

Claim Appeal and Denial Support Add-on



Online Medical Coding Software

This Optum® Claim Appeal and Denial Support Add-on provides the sourcing for any claim edit. For coders, this means no more searching for code guidelines for claims appeal support.

Additionally, for each code, this tool provides information from Optum *Evaluation and Management Coding Advisor* and the *Auditors' Desk Reference* books, as well as access to the Optum® LYNX E/M coding tool. The features and content in this add-on provide information that would assist in avoiding denials and the evidence for effective appeals.

The E/M code evaluation tool includes 2021 coding guidelines and logic. Additionally, the supportive publications include 2021 E/M guideline support for proper E/M coding.

Key features and benefits

- **Optum Product Exclusive – Claim edit sourcing within the compliance editor.** Credible information sources are provided for each claim edit within the physician compliance editor feature of EncoderPro.com Expert and Payer versions. Each “scrubbed” claim now has industry-standard coding guidelines that explain the coding errors identified on the claim. This claim edit information is essential when providing evidence for claim appeals for nonpayment. You can also access hyperlinked state-level Medicaid compliance information to save you time.
- **Optum Product Exclusive – E/M code-level access to Optum Evaluation and Management code book data.** This gives clarity to E/M coding, which has been traditionally the most difficult section of codes. Code E/M services at the right level and ensure that you have correct guidelines to support your E/M code selections. This includes new guidelines based on recent E/M updates.
- **Optum Product Exclusive – Access the Optum E/M code evaluation tool.** The E/M code evaluation tool now includes 2021 coding guidelines and logic. Users can identify and select their history, exam and medical decision-making levels, and the Optum E/M code evaluation tool will supply the correct code based on 1995, 1997 and 2021 E/M coding guidelines and logic.
- **Optum Product Exclusive – Access the Optum Auditors' Desk Reference code book content.** By code, know what coding auditors evaluate when checking for correct coding. Understand those “agree” pitfalls and learn the correct coding methods to overcome common denials and coding mistakes.

Optum Claim Appeal and Denial Support

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* May only be purchased with a new or existing Optum online coding tool subscription; multi-user licenses available.

Claim edit sourcing within the Compliance Editor

Credible information sources are provided for each claim edit within the Physician Compliance Editor feature of EncoderPro.com Expert and Payer versions.

The screenshot displays the Compliance Editor interface. On the left, a table lists claim lines with columns for Line, Date of Service, Code, Modifiers, Primary Dx, and Additional Dx. On the right, a 'Source Rationale - Internet Explorer' window is open, showing details for an sMN edit. The window includes the following information:

- Mnemonic:** sMN
- Edit Type:** REVIEW
- Edit Message:** [Pattern 6873] Per Medicaid guidelines, a diagnosis code which meets medical necessity is missing or invalid for procedure code 13152 on Claim ID 11865556.cs1122, Line ID 32945847.
- DDR ID:** Pattern 6873
- Source:** Oregon Prioritized List/Oregon Health Evidence Review Commission
- URL Location of Source:** [Click here for sourcing information](#)
- Source Information for claim/codes provided:**
 - "The Oregon Health Evidence Review Commission (HERC) ranks health care condition and treatment pairs in order of clinical effectiveness and cost-effectiveness. The Prioritized List emphasizes prevention and patient education. In general: Treatments that help prevent illness are ranked higher than services that treat illness after it occurs. OHP covers treatments that are ranked on a covered Prioritized List line for the claim's reported medical condition. Effective Jan. 1, 2018, the OHP covers Prioritized List lines 1 through 469."
- Additional Edit Information:**
 - The sMN edit utilizes state Medicaid policies and guidelines to identify claim lines that contain a diagnosis code that does not meet medical necessity.
 - Optum bases coding relationships and edits on guidelines from generally accepted third-party industry sources such as the American Medical Association (AMA), the Centers for Medicare and Medicaid Services (CMS), published ICD-9-CM or ICD-10-CM Official Guidelines for Coding and Reporting, and specialty specific coding rules, when these rules and/or guidelines are available. Individual states establish and administer their own Medicaid programs and determine the type, amount, duration, and scope of services within broad federal guidelines.
 - The Centers for Medicare and Medicaid Services defines medical necessity as services that are: "Reasonable and necessary, for the diagnosis or treatment of an illness or injury or to improve the functioning of a malformed body member, and not excluded under another provision of the Medicare Program". Per CMS Policy, if the diagnoses provided do not support medical necessity, the items or services will be denied.
 - The sMN edit will identify Medicaid claim lines that do not contain a valid diagnosis code that meets medical necessity as

Access the Optum E/M code evaluation tool

The E/M code evaluation tool includes **2021 coding guidelines and logic**. This tool walks you through E/M code selection by looking at different components of the E/M code (e.g., Exam, History, Risk/Complexity (Medical Decision Making or Time Based), then the tool will supply the correct code based on 1995, 1997 and 2021 E/M coding guidelines and logic.

