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Navigating Physician Denials: Insights and Claim Review Tools

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70%

of healthcare leaders say that managing claims is more important now than before the pandemic.[1]

$20b

total administrative cost tied to reworking or appealing denials.[1]

1. Navigating the rising tide of denials | HFMA

Claim denials are on the rise

84% of organizations cited reducing denials is now a priority for them[1]

77% of respondents said frequent changes to payer policies also created reimbursement challenges[1]

73% of organizations have evaluated their claims process within the past year[1]

1. Claims Denials Are on the Rise, AAPC, Nov. 2024

Identifying the problem tied to denials

- **Prior authorization** – In the event that prior authorization is not obtained prior to the service being performed, a claim may be denied.
- **Missing or incorrect information** – This can be anything from a blank field (e.g., Social Security number or demographic information) or incorrect plan code, to technical errors like a missing modifier.
- **Medical necessity requirements not met** – A medically unnecessary healthcare service is not covered by the policy, and the payer disagrees with the physician about what services you need for your condition.
- **Procedure not covered by payer** – This is generally easy to avoid by simply reviewing a patient's plan or calling their insurer before the claim is submitted.
- **Provider out of network** – The payer may deny all or part of the claim if the services are performed by an out-of-network provider.
- **Duplicate claims** – Claims submitted for a single encounter on the same day by the same provider for the same patient for the same service item.
- **Coordination of benefits** – Claims for patients covered by more than one health plan can result in delays and even denials until the patient's coordination of benefits are updated.
- **Bundling** – Rather than paying fees for two separate services, the payer groups them together and pays one, smaller fee.
- **Services already included in payment of another service or procedure** – This happens when payment is adjusted because the benefit for the service is included in the payment or allowance for another service or procedure that has already been adjudicated.
- **Exceeded timely filing limit** – This happens when claims are filed outside the payer's required days of service; this should be factored into the time it takes to rework rejected claims.

Poland, L. Claims Denials: A Step-by-Step Approach to Resolution, Journal of AHIMA, Apr. 2022.

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Best practices to combat denials

- Know the stats
- Keep the process organized
- Identify trends
- Act quickly
- Establish a team
- Collaborate with payers
- Quality over quantity
- Track progress
- Conduct performance audits
- Verify patient information
- Learn from previous rejections
- Meet deadlines
- Know the clearinghouse
- Understand claim formats
- Conduct regular follow-ups
- Follow a decision tree approach

Poland, L. Claims Denials: A Step-by-Step Approach to Resolution, Journal of AHIMA, Apr. 2022.

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Outpatient coding scenario

Patient Case:

- 41-year-old patient visit for chronic knee pain. Minor procedure performed: joint injection.
- Provider documents the injection and a brief note on knee pain. No clear indication of a significant, separately identifiable E/M service beyond the procedure

Claim Submission:

CPT® Codes:

- 20610 – Arthrocentesis, aspiration/injection, major joint
- 99213 – Office/outpatient visit, established patient

Modifier: None applied

Diagnosis Codes:

- M17.11 – Unilateral primary osteoarthritis, right knee

Why Denied:

- Payer review denies due to E/M service as bundled with the procedure. Missing Modifier 25 to indicate a significant, separately identifiable E/M service. Payment only for injection; E/M denied

Avoidance Strategy:

- Always apply Modifier 25 when an E/M service is significant and separately identifiable from a procedure
- Ensure documentation clearly supports medical necessity for both services
- Avoid upcoding or unbundling; follow CPT and payer guidelines
- Use claim scrubbers or coding software to catch missing modifiers and mismatched codes

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The example shown in this slide is for illustrative purposes only. It is not based on a real patient scenario and does not contain any actual patient data. Any resemblance to real persons, living or dead, is purely coincidental. The content is intended solely to demonstrate coding concepts and should not be interpreted as clinical guidance or used for real-world decision-making.

