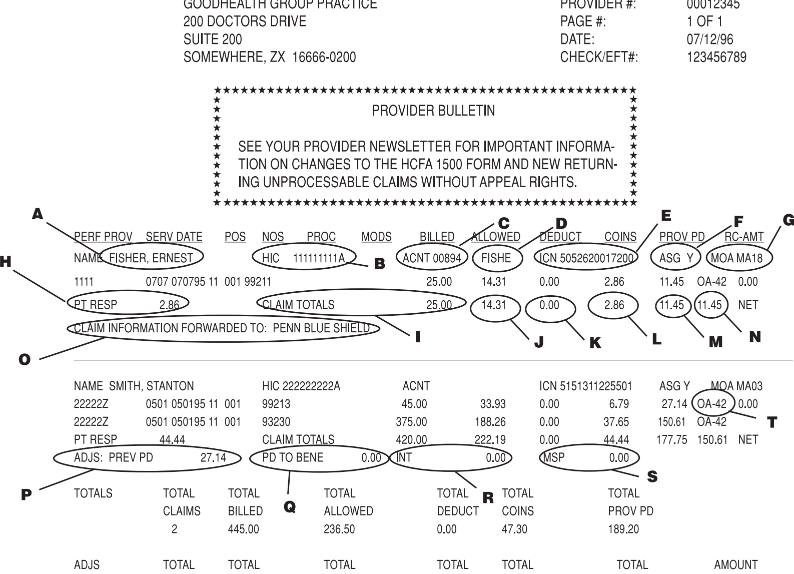
Sample Remittance Advice Notice

PAPER REMITTANCE ADVICE NOTICE
NEW FORMAT

CARRIER NAME
ADDRESS
CITY, STATE, ZIP CODE
TELEPHONE NUMBER



GOODHEALTH GROUP PRACTICE		PROVIDER #:	00012345
200 DOCTORS DRIVE		PAGE #:	1 OF 1
SUITE 200		DATE:	07/12/96
SOMEWHERE, ZX 16666-0200		CHECK/EFT#:	123456789

PROVIDER BULLETIN

SEE YOUR PROVIDER NEWSLETTER FOR IMPORTANT INFORMATION ON CHANGES TO THE HCFA 1500 FORM AND NEW RETURNING UNPROCESSABLE CLAIMS WITHOUT APPEAL RIGHTS.

PERF PROV	SERV DATE	POS	NOS	PROC	MODS	BILLED	ALLOWED	DEDUCT	COINS	PROV PD	RC-AMT	
NAME FISHER, ERNEST			HIC 111111111A			ACNT 00894	FISHE	ICN 5052620017200		ASG Y	MOA MA18	
1111	0707 070795	11	001	99211		25.00	14.31	0.00	2.86	11.45	OA-42	0.00
PT RESP 2.86			CLAIM TOTALS			25.00	14.31	0.00	2.86	11.45	11.45	NET

CLAIM INFORMATION FORWARDED TO: PENN BLUE SHIELD

NAME SMITH, STANTON			HIC 222222222A			ACNT		ICN 5151311225501		ASG Y	MOA MA03	
22222Z	0501 050195	11	001	99213		45.00	33.93	0.00	6.79	27.14	OA-42	0.00
22222Z	0501 050195	11	001	93230		375.00	188.26	0.00	37.65	150.61	OA-42	
PT RESP 44.44			CLAIM TOTALS			420.00	222.19	0.00	44.44	177.75	150.61	NET

ADJS: PREV PD 27.14 PD TO BENE 0.00 INT 0.00 MSP 0.00

TOTALS	TOTAL CLAIMS	TOTAL BILLED	TOTAL ALLOWED	TOTAL DEDUCT	TOTAL COINS	TOTAL PROV PD	
	2	445.00	236.50	0.00	47.30	189.20	
ADJS	**TOTAL PREV PD**	**TOTAL PD TO BENE**	**TOTAL INT**	**TOTAL MSP**	**TOTAL OFFSET**	**TOTAL OTHER ADJS**	**AMOUNT OF CHECK**
	27.14	0.00	0.00	0.00	0.00	0.00	189.20

