Part B Insider (Multispecialty) Coding Alert

MODIFIERS: Prepare For Audits Of Modifiers 25 And 59

Pitfall: A quarter of modifier 59 claims didn't have enough documentation

The **HHS Office of Inspector General** cast a spotlight on your use of the 25 and 59 modifiers, and the results weren't pretty.

Bad news: The OIG found a 40-percent error rate for the 59 modifier in its sample of claims, and a 35-percent error rate for the 25 modifier. In both cases, the OIG encouraged the **Centers for Medicare & Medicaid Services** to sic the Part B carriers and Recovery Audit Contractors on your claims that use these modifiers. You can expect to see a lot more prepayment and postpayment audits for both modifiers.

Modifier 59

Out of the claims with the 59 modifier (Distinct procedural service) that the OIG audited, 15 percent weren't distinct because "they were performed at the same session, same anatomical site and/or through the same incision," the OIG says. Providers used the 59 modifier improperly to couple bone marrow biopsy (38221) and bone marrow aspiration (38220) or physical therapy codes **CPT 97140** and **CPT 97530** . Also, chemotherapy and IV infusion seemed to be frequent culprits.

Another 25 percent of 59 modifier claims lacked enough documentation to support one or both of the services. And in 7 percent of cases, the provider should have billed a different code altogether for one of the services. Also, 11 percent of claims had the 59 modifier attached to the primary code instead of the second code, and another 13 percent had the 59 modifier attached to both primary and secondary codes.

The OIG suggested that carriers could focus on the handful of code pairs that it already identified problems with. And the OIG said CMS should make sure carriers only pay claims when the 59 modifier is attached to the secondary code, not the primary, but CMS responded that it lacks the technical ability to put in place such an edit.

Orthopedics: Make sure the physician is working in a separate compartment (of the knee) or body area before you use the 59 modifier, says **Margie Vaught**, a coding consult in Ellensburg, WA. Or if your physician is performing biopsys of lesions, make sure they're multiple lesions and not just multiple biopsys of the same lesion. You should also make sure you use separate ICD-9 codes for the diagnoses behind the separate procedures, she advises.

Fix Your Documentation, Or You'll Be In A Fix

Meanwhile, Medicare spent $538 million on improper claims using the 25 modifier (Significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service), the OIG says.

Only 2 percent of these improper claims involved E/M services that weren't significant and separately identifiable, the OIG says. Another 34 percent of claims involved missing or incomplete documentation.

Some 27 percent of 25 modifier claims had documentation of the procedure, but not the separate E/M. For example, documentation showed that the provider gave the patient a flu shot, but no information about a separate E/M service. Another 4 percent were missing identifying information about the physician or patient.

Also, in 9 percent of cases (2.6 million claims), the provider used the 25 modifier even though the E/M visit was the only

service billed that day--meaning the modifier was unnecessary.

The OIG says CMS should educate providers and reinforce the requirement that you should only use the modifier 25 with services that are "significant, separately identifiable" and "above and beyond the usual preoperative and postoperative care associated with the procedure." Also, CMS promised to modify the Medical Claims Processing Manual to require proper documentation for the 25 modifier.

Quick tip: When you're applying the 25 modifier, you should remember the maxim: "If you don't have a HEM, you can't bill an E/M," says **Laureen Jandroep**, director and senior instructor for **CRN Institute** in Absecon, NJ. Here, "HEM" stands for "history, exam and medical decision-making." All procedures include a mini-E/M visit related to the procedures, but a separate E/M should include its own HEM, Jandroep insists.

"When you put the 25 modifier on, you're telling the payor, 'I have documentation to back it up,'" adds Jandroep.

Final warning: Carriers are already scrutinizing the 25 modifier, and many private payors have balked at paying for E/M services with the 25 modifier for years, says Vaught. But many carriers haven't looked at the 59 modifier for surgical services before, and providers may not be used to having their use of the 59 modifier audited, she warns.