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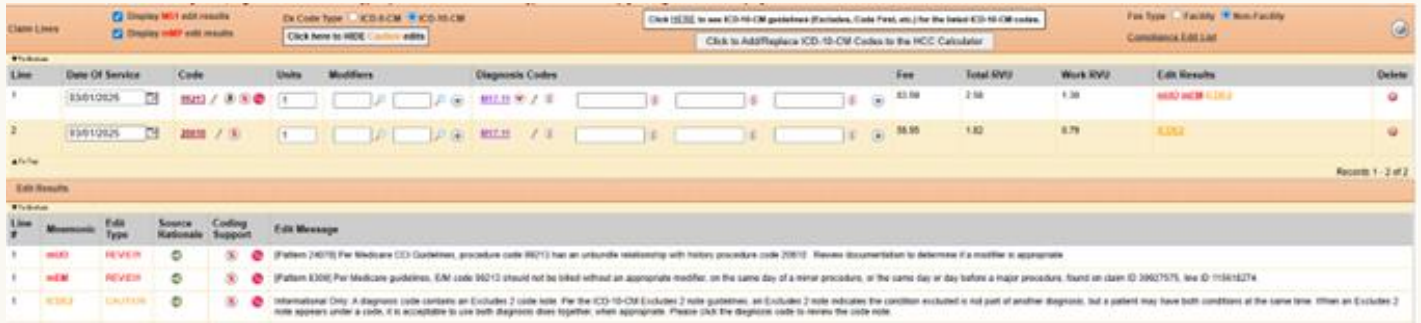
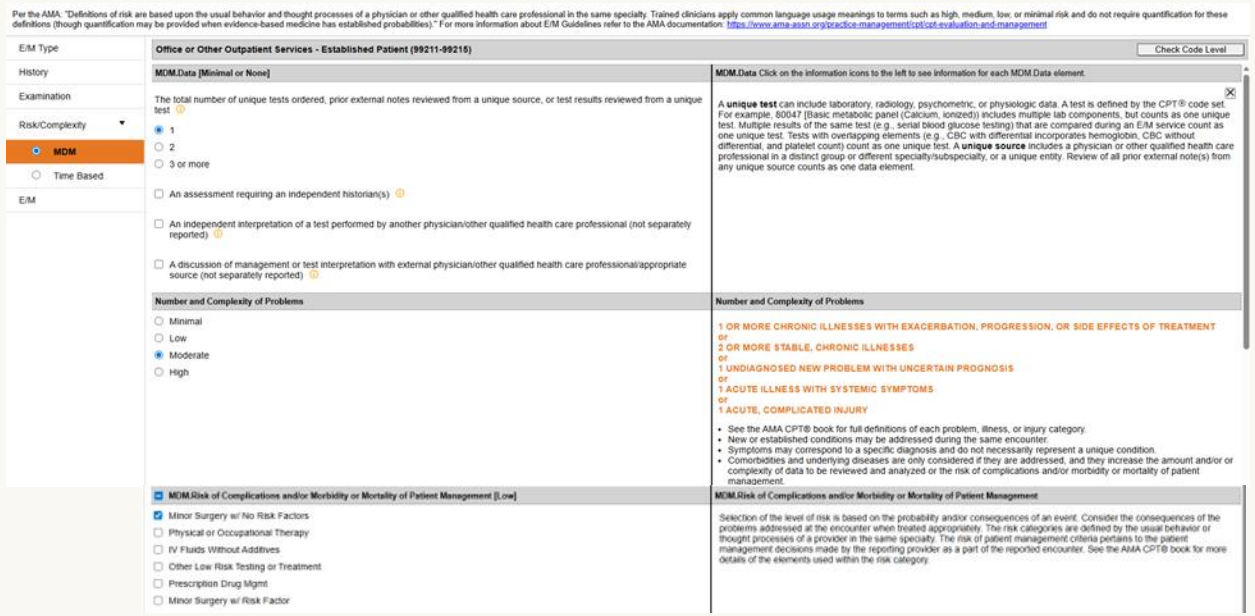
Compliance Review

For Medicare, Medicaid, and Commercial Review



E&M Support Tools



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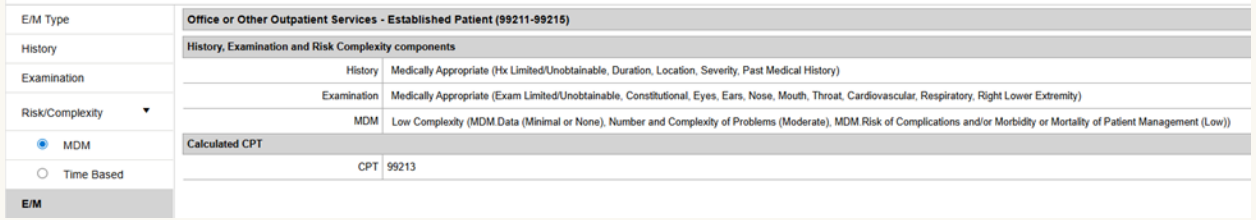
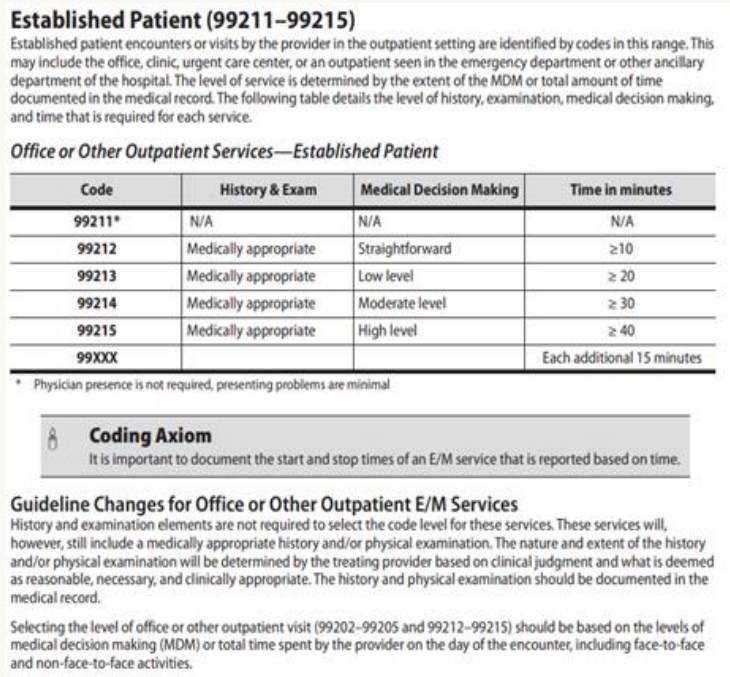
Additional E&M Support