REASON CODES:

OA-42 CHARGES EXCEED OUR FEE SCHEDULE OR MAXIMUM ALLOWABLE AMOUNT

MOA CODES:

MA18 THE CLAIM INFORMATION IS ALSO BEING FORWARDED TO THE PATIENT'S SUPPLEMENTAL INSURER. SEND ANY QUESTIONS REGARDING SUPPLEMENTAL BENEFITS TO THEM.

MAO3 IF YOU DO NOT AGREE WITH THE MEDICARE APPROVED AMOUNTS AND $100 OR MORE IS IN DISPUTE (LESS DEDUCTIBLE AND COINSURANCE), YOU MAY ASK FOR A HEARING. YOU MUST REQUEST A HEARING WITHIN SIX MONTHS OF THE DATE OF THIS NOTICE. TO MEET THE $100, YOU MAY COMBINE AMOUNTS ON OTHER CLAIMS THAT HAVE BEEN REVIEWED OR RECONSIDERED. THIS INCLUDES THE REOPENED REVIEWS IF YOU RECEIVED A REVISED DECISION. YOU MUST APPEAL EACH CLAIM ON TIME. AT THE HEARING, YOU MAY PRESENT ANY NEW EVIDENCE WHICH COULD AFFECT OUR DECISION. (AN INSTITUTIONAL PROVIDER, E.G., HOSPITAL, SNF, HHA, MAY APPEAL ONLY IF THE CLAIM INVOLVES A MEDICAL NECESSITY DENIAL, A SNF RE-CERTIFIED BED DENIAL OR A HOME HEALTH DENIAL BECAUSE THE PATIENT WAS NOT HOMEBOUND OR WAS NOT IN NEED OF INTERMITTENT SKILLED NURSING SERVICES AND EITHER THE PATIENT OR PROVIDER IS LIABLE UNDER SECTION 1879 OR THE SOCIAL SECURITY ACT AND THE PATIENT CHOOSES NOT TO APPEAL.)

Source: C&S Administrative Services® for Medicare, February/March 1996

Key for Remittance Advice Notice Format

In the box above, we have provided a sample of the new Medicare paper remittance advice notice. Below is a key for decoding the new format so you are able to find the information needed with ease.

- A Patient name
- B Patient Medicare ID number
- C Patient account number as assigned by physician
- D Provider name
- E Claim processing identification number
- F Assignment accepted (Y=yes, N=no)
- G Codes/group codes/remittance advice remark codes (RARC)
- H Amount patient may be billed
- I Claim totals
- J Allowed amount (difference between J and I must be written off)
- K Amount applied to deductible

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Chapter 6:
Fraud, Appeals, and Medical Reviews

Payers establish specific processes to review claims, identify fraud, and allow providers to appeal payment and coverage decisions.

Medical Reviews

A medical review is the analysis of claims data performed by a third-party payer to identify areas of overutilization. The statutory authority for the majority of medical review policies can be found in section 1862 (a)(1)(A) of the Social Security Act, which prohibits Medicare payment for "items or services that are not considered to be reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member." Medicare routinely monitors claims, which means that many claims submitted undergo some type of pre-payment review without a provider being notified or aware of it. Paid claims may also be subject to review.

Medicare medical review activities are directed toward areas where an analysis of data indicates questionable billing patterns. Validating initial findings of the medical review evaluation may require additional review resulting in corrective action.

CMS contracts with fiscal intermediaries (FI), carriers, Part A and Part B Medicare administrative contractors (A/B MAC), durable medical equipment Medicare administrative contractors (DME MAC), and Zone Program Integrity contractors (ZPIC) (replaced Program Safeguard Contractors [PSC]) who work together to identify atypical billing patterns and perform claims review. These entities are referred to as Medicare contractors.

