Modifiers Under Scrutiny
How to Avoid Adverse Audits

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Financial Interest

I acknowledge a financial interest in the subject matter of this presentation.

Global Fee Periods

• Before using modifiers, it’s important to understand global fee concept
• A global fee is defined as:
  – A single fee that involves all necessary services normally furnished by the surgeon before, during and after the surgical procedure

Global Fee Periods

• Services included in global fee period:
  – Pre-op visits
  – Intra-operative services
    • Services performed day of or during service
  – Complications following surgery that do not require a return to the OR
  – Post-operative visits
  – Supplies

Global Fee Periods

• Services not included in global fee period:
  – Initial new patient exam
    • Modifier -25 or -57 not required
  – Visits unrelated to diagnosis for which surgery was performed
  – Treatment for underlying condition or added course of treatment
  – Diagnostic tests

Global Fee Periods

• Unrelated surgical procedures
  • Not reoperations or treatment for complications
  – Treatment for post-op complications requiring return to OR
  – More extensive procedure following a failed less extensive procedure
    • Retinal detachment repair following focal laser
  – Separate procedures performed in stages
    • 5FU injections in lane following trabeculectomy
Global Fee Periods

- There are two types of global fee periods – Minor and Major
  - **Minor Surgery - “0” day global fee period**
    - Includes day of surgery only for such procedures as:
      - Biopsies
      - A/C tap
      - Subconjunctival or Sub-Tenon injections
      - Trichiasis by forceps
  - **Minor Surgery - “10” day global fee period**
    - Includes day of surgery and 10 days following surgery such as:
      - Punctum plug insertions
      - Lesion removals
      - Epilation trichiasis
      - Argon Laser Trabeculoplasty (ALT) - code 65855
      - Laser Iridotomy/Iridectomy - code 66761
  - **Major Surgery – 90 day global fee period**
    - Includes day before surgery, day of surgery, and 90 days following surgery for such procedures as:
      - Blepharoplasty
      - Ectropion/Entropion repair
      - Cataracts
      - YAG laser capsulotomy
      - Retinal Detachments/Repairs
      - Laser procedures (except ALT & laser iridotomy/iridectomy)
      - Vitrectomy
      - Glaucoma filter procedures

Global Fee Periods

- Medicare considers all doctors in a group practice to be considered the “same” doctor with regard to providing post-operative care
  - Patient develops edema following cataract surgery and sent to retina doctor to treat
    - Office visit not billable
    - Treatment billable if it requires a “return to OR” (-78 modifier)

- Allied staff should monitor patient's global fee period
  - Inappropriate billing and fragmentation of services could result in unnecessary denials and/or a Medicare audit
    - i.e., documenting that the visit should be billed as unrelated when the patient was scheduled for post-op follow-up visit
      - Can’t bill with -24 modifier even if doctor discovers another problem during that visit

Why Modifiers Are Required
Modifiers

• Modifiers are:
  – Integral part of billing process
  – Permit services to be paid that would otherwise be denied
• Modifiers are needed to:
  – Ensure proper payment
  – Prevent excessive denials and lost revenue
  – Identify special circumstances
  – Permit payment in global fee period

Modifiers

• Modifiers may indicate:
  – Service performed by more than one physician
  – Bilateral procedure was performed
  – A cancelled surgery
  – Multiple procedures were performed
  – Services performed in global fee period:
    • Unrelated to surgical event itself
    • Treatment of complication requiring return to OR

Modifiers

• Incorrect or missing modifiers are the most common reasons claims are denied
• Modifiers may also trigger an audit
• Modifiers can change from year-to-year
  – Resources should be current
• Modifiers alert 3rd party payers that special circumstance warrants payment

Modifiers Under Scrutiny

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Modifier -22

• Increased procedural service
  – Work during surgery is substantially greater than usual
  – Documentation (op report) must support additional work and reason for the work
  – For example:
    • Increased intensity
    • Time
    • Technical difficulty of procedure
    • Severity of patient’s condition

Modifier -24

• Unrelated service during post-op period
  – Office visit is not related to:
    • Underlying condition for which surgery was performed, or
    • Surgical episode itself such as complications
  – Before appending modifier -24 should always ask:
    • Would patient have needed exam if the surgery had not been performed
      – If answer is yes, then modifier -24 is appropriate
## Modifier -24

- Do not use modifier -24 for office visits related to complications of surgery
  - Post-op follow-up visits
  - Second eye surgery exam if visit addresses surgical eye and no new complaints in fellow eye
  - Known complications of surgery such as
    - Endophthalmitis
    - Conjunctivitis

## Modifier -24

- Example:
  - Surgery patient returns in global fee period of cataract surgery for scheduled 3-month glaucoma follow-up
  - Modifier -24 is appropriate
    - Glaucoma diagnosis unrelated to cataract surgery
    - Make sure CC does not state “here for PO exam”
    - Diagnosis must be glaucoma, not cataract
      - This is a common billing error
      - Billers can’t bill appropriately if chart not correct