E/M Type	Office or Other Outpatient Services - Established Patient (99211-99215)	
History	History, Examination and Risk Complexity components	
Examination	History	Medically Appropriate (Hx Limited/Unobtainable, Duration, Location, Severity, Past Medical History)
Risk/Complexity	Examination	Medically Appropriate (Exam Limited/Unobtainable, Constitutional, Eyes, Ears, Nose, Mouth, Throat, Cardiovascular, Respiratory, Right Lower Extremity)
MDM	MDM	Low Complexity (MDM Data (Minimal or None), Number and Complexity of Problems (Moderate), MDM Risk of Complications and/or Morbidity or Mortality of Patient Management (Low))
Time Based	Calculated CPT	
E/M	CPT	99213



Established Patient (99211–99215)

Established patient encounters or visits by the provider in the outpatient setting are identified by codes in this range. This may include the office, clinic, urgent care center, or an outpatient seen in the emergency department or other ancillary department of the hospital. The level of service is determined by the extent of the MDM or total amount of time documented in the medical record. The following table details the level of history, examination, medical decision making, and time that is required for each service.

Office or Other Outpatient Services—Established Patient

Code	History & Exam	Medical Decision Making	Time in minutes
99211*	N/A	N/A	N/A
99212	Medically appropriate	Straightforward	≥10
99213	Medically appropriate	Low level	≥ 20
99214	Medically appropriate	Moderate level	≥ 30
99215	Medically appropriate	High level	≥ 40
99XXX			Each additional 15 minutes

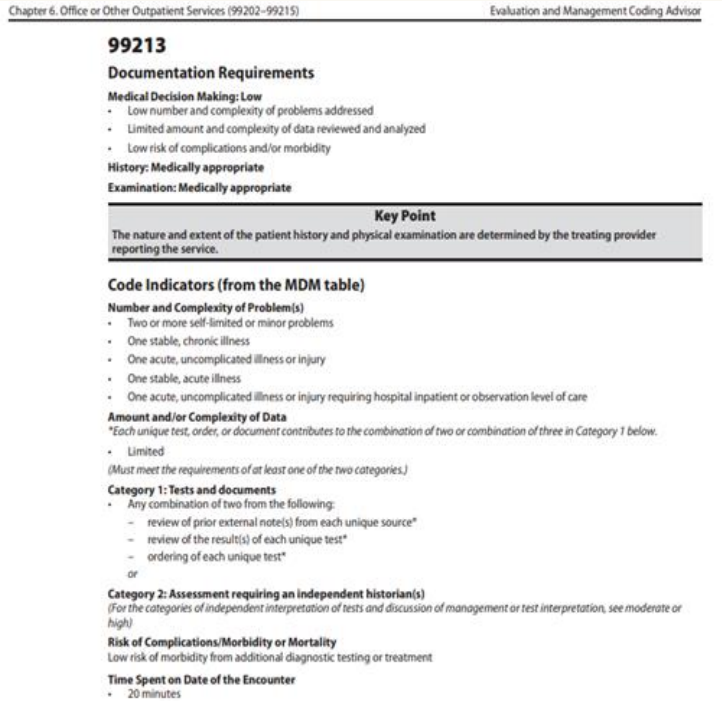
* Physician presence is not required, presenting problems are minimal

Coding Axiom
It is important to document the start and stop times of an E/M service that is reported based on time.

Guideline Changes for Office or Other Outpatient E/M Services

History and examination elements are not required to select the code level for these services. These services will, however, still include a medically appropriate history and/or physical examination. The nature and extent of the history and/or physical examination will be determined by the treating provider based on clinical judgment and what is deemed as reasonable, necessary, and clinically appropriate. The history and physical examination should be documented in the medical record.

Selecting the level of office or other outpatient visit (99202–99205 and 99212–99215) should be based on the levels of medical decision making (MDM) or total time spent by the provider on the day of the encounter, including face-to-face and non-face-to-face activities.



99213

Documentation Requirements

Medical Decision Making: Low
- Low number and complexity of problems addressed
- Limited amount and complexity of data reviewed and analyzed
- Low risk of complications and/or morbidity

History: Medically appropriate

Examination: Medically appropriate

Key Point
The nature and extent of the patient history and physical examination are determined by the treating provider reporting the service.

Code Indicators (from the MDM table)

Number and Complexity of Problem(s)
- Two or more self-limited or minor problems
- One stable, chronic illness
- One acute, uncomplicated illness or injury
- One stable, acute illness
- One acute, uncomplicated illness or injury requiring hospital inpatient or observation level of care

Amount and/or Complexity of Data
**Each unique test, order, or document contributes to the combination of two or combination of three in Category 1 below.*
- Limited

(Must meet the requirements of at least one of the two categories.)

Category 1: Tests and documents
- Any combination of two from the following:
  - review of prior external note(s) from each unique source*
  - review of the result(s) of each unique test*
  - ordering of each unique test*

or

Category 2: Assessment requiring an independent historian(s)
(For the categories of independent interpretation of tests and discussion of management or test interpretation, see moderate or high)

Risk of Complications/Morbidity or Mortality
Low risk of morbidity from additional diagnostic testing or treatment

Time Spent on Date of the Encounter
- 20 minutes

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Medical Necessity (LCD)

A59030 — Expand All | Collapse All

Group 2 (2 Codes)

Group 2 Paragraph

Note: Providers are reminded to refer to the long descriptors of the codes in their CPT® book.