Circumstances that appear suspicious may include, but are not limited to:

- Sudden billing changes
- Spike billing
- Billing by inappropriate specialties
- Billing of inappropriate diagnoses
- Increased complaints from beneficiaries
- Compromised beneficiary and provider identities
- Geographical billing changes in billing
- High CERT rate
- Identity theft (provider and or beneficiary)
- Beneficiary recruitment (capping)
- High utilization accounting for a disproportionate share of "ordered" services for a provider or group
- Submitting claims on behalf of deceased patients with dates of service *after* the date of death
- Billing for Part B services during an inpatient, Part A, institutional stay

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Worksheet for Surgical Auditing

<table>
<tr><td colspan="11">Account/medical record number: ____________________ Date of service: ________
Date of review: ____________________ Reviewer: ___________
Type of review: ____________________</td></tr>
<tr><td colspan="11">CPT Code Assignment</td></tr>
<tr><td colspan="2">Procedure</td><td>Code Assigned</td><td>Code Documented</td><td>Modifier Assigned</td><td>Modifier Documented</td><td colspan="5" rowspan="7">Comments</td></tr>
<tr><td colspan="2"></td><td></td><td></td><td></td><td></td></tr>
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<tr><td colspan="2"></td><td></td><td></td><td></td><td></td></tr>
<tr><td colspan="5">Place of Service</td><td></td><td colspan="5">Number of Units</td></tr>
<tr><td colspan="2">Indicated on Claim</td><td></td><td colspan="2">Documented</td><td></td><td colspan="2">Indicated on Claim</td><td></td><td colspan="2">Documented</td></tr>
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<tr><td colspan="5">Billable Supplies</td><td></td><td colspan="5">Nonbillable Supplies</td></tr>
<tr><td colspan="2">Under Coding</td><td></td><td colspan="2">Overcoding</td><td></td><td colspan="2">Undercoding</td><td></td><td colspan="2">Overcoding</td></tr>
<tr><td>Code</td><td>Payment</td><td></td><td>Code</td><td>Payment</td><td></td><td>Code</td><td>Payment</td><td></td><td>Code</td><td>Payment</td></tr>
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<tr><td colspan="5"></td><td colspan="2">Total Impact on Claim</td><td colspan="4"></td></tr>
</table>

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Category: Missing/Invalid Provider Information

Code Type: Claim Adjustment Reason Codes

206	National Provider Identifier - missing. *Start: 07/09/2007 | Last Modified: 09/30/2007*
207	National Provider identifier - Invalid format *Start: 07/09/2007 | Last Modified: 06/01/2008*
208	National Provider Identifier - Not matched. *Start: 07/09/2007 | Last Modified: 09/30/2007*

Code Type: Remittance Advice Remark Codes

N257	Missing/incomplete/invalid billing provider/supplier primary identifier. *Start: 12/02/2004*
N516	Records indicate a mismatch between the submitted NPI and EIN. *Start: 03/01/2009*

Explanation
This denial message indicates that the rendering physician information was entered incorrectly or left blank.

Background
All claims for Medicare covered services and items that are the result of a physician or nonphysician order or referral must include the referring/ordering physician's name and NPI/UPIN. The following services/situations require the submission of the referring/ordering provider information:

- Medicare covered services and items that result from a physician's order or referral
- Parenteral and enteral nutrition
- Immunosuppressive drug claims
- Hepatitis B claims
- Diagnostic laboratory services
- Diagnostic radiology services
- Portable x-ray services
- Consultative services
- Durable medical equipment
- When the ordering physician is also the performing physician (as often is the case with in-office clinical laboratory tests)
- When a service is incident to the service of a physician or nonphysician practitioner, the name of the physician or nonphysician practitioner who performs the initial service and orders the nonphysician service must appear in item 17
- When a physician extender or other limited licensed practitioner refers a patient for consultative service, submit the name of the physician who is supervising the limited licensed practitioner

A referring physician is a physician who requests an item or service for the beneficiary for which payment may be made under the Medicare program.