The screenshot shows the Optum E/M code evaluation tool interface. It is divided into three main sections:

- Selection Step:** The user selects 'Office or Other Outpatient Services - New Patient (99202-99205)'. Under 'Risk/Complexity', 'MDM' is selected. Under 'Time Based', 'Time Based' is selected.
- Intermediate Step:** The tool shows 'Time With Patient: 15 to 29 Minutes' and 'Risk/Complexity' set to 'MDM'. 'Time Based' remains selected.
- Final Step:** The tool displays 'Office or Other Outpatient Services - Established Patient (99211-99218)'. Under 'History, Examination and Risk Complexity components', 'Examined Detailed' is selected. The 'Calculated CPT' is shown as 'CPT: 99214'.

A large downward-pointing arrow is positioned between the first and second sections, indicating the flow of the tool.

Access valuable code book content

Access the Optum Auditors' Desk Reference code book content at the code level.

CPT® Code Detail - 13152 View Range

Medicare Reference	Code Information	Optum360® Data																																								
<p>Code-Specific Edits</p> <ul style="list-style-type: none"> CCI Unbundles Internet Only Manuals Physician Fee Schedule Information <p>Medicare Carrier/Locality Medicare Fee</p> <p>Medicare Carrier/Locality 00000-00 NATIONAL</p> <p>Make default Medicare Carrier/Locality <input type="checkbox"/></p> <p>Conversion Factor 35.9996</p> <p>- OR -</p> <p>% of Medicare 100.0</p> <p>Calculate</p> <p>For Fee adjustments click here</p> <table border="1"> <thead> <tr> <th>Facility:</th> <th>National</th> <th>Global (Locality)</th> <th>Z8</th> <th>IC</th> </tr> </thead> <tbody> <tr> <td>Non-Facility:</td> <td>\$361.44</td> <td>\$361.44</td> <td>n/a</td> <td>n/a</td> </tr> <tr> <td></td> <td>\$519.11</td> <td>\$519.11</td> <td>n/a</td> <td>n/a</td> </tr> </tbody> </table> <p>RVUs - Non-Facility</p> <table border="1"> <thead> <tr> <th></th> <th>National</th> <th>Global (Locality)</th> <th>Z8</th> <th>IC</th> </tr> </thead> <tbody> <tr> <td>Work RVU:</td> <td>5.34000</td> <td>5.34000</td> <td>n/a</td> <td>n/a</td> </tr> <tr> <td>PE RVU:</td> <td>8.28000</td> <td>8.28000</td> <td>n/a</td> <td>n/a</td> </tr> <tr> <td>Malpractice RVU:</td> <td>0.82000</td> <td>0.82000</td> <td>n/a</td> <td>n/a</td> </tr> <tr> <td>Total RVU:</td> <td>14.42000</td> <td>14.42000</td> <td>n/a</td> <td>n/a</td> </tr> </tbody> </table> <p>Conversion Factor: 35.99960</p>	Facility:	National	Global (Locality)	Z8	IC	Non-Facility:	\$361.44	\$361.44	n/a	n/a		\$519.11	\$519.11	n/a	n/a		National	Global (Locality)	Z8	IC	Work RVU:	5.34000	5.34000	n/a	n/a	PE RVU:	8.28000	8.28000	n/a	n/a	Malpractice RVU:	0.82000	0.82000	n/a	n/a	Total RVU:	14.42000	14.42000	n/a	n/a	<p>Code Description</p> <p>13152</p> <p>Suturing of Complicated Wounds (13100–13160) Codes for the complicated repair of a wound include:</p> <ul style="list-style-type: none"> Administration of local anesthesia Creation of a limited defect for repair Debridement of complicated wounds/avulsions More complicated than layered closure Simple <ul style="list-style-type: none"> exploration of nerves, vessels, tendons in wound not resulting in substantial dissection or repair vessel ligation in wound Undermining, stents, retention sutures <p>Complex repairs do not include excision of benign or malignant lesions.</p> <p>Coding guidelines instruct that when multiple wounds are repaired, wounds of the same anatomical site requiring the same type of closure (i.e., simple, intermediate, complex) be added together and the sum is used to determine correct code assignment. For example, a patient presents with three lacerations on the leg. Laceration A is 1.0 cm and laceration B is 1.5 cm and require simple closure. Laceration C is 3.6 cm and requires layered closure. To determine correct code assignment, lacerations A and B are added together, and the correct code for simple repair of a 2.5 cm lesion is assigned. This is true regardless of the shape of the wound.</p> <p>ed, or deeply lacerated tissue. The physician irrigates and cleanses the wound. The physician repairs the defect requiring repair. Stents or clips. Report 13152 for wounds 1.1 cm to 2.5 cm in length. Report 48652 for wounds 2.6 cm to 5.0 cm in length. Report 48653 for wounds greater than 5.0 cm in length. For physician offices, supplies are included in the global fee.</p> <p>ing sizable portions of skin or extensive dissection and report as a single item. Report 48650 up to half-vertical height; see 48652 emergency room. For physician offices, supplies are included in the global fee.</p>	<p>Color Codes</p> <ul style="list-style-type: none"> ASC Payment Indicator - A2 Surgical procedure on ASC list in CY 2007; payment based on OPPS relative payment weight. Multiple Procedure Reduction Guidelines Medically Unlikely Edits Global Days <p>Crosscodes</p> <p>Code Specific Links</p> <ul style="list-style-type: none"> Modifiers Crosscodes <p>Coding Support</p> <p>Auditor Desk Reference</p> <p>Additional Reference for Auditing and/or Evaluation and Management Coding</p>
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CPT® Code Detail - 99212 View Range