Group 2 Codes

Code	Description
20610	ARTHROCENTESIS, ASPIRATION AND/OR INJECTION, MAJOR JOINT OR BURSA (EG, SHOULDER, HIP, KNEE, SUBACROMIAL BURSA); WITHOUT ULTRASOUND GUIDANCE
20611	ARTHROCENTESIS, ASPIRATION AND/OR INJECTION, MAJOR JOINT OR BURSA (EG, SHOULDER, HIP, KNEE, SUBACROMIAL BURSA); WITH ULTRASOUND GUIDANCE, WITH PERMANENT RECORDING AND REPORTING

CPT/HCPCS Modifiers — Expand All | Collapse All

Group 1 (7 Codes)

Group 1 Paragraph

N/A

Group 1 Codes

Code	Description
25	SIGNIFICANT, SEPARATELY IDENTIFIABLE EVALUATION AND MANAGEMENT SERVICE BY THE SAME PHYSICIAN ON THE SAME DAY OF THE PROCEDURE OR OTHER SERVICE. THE PHYSICIAN MAY NEED TO INDICATE THAT ON THE DAY A PROCEDURE OR SERVICE IDENTIFIED BY A CPTCODE WAS PERFORMED, THE PATIENT'S CONDITION REQUIRED A SIGNIFICANT, SEPARATELY IDENTIFIABLE E/M SERVICE ABOVE AND BEYOND THE OTHER SERVICE PROVIDED OR BEYOND THE USUAL PREOPERATIVE AND POSTOPERATIVE CARE ASSOCIATED WITH THE PROCEDURE THAT WAS PERFORMED. THE E/M SERVICE MAY BE PROMPTED BY THE SYMPTOM OR CONDITION FOR WHICH THE PROCEDURE AND/OR SERVICE WAS PROVIDED. AS SUCH, DIFFERENT DIAGNOSES ARE NOT REQUIRED FOR REPORTING OF THE E/M SERVICES ON THE SAME DATE. THIS CIRCUMSTANCE MAY BE REPORTED BY ADDING THE MODIFIER -25 TO THE APPROPRIATE LEVEL OF E/M SERVICE, OR THE SEPARATE FIVE DIGIT MODIFIER 09925 MAY BE USED. NOTE: THIS MODIFIER IS NOT USED TO REPORT AN E/M SERVICE THAT RESULTED IN A DECISION TO PERFORM SURGERY. SEE MODIFIER -57.
50	BILATERAL PROCEDURE: UNLESS OTHERWISE IDENTIFIED IN THE LISTINGS, BILATERAL PROCEDURES THAT ARE PERFORMED AT THE SAME OPERATIVE SESSION SHOULD BE IDENTIFIED BY ADDING THE MODIFIER -50 TO THE APPROPRIATE FIVE DIGIT CODE OR BY USE OF THE SEPARATE FIVE DIGIT MODIFIER CODE 09950

Group 1 (8 Codes)

Group 1 Paragraph

It is the provider's responsibility to select codes carried out to the highest level of specificity and selected from the ICD-10-CM code book appropriate to the year in which the service is rendered for the claim(s) submitted.

Group 1 Codes

Code	Description
M17.0	Bilateral primary osteoarthritis of knee
M17.11	Unilateral primary osteoarthritis, right knee
M17.12	Unilateral primary osteoarthritis, left knee
M17.2	Bilateral post-traumatic osteoarthritis of knee
M17.31	Unilateral post-traumatic osteoarthritis, right knee
M17.32	Unilateral post-traumatic osteoarthritis, left knee
M17.4	Other bilateral secondary osteoarthritis of knee
M17.5	Other unilateral secondary osteoarthritis of knee

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AHA Coding Clinics

AHA: 2020.2Q.14
AHA: 2016,4Q,147
AHA: 2016,4Q,146-147
AHA: 2018,2Q,15

Question:
When coding "arthritis of the knee," it appears that the index leads to code M19.90, Unspecified osteoarthritis, unspecified site. However, the provider documented "arthritis is of the knee." What is the appropriate code assignment?

Answer:
Assign code M17.10, Unilateral primary osteoarthritis, unspecified knee, for a diagnosis of arthritis of the knee. When reviewing the tabular list, it is important to review other codes in the related area to determine whether a more specific code can be assigned. In this case, code M17.10 is more specific than code M19.90, and more accurately captures the diagnostic statement.

In the United States "arthritis" is primarily meant to represent osteoarthritis, and defaults in ICD-10-CM were adjusted to recognize this.

Physician Tips

Physician Tip: Assign a primary osteoarthritis code when the site of the osteoarthritis is documented but the type of osteoarthritis - primary, secondary, generalized, or post-traumatic - is not documented. Primary is considered the default.