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An ordering physician is a physician or, when appropriate, a nonphysician practitioner who orders nonphysician services for the patient. Examples of services that might be ordered include diagnostic laboratory tests, clinical laboratory tests, pharmaceutical services, durable medical equipment, and services incident to that physician's or nonphysician practitioner's service.

Where to Look:

Item 17 Name of the Referring Provider or Other Source
Enter the name of the referring or ordering physician if the service or item was ordered or referred by a physician. All physicians who order services or refer Medicare beneficiaries must report this data. When a claim involves multiple referring and/or ordering physicians, a separate CMS-1500 should be used for each ordering/referring physician. Use the physician's last name and as much of the first name as will fit in item 17.

Item 17a
Other ID number of the referring/ordering/supervising provider is reported in the shaded area of this field. A qualifier indicating what the number represents is reported in the qualifier field to the immediate right of 17a.

NUCC defines the following qualifiers because they are the same as those used in the electronic 837 Professional 4010A1:

- 0B State License Number
- 1B Blue Shield Provider Number
- 1C Medicare Provider Number
- 1D Medicaid Provider Number
- 1G Provider UPIN Number
- 1H CHAMPUS Identification Number
- EI Employer's Identification Number
- G2 Provider Commercial Number
- LU Location Number
- N5 Provider Plan Network Identification Number
- SY Social Security Number (The social security number may not be used for Medicare.)
- X5 State Industrial Accident Provider Number
- ZZ Provider Taxonomy

The aforementioned code list contains provider identifiers and the provider taxonomy code. The provider identifier codes are assigned to the provider by a specific payer or third party to uniquely identify the provider. Taxonomy codes designated by the provider identify his or her provider type, classification, and/or area of specialization. Both provider identifiers and taxonomy codes may be reported in this field.

Item 17b NPI Number Supervising
Enter the NPI of the referring/ordering/provider listed in item 17b. All physicians who order services or refer Medicare beneficiaries must report this data.

Item 24J Rendering Provider ID Number
Enter the individual provider rendering the service in this field. The original fields for 24J and 24K are now combined and re-numbered as 24J. The non-NPI ID number should be entered in the shaded area of the field and the NPI number in the unshaded area of the field.

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Rendering provider is defined as the person or company (laboratory or other facility) who rendered or supervised the care. In the case where a substitute provider (locum tenens) was used, enter that provider's information here. Report the identification number in Items 24I and 24J only when different from data recorded in items 33a and 33b.

Item 33 Billing Provider Info and Phone Number
Enter the provider of service/supplier's billing name, address, ZIP code, and telephone number. This is a required field.

Item 33a NPI Number
Enter the NPI of the billing provider or group.

Item 33b Other ID Number
The two-digit qualifier identifying the non-NPI number followed by the ID number is reported in this field. No space, hyphen, or other separator should be used between the qualifier and number.

NUCC defines the following qualifiers because they are the same as those used in the electronic 837 Professional 4010A1:

- 0B State License Number
- 1B Blue Shield Provider Number
- 1C Medicare Provider Number
- 1D Medicaid Provider Number
- 1G Provider UPIN Number
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Corrective Actions

All physicians who order or refer Medicare beneficiaries or services must obtain an NPI even though they may never bill Medicare directly.

Verify the provider's address, phone number, and NPI before resubmitting the claim.

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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.

Date of Service

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.

Immune Globulins (90281–90399)

Broad spectrum and anti-infective immune globulins, antitoxins, and erythrocytic isoantibodies are included in this section. The specific code is selected based upon the type of immune globulin that is administered. The name and dose of the substance must be documented in the medical record.

Auditor Alert

These codes must be reported in addition to the IV infusion, subcutaneous, or intramuscular administration of the product (96360–96374).

Administration of Vaccines/Toxoids (90465–90749)

The administration of the vaccine or toxoid is coded in addition to the code for the vaccine/toxoid product (90476–90749). Correct reporting of the administration is dependent upon the type of administration (i.e., percutaneous, intradermal, subcutaneous, intramuscular, jet injection, intranasal, or oral methods).