## Modifier -24

- Example:
  - Patient presents during global fee period of cataract surgery with pain and foreign body sensation in fellow eye
    - Exam determines need for removal of foreign body
  - Modifier -24 is appropriate
    - Complaint in “fellow eye” not surgical eye
      - This exam may actually warrant the -24 and -25 modifiers

## Modifier -24

- Example:
  - Patient presents during global fee period of cataract surgery with decreased vision in the surgical eye so severe it’s affecting their ability to function
    - Exam identifies severe posterior capsular opacification and YAG laser surgery recommended same day
  - Modifier -24 is not appropriate
    - PCO is known complication of cataract surgery
      - If patient outside global fee period, then -57 modifier would apply

## Modifier -24

- Example:
  - Patient evaluated and found to have bilateral cataracts at initial visit
    - Patient is scheduled for surgery, has right cataract removed and is seen post-operatively
  - At second post-op visit, patient ready to schedule surgery for left eye
    - Chart indicates “first eye healed and stable”
  - Modifier -24 is not appropriate
    - Visit primarily for post-operative follow-up of first surgery
    - Only a brief exam of second eye was performed

- Modifier -24 would be appropriate if:
  - Exam was more than 90 days after first cataract surgery
  - Patient presents with new symptoms or new complaints in second eye
  - Significant change in health requiring new evaluation prior to proceeding with second eye surgery
### Modifier -24

- CMS and OIG have been looking closely at office visits/modifiers billed during global fee period for several years
  - Prior audits have shown improper use of modifiers during global fee periods resulting in inappropriate payments to providers
  - Suggest you conduct internal audits of post-operative modifiers on a regular basis

### Modifier -25

- Significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service
  - Source: CPT Coding Manual
  - Exam is not just incidental to surgery
  - Visit above and beyond usual pre- and post-operative care associated with minor surgery
  - Append modifier -25 to office visit not procedure or diagnostic test

### Modifier -25

- Not used to report exam that resulted in a decision to perform surgery
  - See Modifier -57
- Most common misconception among doctors
  - Modifier -57 applies to major surgery (90 day global) not minor surgeries or procedures

### Modifier -25

- Does NOT apply to new patients for Medicare
  - Doesn’t hinder processing if applied
  - RAs don’t always know this rule
  - May be required by commercial carriers
  - New patient is defined as any patient who has not been seen by a physician of same specialty in the practice in the previous 3 years

### Modifier -25

- Example:
  - Patient presents with complaint of pain and foreign body sensation after being hit in eye with tree limb
    - Complete exam performed to determine extent of injury and cause of pain – FB removed
    - Modifier -25 is appropriate
  - If only slit lamp performed and foreign body removed without complete eye exam, office visit not billable

### Modifier -25

- Example:
  - Serial tonometry performed on same day as exam
    - Modifier -25 is not needed when only service performed is diagnostic test
  - Continually appending -25 modifier with tests may draw unnecessary attention to your practice
    - Medicare and OIG currently investigating use of this modifier
Modifier -25

• Retinal injections are particular area of concern
  – Huge increase in intravitreal injection visits billed with -25 modifier
  – Modifier -25 should always be the exception not the rule
    • Does not have to be a different diagnosis
    • Must address more than the decision for surgery that extends above and beyond pre-operative care

Modifier -25

• Example:
  – Patient presents with neovascular AMD in left eye status-post Lucentis injection 4 weeks ago
    • States vision improved in left eye but now has decreased vision and distortion in right eye
  – Exam shows new AMD in right eye
    • Left eye has active AMD
    • Pt treated with Lucentis in RT eye – Told to return for Lucentis in LT eye in 3 days
  – Modifier -25 is appropriate

Modifier -25

• Example:
  – Patient presents for injection #4 in left eye
    • States vision not that great but stable
  – Surgeon recommends intravitreal injection today and FU in 2 months with OCT
    • No new complaints or medical necessity to perform exam over and above need for injection
  – Modifier -25 is not appropriate

Modifier -25

• Example:
  – Patient presents for reassessment of wet AMD in right eye, floaters in both eyes, and dry eyes
    • Patient states doing well, no changes in vision, floaters decreasing, dry eyes improved
  – OCT shows marked improvement
  – Surgeon recommends
    • Intravitreal injection today, continue dry eye regimen adding ointment at night as needed
    • Continue to monitor floaters
  – Modifier -25 is appropriate

Modifier -25

• In Summary
  – Modifier requires exam over and above usual pre- and post-operative care associated with procedure
  – Use with office visits only
    • Not on tests or surgeries
  – Procedure must have a "0" or "10" day global fee period
  – May sometimes need to append both -24 and -25 modifiers
### Modifier -25
- Only applies to the physician performing the surgery
- Can’t use on re-evaluations when patient asked to return for the surgery
- Diagnosis does not have to be different
  - *But, different diagnosis, in itself, may not warrant the use of modifier -25 either*

### Modifier -59
- **Procedure or service is distinct or independent from other services performed on the same day**
  - Used to unbundle codes included in the Correct Coding Initiative (CCI) edits
  - Distinguishes procedures not normally reported together:
    - Different session or encounter
    - Different procedure or surgery
      - Separate excision/incision

