Optum

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

Designed for all markets

Available: Now
Item No: WA32

$499.95 Single-user; multi-user licenses available

Subscribe today

Contact your sales representative or 1-800-464-3649, option 1, to purchase.

Visit: optumcoding.com/addons

* 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.

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.

Access valuable code book content

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

CPT® Code Detail - 13152

Add To Notepad | Add To User Notes | Print Code Detail Summary

Medicare Reference | Code Information | Optum360® Data

Code-Specific Edits
- CCI Unbundles

Internet Only Manuals
- 100-04,12,90.3

Physician Fee Schedule Information

Medicare Carrier/Locality
Medicare Fee

Medicare Carrier/Locality: 00000-00 NATIONAL

Make default Medicare Carrier/Locality

Conversion Factor 35.9996

-- OR --

% of Medicare 100.0

Calculate

For Fee adjustments click here

	National	Global (Locality)	26	TC
Facility:	$361.44	$361.44	n/a	n/a
Non-Facility:	$519.11	$519.11	n/a	n/a

RVUs - Nonfacility

	National	Global (Locality)	26	TC
Work RVU:	5.34000	5.34000	n/a	n/a
PE RVU:	8.28000	8.28000	n/a	n/a
Malpractice RVU:	0.80000	0.80000	n/a	n/a
Total RVU:	14.42000	14.42000	n/a	n/a
Conversion Factor:	35.99960			

Code Description

13152

Suturing of Complicated Wounds (13100–13160)

Codes for the complicated repair of a wound include:

- Administration of local anesthesia
- Creation of a limited defect for repair
- Debridement of complicated wounds/avulsions
- More complicated than layered closure
- Simple
  - exploration of nerves, vessels, tendons in wound not resulting in substantial dissection or repair
  - vessel ligation in wound
- Undermining, stents, retention sutures

Complex repairs do not include excision of benign or malignant lesions.

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.

Color Codes
- A2 ASC Payment Indicator - A2
  Surgical procedure on ASC list in CY 2007; payment based on OPPS relative payment weight.
- Multiple Procedure Reduction Guidelines Apply
- MUE Medically Unlikely Edits
- 10 Global Days

Crosscodes

Code Specific Links
- Modifiers
- Crosscodes

Coding Support
- Auditor Desk Reference
- Additional Reference for Auditing and/or Evaluation and Management Coding

CPT® Code Detail - 99212

Add To Notepad | Add To User Notes | Print Code Detail Summary | The Evaluation and Management Code Auditor

Medicare Reference | Code Information | Optum360® Data

Code-Specific Edits
- CCI Unbundles
- MIPS- Quality Performance Category Measures

Internet Only Manuals
- 100-04,11,40.1.3
- 100-04,12,30.6.1
- 100-04,12,30.6.10
- 100-04,12,230.1
- 100-03,70.1
- 100-04,12,190.7
- 100-04,18,80.2
- 100-04,12,230
- 100-04,12,30.6.1.1
- 100-04,12,30.6.7
- 100-04,13,70.2
- 100-04,12,190.6.1
- 100-02,15,30
- 100-04,12,230.2
- 100-04,12,230.3
- 100-04,12,30.6.15.1
- 100-04,32,130.1
- 100-04,12,40.2
- 100-04,11,40.2
- 100-04,12,40.3
- 100-03,70.2
- 100-04,12,190.6
- 100-04,12,90.4.5
- 100-04,12,30.6.17
- 100-04,12,190.3
- 100-04,6,20.1.1.2
- 100-04,32,12.1
- 100-04,12,30.6.4
- 100-04,12,100.1.1

Physician Fee Schedule Information

Medicare Carrier/Locality
Medicare Fee

Medicare Carrier/Locality: 00000-00 NATIONAL

Make default Medicare Carrier/Locality

Conversion Factor 34.8931

-- OR --

% of Medicare 100.0

Code Description

99212

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.

Chapter 5: Office or Other Outpatient Services (99202–99215)

99212

Documentation Requirements

Medical Decision Making: Straightforward
- 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

History: Medically appropriate

Examination: Medically appropriate

Code Indicators (from the MDM table)

Number and Complexity of Problem(s)
- One self-limited or minor problem

Amount and/or Complexity of Data
- Minimal or none

Risk of Complications/Morbidity or Mortality
Minimal risk of morbidity from additional diagnostic tests or treatment

Time Spent on Date of the Encounter
- 10–19

Key Point

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.

Key Point

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

Sample Documentation—99212

Level II Established Patient Office Visit

Patient comes in for suture removal; three sutures were placed in left index finger 10

Color Codes
- Revised Code
- IM 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
- MUE Medically Unlikely Edits

Crosscodes

Code Specific Links
- Modifiers
- Crosscodes

Coding Support
- Evaluation and Management Coding Advisor

All add-on modules may only be purchased with a new or existing subscription to an Optum online coding tool; multi-user licenses available.

CPT is a registered trademark of the American Medical Association.

optumcoding.com

Optum is a registered trademark of Optum, Inc. in the U.S. and other jurisdictions. All other brand or product names are the property of their respective owners. Because we are continuously improving our products and services, Optum reserves the right to change specifications without prior notice. Optum is an equal opportunity employer.

© 2022 Optum, Inc. All rights reserved. WF6246064 SPRJ6350 03/22