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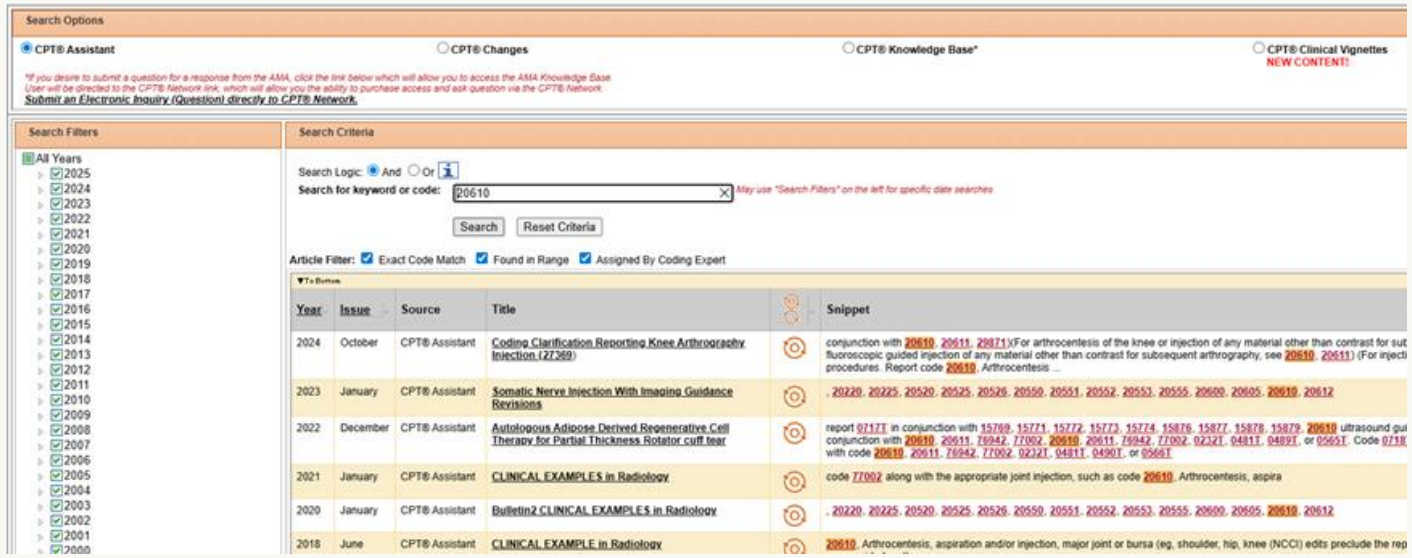
AMA CPT Assistant, Knowledge Base, Clinical Vignettes



Surgery	Musculoskeletal System	When aspiration of fluid from the knee joint is performed as well as injection of medication into the knee joint, can code 20610 (REVISED IN 2015), Arthrocentesis, aspiration and/or injection; major joint or bursa (eg, shoulder, hip, knee joint, subacromial bursa), be reported two times, once for the aspiration of fluid and once for the injection of medication?

From a CPT coding perspective, the term "and/or" in the code descriptor of code 20610 indicates that the code includes the performance of one or all of the procedures described in the same major joint or bursa. Therefore, code 20610 should only be reported one time when both aspiration and injection are performed in the same major joint or bursa.

CPT® Code	AMA CPT® Vignettes
20610	**typical patient:** A 50-year old patient presents with inflammation of a major joint (eg, shoulder, hip, knee) and is treated by aspiration of the joint, followed by injection of a steroid. **pre service info:** Explain procedure to patient/family. Discuss possible complications and obtain consent. Verify that all required instruments and supplies are available. The patient is positioned appropriately for injection access to the joint. Injection site is marked and confirmed. The site is prepped. **intra service info:** Intra-Work - Shoulder. The glenohumeral joint can be injected from an anterior, posterior, or superior approach. Anterior Approach - The needle is placed just medial to the head of the humerus and 1 cm lateral to the coracoid process. The needle is directed posteriorly and slightly superiorly and laterally. If the needle hits against bone, it should be pulled back and redirected at a slightly different angle. Posterior Approach - The needle is inserted 2 to 3 cm inferior to the posterolateral corner of the acromion and directed anteriorly in the direction of the coracoid process. The injection of medication is performed slowly, but with consistent pressure. The needle is removed.Intra-Work - Subacromial. The distal, lateral, and posterior edges of the acromion are palpated. A needle is inserted just inferior to the posterolateral edge of the acromion and directed toward the opposite nipple. The injection of medication is performed slowly, but with consistent pressure. The needle is removed.Intra-Work - Knee. The needle is inserted into the suprapatellar pouch, from the lateral aspect above the patella. The needle is directed medial. The injection of medication is performed slowly, but with consistent pressure. The needle is removedIntra-Work-- Thigh. The needle is inserted through the lateral approach superior to the greater tronchanter. Synovial fluid is aspirated to confirm the location of the needle prior to injection. The injection of medication is performed slowly, but with consistent pressure. The needle is removed. **post service info:** The injection area is cleansed and a bandage is applied. The patient is monitored for any potential complications from the injection. To ascertain whether the pharmaceuticals have been delivered to the appropriate location, the joint or area is put through passive range of motion. The patient is instructed to avoid strenuous activity involving the injected region for at least 48 hours. Patients should be cautioned that they might experience worsening symptoms during the first 24 to 48 hours, related to a possible steroid flare, which can be treated with ice and NSAIDs. Dictate procedure for medical record, copy PCP and insurance. **RUC review date:** 2010-10 Learn more about RUC by clicking HERE