Medicare Reference	Code Information	Optum360® Data
<p>Code-Specific Edits</p> <ul style="list-style-type: none"> CCI Unbundles MIPS - Quality Performance Category Measures Internet Only Manuals Physician Fee Schedule Information <p>Medicare Carrier/Locality Medicare Fee</p> <p>Medicare Carrier/Locality 00000-00 NATIONAL</p> <p>Make default Medicare Carrier/Locality <input type="checkbox"/></p> <p>Conversion Factor 34.8931</p> <p>- OR -</p> <p>% of Medicare 100.0</p> <p>Calculate</p>	<p>Code Description</p> <p>99212</p> <p>Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using time for code selection, 10-19 minutes of total time is spent on the date of the encounter.</p> <p>Chapter 5: Office or Other Outpatient Services (99202–99215)</p> <p>99212</p> <p>DOCUMENTATION REQUIREMENTS</p> <p>Medical Decision Making: Straightforward</p> <ul style="list-style-type: none"> Minimal number and complexity of problems addressed No or minimal amount and complexity of data reviewed and analyzed Minimal risk of complications and/or morbidity <p>History: Medically appropriate</p> <p>Examination: Medically appropriate</p> <p>Code Indicators (from the MDM table)</p> <ul style="list-style-type: none"> Number and Complexity of Problem(s) <ul style="list-style-type: none"> One self-limited or minor problem Amount and/or Complexity of Data <ul style="list-style-type: none"> Minimal or none Risk of Complications/Morbidity or Mortality <ul style="list-style-type: none"> Minimal risk of morbidity from additional diagnostic tests or treatment Time Spent on Date of the Encounter <ul style="list-style-type: none"> 10–19 <p>Sample Documentation—99212</p> <p>Level II Established Patient Office Visit</p> <p>Patient comes in for suture removal; three sutures were placed in left index finger 10</p> <p>KEY POINT</p> <p>The redefined MDM guidelines were published by the AMA in the 2021 edition of CPT and adopted by CMS in the CY2020 Physician Fee Schedule Final Rule.</p> <p>KEY POINT</p> <p>The nature and extent of the patient history and physical examination are determined by the treating provider reporting the service.</p>	<p>Color Codes</p> <ul style="list-style-type: none"> Revised Code ASC Payment Indicator - IM Not allowable on a Medicare ASC claim. These codes represent physician and nonphysician practitioner professional services or services billable only by another type of entity. Physician and nonphysician practitioner professional services must be billed on a separate claim from the ASC services. Assist-at-Surgery Allowed With Documentation Modifier 95 - Telemedicine Service Medically Unlikely Edits <p>Crosscodes</p> <p>Code Specific Links</p> <ul style="list-style-type: none"> Modifiers Crosscodes <p>Coding Support</p> <p>Evaluation and Management Coding Advisor</p>

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