Identify the number of single or combination vaccines/toxoids administered before assigning the code. Code 90466 is used in combination with 90465 to report each additional vaccine.

Auditor Alert

Administration to a patient younger than 8 years of age (90465-90468) includes face-to-face physician counseling with the patient and/or family and, therefore, should not be reported separately.

Hepatitis B vaccines are reported according to the age of the patient. For dialysis or immunosuppressed patients of any age requiring the hepatitis B vaccine, use 90747.

Code 90721 is a combination code for diphtheria, tetanus toxoids, and pertussis (DTaP) and Hemophilus influenza B (HiB).

Immunization with a combined active hepatitis B (HepB) and Hemophilus influenza B (HiB) vaccine is coded as 90748.

This subsection also includes code for vaccines or immunizations that have been developed by the manufacturer and are awaiting approval from the Federal Drug Administration (FDA). These are identified by the thunderbolt icon. AMA errata released during the year removes the icon when FDA approval is obtained.

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Coding Tips

- Identify the number of single or combination vaccines or toxoids administered to determine if the assigned code is correct. Code 90466 is used in combination with 90465 to report each additional vaccine.
- Immunizations are usually provided in conjunction with a medical service.
- As add-on codes, 90466, 90468, 90472, and 90474 are not subject to multiple procedure rules. No reimbursement reduction or modifier 51 is applied. Add-on codes describe additional intraservice work associated with the primary procedure. They are performed by the same physician on the same date of service as the primary service/procedure, and must never be reported as a stand-alone code.
- Use 90466 and 90468 in conjunction with 90465 and 90467.
- Use 90472 and 90474 in conjunction with 90471 and 90473.

Auditor Alert

Medicare offers three combinations of HCPCS Level II codes for administration and CPT codes for the vaccine or toxoid product. To report the administration of the following vaccines or toxoids, the combinations listed should be reported:

- Influenza virus vaccine (90655–90663 and G0008, G9141, and G9142)
- Pneumococcal vaccine (90732 and G0009)
- Hepatitis B vaccine (90744–90748 and G0010)

Coding Traps

- Do not report 90465 in conjunction with 90467.
- Do not report 90467 in conjunction with 90465.
- Do not report 90471 in conjunction with 90473.
- Do not report 90473 in conjunction with 90471

Psychiatry (90801–90899)

Psychiatric Diagnostic Evaluation Interview Procedures

These procedures are reported when the physician interviews the patient in order to gain insight into the nature of the patient's condition. It includes a history, mental status, and a disposition. Code 90802 is used when the provider must use aides to communicate with a patient, such as dolls, pictures, etc. This is usually necessary for children but may also be necessary for patients who have communication problems.

Auditor Alert

Testing, such as personality and psychopathology tests, should be reported separately.

Psychotherapy

- When reporting psychotherapy, the medical record should be examined to determine the following patient information:
- The type of therapy provided (e.g., insight oriented, behavior modifying, or interactive)
- The amount of time spent providing the therapy
- The site of service
- If E/M services were also provided

Psychotherapy is the treatment of mental illness and behavioral disturbances. Some patients receive psychotherapy and medical E/M. When medical management is provided at the same time as psychotherapy, no evaluation and management code should be reported. The appropriate psychotherapy code that includes medical E/M should be reported. When medical management is provided on a day that psychotherapy is not provided, assign the appropriate E/M code for the service.

Auditor Alert

Psychotherapy codes that include medical management should not be reported when the provider only managed the patient's medications. Pharmacologic management is reported with 90862 and includes review of past and current medications, patient's response, adverse effects, and ongoing medication. Medicare requires this service to be reported with M0064.

Dialysis Services (90935–90999)

This subsection is divided into three subcategories: hemodialysis, end-stage renal disease services, and miscellaneous dialysis procedures.

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