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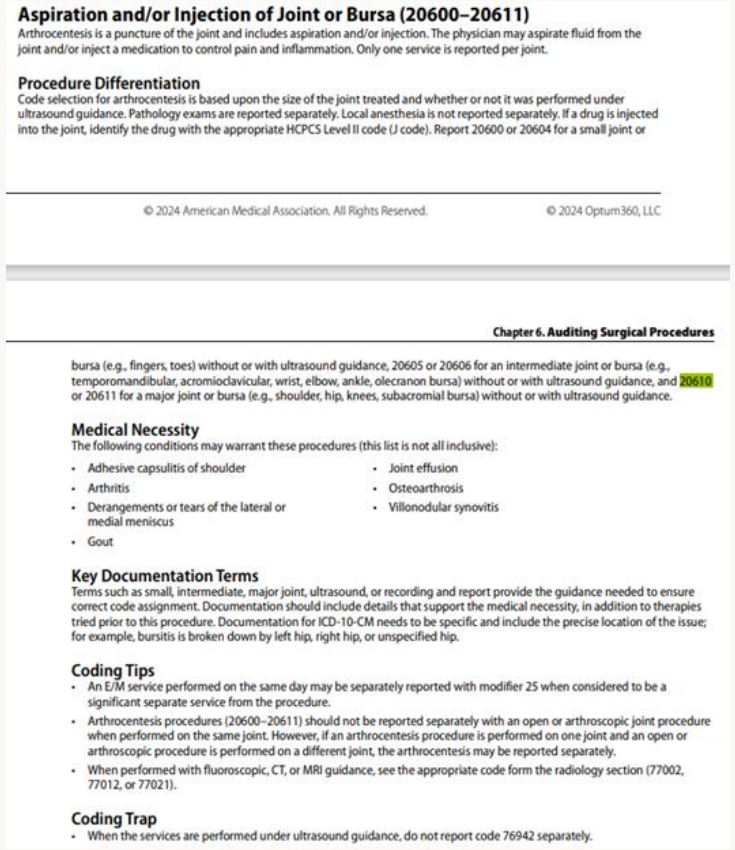
Coding Tips and Auditing



Aspiration and/or Injection of Joint or Bursa (20600–20611)

Arthrocentesis is a puncture of the joint and includes aspiration and/or injection. The physician may aspirate fluid from the joint and/or inject a medication to control pain and inflammation. Only one service is reported per joint.

Procedure Differentiation

Code selection for arthrocentesis is based upon the size of the joint treated and whether or not it was performed under ultrasound guidance. Pathology exams are reported separately. Local anesthesia is not reported separately. If a drug is injected into the joint, identify the drug with the appropriate HCPCS Level II code (J code). Report 20600 or 20604 for a small joint or

bursa (e.g., fingers, toes) without or with ultrasound guidance, 20605 or 20606 for an intermediate joint or bursa (e.g., temporomandibular, acromioclavicular, wrist, elbow, ankle, olecranon bursa) without or with ultrasound guidance, and 20610 or 20611 for a major joint or bursa (e.g., shoulder, hip, knees, subacromial bursa) without or with ultrasound guidance.

Medical Necessity

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

- Adhesive capsulitis of shoulder
- Arthritis
- Derangements or tears of the lateral or medial meniscus
- Gout
- Joint effusion
- Osteoarthrosis
- Villonodular synovitis

Key Documentation Terms

Terms such as small, intermediate, major joint, ultrasound, or recording and report provide the guidance needed to ensure correct code assignment. Documentation should include details that support the medical necessity, in addition to therapies tried prior to this procedure. Documentation for ICD-10-CM needs to be specific and include the precise location of the issue; for example, bursitis is broken down by left hip, right hip, or unspecified hip.

Coding Tips

- An E/M service performed on the same day may be separately reported with modifier 25 when considered to be a significant separate service from the procedure.
- Arthrocentesis procedures (20600–20611) should not be reported separately with an open or arthroscopic joint procedure when performed on the same joint. However, if an arthrocentesis procedure is performed on one joint and an open or arthroscopic procedure is performed on a different joint, the arthrocentesis may be reported separately.
- When performed with fluoroscopic, CT, or MRI guidance, see the appropriate code form the radiology section (77002, 77012, or 77021).

Coding Trap

- When the services are performed under ultrasound guidance, do not report code 76942 separately.

☑ **Coding Tip**	These codes should be reported only once even if an aspiration and injection are performed during the same session. Local anesthesia is included in these services. To report imaging guidance see 77002, 77012, and 77021. Ultrasonic guidance (76942) should not be reported with 20600–20611. Do not report 20600 or 20604 with 0489T-0490T. Do not report 20610 or 20611 with 27369. For aspiration or injection of a ganglion cyst, see 20612. For physician offices, supplies may be reported with the appropriate HCPCS Level II code. Check with the specific payer to determine coverage. Code selection depends on the size of the joint and whether the procedure was performed with or without ultrasonic guidance. If fluoroscopic, CT, or MRI guidance is performed, see 77002, 77012, and 77021. Do not report 20600–20611 with 76942. Do not report 20600 or 20604 with 0489T–0490T. Do not report 20610–20611 with 27369. When more than one procedure is performed on the same joint, do not report separately. For aspiration or injection of a ganglion cyst, any location, see 20612. Report the drug used in the injection with the appropriate HCPCS Level II code when provided in the physician office.
☑ **Documentation Tip**	Medical record documentation should include the specific joint or bursa addressed with a description of the aspiration and/or injection, along with any imaging guidance used. If an injection is performed, the medical record should indicate the drug that was injected and the dosage.
☑ **Reimbursement Tip**	Medicare considers one unit of service to include a joint and its surrounding bursae. If the practitioner aspirates or injects the joint and the bursae surrounding it, only one unit can be reported. Coverage of these procedures varies by payer. Check with the payer for specific coverage guidelines.

