COSMOS
Navigate the Compliance Universe

Compliance Today - August 2020
2020: Abuse, misuse, and misunderstandings of modifiers -25, -59, and -62

By Sonal Patel, CPMA, CPC, CMC, ICD-10-CM

Sonal Patel (sonalpatel@nexsenpruet.com) is a Health Care Coding & Compliance Consultant at Nexsen Pruet LLC in Charleston, SC.

There is no easy way to say this, so I will state the simple facts. Over the years, the misuse and misunderstandings of modifiers in healthcare coding have led to the many spotlights set forth by the Office of Inspector General's (OIG) Work Plan. The sheer volume of misuse and misunderstanding has often led to cases of identified abuse.[1] Moreover, with known intent thrown in the mix, this erroneous usage becomes fraud, according to the definitions set forth by the False Claims Act.[2]

Healthcare coding and compliance industry professionals must continue providing education and best practices on appropriate modifier usage on services rendered by physicians and other qualified healthcare professionals. These concentrated efforts will allow medical practices to retain their reimbursement levels the first time claims are processed and will further bypass scrutiny in a post-payment audit, should one occur.

This article highlights the three modifiers already on the OIG's radar during the writing of this article in April 2020.

OIG Work Plan

"The OIG Work Plan sets forth various projects including OIG audits and evaluations that are underway or planned to be addressed during the fiscal year and beyond by OIG's Office of Audit Services and Office of Evaluation and Inspections."[3]

Since June 15, 2017, the OIG has published monthly updates to its Work Plan for increased transparency. Healthcare organizations and provider offices should review the updates and address any applicable items before the expected OIG issue date. It is imperative to monitor areas of potential risk in the Work Plan in your own healthcare organizations and provider offices to ensure compliance.

Modifier -25

Modifier -25 is an infamous payment modifier.

No-no's of modifier -25

A recent OIG enforcement on February 4, 2020, involved a retina surgery physician group in Tennessee that unfortunately abused its use of modifier -25 on its billing of evaluation and management (E/M) services.[4] In this case, no separate and distinct qualifiers were identified in documentation from 2009 through 2016.

Another example from July 2, 2018, highlights a network of urogynecology providers in Florida that settled allegations of fraud, waste, and abuse to the tune of $1.7 million dollars.[5] Here, the providers performed and

billed Medicare for lavage treatments and pelvic floor therapies, then allegedly billed modifier -25 as if they provided another service, even though no additional medical care was provided.

So, despite the fact that the OIG has been issuing reports on modifier -25's erroneous application alongside key educational elements since 2005,[6] the instances of intentional and unintentional fraud and abuse still run rampant in many physician practices.

Correct uses of modifier -25

Here are a few basic facts that will help you apply this payment modifier correctly:

1. By definition, it is a "significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service."[7]
2. It is only appended to the E/M code, not the separate minor procedure (with 000 or 010 global days) or service code.[8]
3. From a coding perspective, all physicians who bill under the same National Provider Identifier (even those sharing one in a group practice) are considered the same provider.[9]

Here are a few tips and tricks to help support the understanding, as well as documentation, of the modifier implementation:

1. All procedures and services (no matter how minor at 000 or 010 global days) include an inherent E/M component (or the pre- and post-operative work for the procedure or service).[10]
2. It can be used for a new patient visit *(Tip: With services such as chemotherapy or nonchemotherapy infusions or injections)*.[11]
3. It can be used for an established patient visit with a new complaint or change in status.[12]
4. It can be used to link diagnoses, signs, and symptoms, as applicable.[13]
5. Documentation should highlight medical necessity for both E/M and same-day procedure or service.[14] *(Bonus points: separate E/M documentation as a stand-alone in electronic medical record to amplify the distinction of services.)*
6. Be mindful of any global periods for a previous procedure.
7. Verify National Correct Coding Initiative (NCCI) edits before submitting modifier -25.[15]*(Tip: Code pairs identified with 0 cannot be submitted separately for reimbursement; code pairs identified with 1 can be submitted separately for reimbursement; code pairs identified with 9 are not subject to NCCI edits and no modifier is required.)*