### Modifier -59
- **Different site or organ system**
  - Anterior segment vs. posterior segment
  - Separate lesion
  - Separate injury
- Modifier -59 should not be appended to office visits
- Should only append modifier -59 on second and subsequent procedures performed at the same session

### Modifier -59
- Documentation in the medical record must satisfy the CCI bundling criteria
  - If not, claim will be denied in post-pay audit and refund requested
- One of the biggest misuses of modifier -59 is related to the definition of "different procedure or surgery"

### Modifier -59
- Example:
  - New patient presents with cataracts, glaucoma, and high IOP
    - Surgeon performs peripheral iridotomy (66761) to lower pressure at that visit
  - Patient returns in afternoon with no improvement
    - Surgeon decides to remove cataract (66984) to aid in lowering intraocular pressure
  - Modifier 59 is appropriate
    - Different procedure/session
Modifier -59

**Example:**
- Patient had cataract surgery and limbal relaxing incisions, code 65772, at same time
- Modifier -59 is not appropriate
  - Code 65772 is only to be used for correction of "surgically induced" astigmatism
  - Following surgery (3 days, 3 weeks, 3 months, etc.)
  - In this instance the surgery is for correction of natural astigmatism and not covered by Medicare
  - Can be billed to patient with code 66999 and 65772

**Example:**
- During cataract surgery (66984), vitreous prolapse occurred
  - Anterior vitrectomy (67010) performed to take care of hemorrhage
  - Modifier -59 is not appropriate
  - Since both the cataract and the anterior vitrectomy were performed in the same segment of the eye, unbundling would not be appropriate
    - Diagnosis alone does not justify unbundling

Modifier -59

**Example:**
- During cataract surgery (66984), vitreous prolapse occurred
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“X” Modifiers

**Example:**
- Instead of modifier -59 can use following modifiers if applicable
  - XE – Separate Encounter
  - XS – Separate Structure
    - Separate organ/structure
  - XP – Separate Practitioner
  - XU – Unusual Non-Overlapping Service
    - Does not overlap usual components of main service
  - No guidelines yet
    - Use optional

Who’s Auditing Modifiers?

**Medicare Administrative Contractors (MACs)**
- CERT audits
  - Performed post-operatively on a statistically-valid random sample of Medicare claims
    - Look to see if claims were paid properly
    - Claims are subject to potential postpayment denials, payment adjustments, or other legal actions
  - CERT audit results are also shared with RAC auditors if audits indicate billing patterns that may suggest fraud
    - Have identified high number of office visits billed at comprehensive level
    - Some included modifiers -24 and -25

Who’s Auditing Modifiers?

**Recovery Auditors (RAs)**
- There are two types of RA audits
  - Paid claims data
    - No medical record required
    - Will receive letter requesting copies of charts
  - Medical record audit
    - Most practices only audited on paid claim data not record request
    - RAs can go back 3 years to audit
      - Medicare contractors only 1 year unless fraud suspected
Who's Auditing Modifiers?

- **Office of Inspector General (OIG)**
  - The big daddy of auditors
  - Looking at global fee modifiers for several years now
  - Particularly interested in modifiers -24, -25 and -59
  - Previous audits showed significant error rates for modifiers -25 and -59
  - 35% of modifier -25 did not meet requirements
    - Resulted in $538 million in improper payment
  - 40% of modifier -59 did not meet requirements
    - Resulted in $59 million in improper payments

- **Zone Program Integrity Contractors (ZPICs)**
  - Work in conjunction with Program Safeguard Contractors (PSCs)
  - Identify cases of suspected fraud and take appropriate corrective actions
    - Have not seen anything specifically related to modifiers
      - Just be aware using -25 excessively on retinal injections could become an issue

Avoiding Scrutiny

- Medicare considers all doctors in a group practice to be considered the “same” doctor with regard to providing post-operative care
  - Patient develops edema following cataract surgery and sent to retina doctor to treat
    - Office visit not billable
    - Treatment billable if it requires a “return to OR” (-78 modifier)

- Run procedure reports on modifiers used most frequently
  - Conduct internal audits to make sure requirements are being met
- Hold in-services as needed if requirements not met
  - Include billers and coders as well as technicians and nurses
    - Remember, just because Medicare paid it doesn’t mean it was paid appropriately

- Modifiers are located in the back of the CPT coding manual
  - Make sure all billing and coding staff refers to these modifiers regularly
- If in doubt whether a particular modifier is needed, ask a supervisor for assistance
  - Compliance is important for:
    - Avoiding audits
    - Getting paid appropriately
### Avoiding Scrutiny

- Correct use of modifiers can improve reimbursement when medical records are documented properly
  - Without supporting documentation, claim could be denied in post-payment audit
- Overuse or incorrect modifiers could subject practice to:
  - Overpayment and refund requests
  - Penalties for fraudulent billing
  - Possible prepayment scrutiny

### Avoiding Scrutiny

- Audit billing practices regularly
  - Regular internal audits
  - External audits at least every 1-2 years
  - Review contractor LCDs on a regular basis
- Modify habits to be in compliance
  - Develop internal policies if needed to effect changes

### Questions

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