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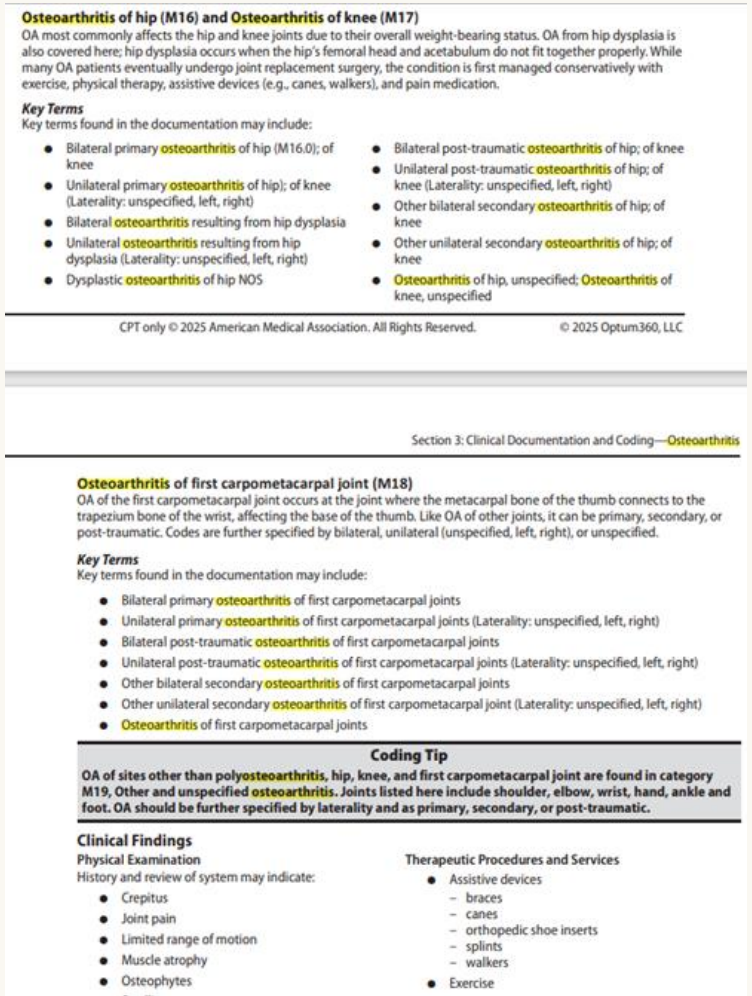
CDI



Osteoarthritis of hip (M16) and Osteoarthritis of knee (M17)

OA most commonly affects the hip and knee joints due to their overall weight-bearing status. OA from hip dysplasia is also covered here; hip dysplasia occurs when the hip's femoral head and acetabulum do not fit together properly. While many OA patients eventually undergo joint replacement surgery, the condition is first managed conservatively with exercise, physical therapy, assistive devices (e.g., canes, walkers), and pain medication.

Key Terms

Key terms found in the documentation may include:

- Bilateral primary osteoarthritis of hip (M16.0); of knee
- Unilateral primary osteoarthritis of hip); of knee (Laterality: unspecified, left, right)
- Bilateral osteoarthritis resulting from hip dysplasia
- Unilateral osteoarthritis resulting from hip dysplasia (Laterality: unspecified, left, right)
- Dysplastic osteoarthritis of hip NOS
- Bilateral post-traumatic osteoarthritis of hip; of knee
- Unilateral post-traumatic osteoarthritis of hip; of knee (Laterality: unspecified, left, right)
- Other bilateral secondary osteoarthritis of hip; of knee
- Other unilateral secondary osteoarthritis of hip; of knee
- Osteoarthritis of hip, unspecified; Osteoarthritis of knee, unspecified

Osteoarthritis of first carpometacarpal joint (M18)

OA of the first carpometacarpal joint occurs at the joint where the metacarpal bone of the thumb connects to the trapezium bone of the wrist, affecting the base of the thumb. Like OA of other joints, it can be primary, secondary, or post-traumatic. Codes are further specified by bilateral, unilateral (unspecified, left, right), or unspecified.

Key Terms

Key terms found in the documentation may include:

- Bilateral primary osteoarthritis of first carpometacarpal joints
- Unilateral primary osteoarthritis of first carpometacarpal joints (Laterality: unspecified, left, right)
- Bilateral post-traumatic osteoarthritis of first carpometacarpal joints
- Unilateral post-traumatic osteoarthritis of first carpometacarpal joints (Laterality: unspecified, left, right)
- Other bilateral secondary osteoarthritis of first carpometacarpal joints
- Other unilateral secondary osteoarthritis of first carpometacarpal joint (Laterality: unspecified, left, right)
- Osteoarthritis of first carpometacarpal joints

Coding Tip

OA of sites other than polyosteoarthritis, hip, knee, and first carpometacarpal joint are found in category M19, Other and unspecified osteoarthritis. Joints listed here include shoulder, elbow, wrist, hand, ankle and foot. OA should be further specified by laterality and as primary, secondary, or post-traumatic.

Clinical Findings

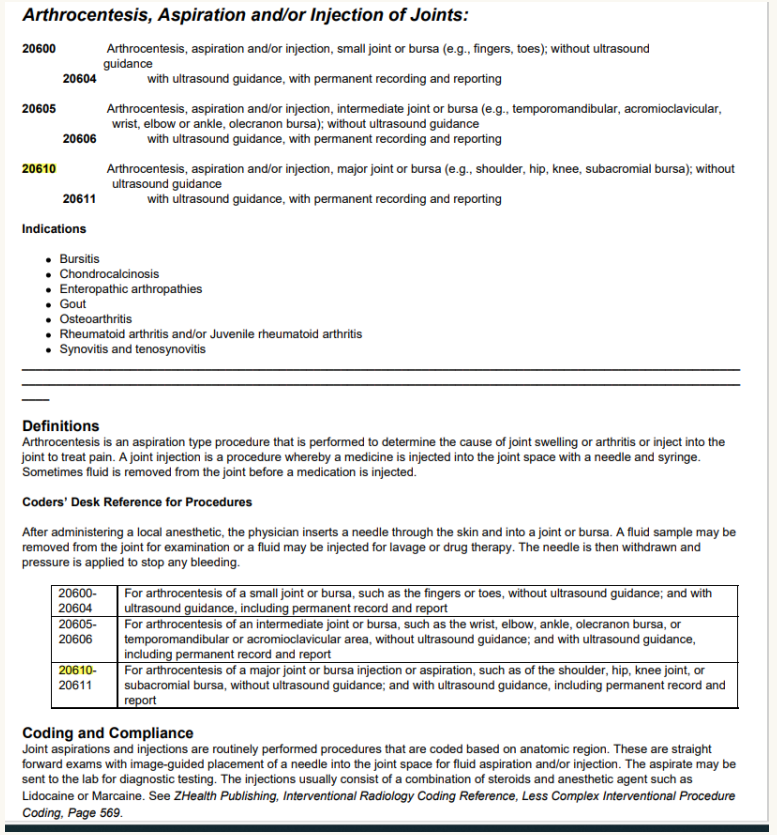
Physical Examination

History and review of system may indicate:

- Crepitus
- Joint pain
- Limited range of motion
- Muscle atrophy
- Osteophytes

Therapeutic Procedures and Services

- Assistive devices
  - braces
  - canes
  - orthopedic shoe inserts
  - splints
  - walkers
- Exercise



Arthrocentesis, Aspiration and/or Injection of Joints:

20600 Arthrocentesis, aspiration and/or injection, small joint or bursa (e.g., fingers, toes); without ultrasound guidance

20604 with ultrasound guidance, with permanent recording and reporting

20605 Arthrocentesis, aspiration and/or injection, intermediate joint or bursa (e.g., temporomandibular, acromioclavicular, wrist, elbow or ankle, olecranon bursa); without ultrasound guidance

20606 with ultrasound guidance, with permanent recording and reporting

20610 Arthrocentesis, aspiration and/or injection, major joint or bursa (e.g., shoulder, hip, knee, subacromial bursa); without ultrasound guidance

20611 with ultrasound guidance, with permanent recording and reporting

Indications

- Bursitis
- Chondrocalcinosis
- Enteropathic arthropathies
- Gout
- Osteoarthritis
- Rheumatoid arthritis and/or Juvenile rheumatoid arthritis
- Synovitis and tenosynovitis

Definitions

Arthrocentesis is an aspiration type procedure that is performed to determine the cause of joint swelling or arthritis or inject into the joint to treat pain. A joint injection is a procedure whereby a medicine is injected into the joint space with a needle and syringe. Sometimes fluid is removed from the joint before a medication is injected.

Coders' Desk Reference for Procedures

After administering a local anesthetic, the physician inserts a needle through the skin and into a joint or bursa. A fluid sample may be removed from the joint for examination or a fluid may be injected for lavage or drug therapy. The needle is then withdrawn and pressure is applied to stop any bleeding.

20600-20604	For arthrocentesis of a small joint or bursa, such as the fingers or toes, without ultrasound guidance; and with ultrasound guidance, including permanent record and report
20605-20606	For arthrocentesis of an intermediate joint or bursa, such as the wrist, elbow, ankle, olecranon bursa, or temporomandibular or acromioclavicular area, without ultrasound guidance; and with ultrasound guidance, including permanent record and report
20610-20611	For arthrocentesis of a major joint or bursa injection or aspiration, such as of the shoulder, hip, knee joint, or subacromial bursa, without ultrasound guidance; and with ultrasound guidance, including permanent record and report

Coding and Compliance

Joint aspirations and injections are routinely performed procedures that are coded based on anatomic region. These are straight forward exams with image-guided placement of a needle into the joint space for fluid aspiration and/or injection. The aspirate may be sent to the lab for diagnostic testing. The injections usually consist of a combination of steroids and anesthetic agent such as Lidocaine or Marcaine. See *ZHealth Publishing, Interventional Radiology Coding Reference, Less Complex Interventional Procedure Coding, Page 569.*

Demo

Claim review tools in EncoderPro.com

Q&A

Thank you

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