HEALTHCARE REGULATORY ROUNDUP

Modifier 25 and Same Day Services:
How the Truth Finally Prevailed in a Recent Appeal

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Introductions

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Objectives

1. Overview of the history of the bundling of Evaluation & Management (E/M) in chemotherapy infusion
2. Understanding common clinical reasoning for performing an E/M during the period of treatment cycles
3. Examples of a successful appeal, and the strategies and tactics applied

OIG

- History of Reports
- OIG Work Plans
- Recent Work Plan

CMS MLN Booklet

- Another example of E/M upcoding is misusing Modifier 25.
  - Modifier 25 allows additional payment for significant, separately identifiable E/M service provided on the same day of a procedure or other service.
  - Upcoding occurs when a provider uses Modifier 25 to claim payment for medically unnecessary E/M service, an E/M service not distinctly separate from the procedure or other service provided, or an E/M service not above and beyond the care usually associated with the procedure.

DOJ Settlements

- Georgia Cancer Specialist (2012)
- Southeast Orthopedic Specialists (2016)
- FWC Urogynocology (2018)
- Skyline Urology (2019)
- Southern Retina Associates (2020)
- Premiere Medical Association (2020)

Private Payors

- CMS and the OIG have documented the Modifier 25 is one of the most frequently misused modifiers by medical providers.
- WellCare may require medical records prior to payment for evaluation and management services to which Modifier 25 is appended in certain situations to validate that the documentation demonstrates that the evaluation and management service is significant and separately identifiable.

Overview of the Modifier 25 Guidelines

Modifier 25 Definitions

- **Modifier 25 definition**
  - Significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service
- **Modifier 25 is used by both physicians and hospitals**
  - Physicians reimbursed under the Medicare Physician Fee Schedule (MPFS)
  - Hospitals reimbursed under the Ambulatory Payment Classifications (APC)

Global Period Overview

- **Global Surgical Period**
  - The National Physician Fee Schedule Relative Value File lists the global period applicable to surgical procedures.
    - Codes with a global day status of 000 or 010 (0 and 10 global days respectively) are considered minor surgical procedures.
    - Modifier 25 is appended to E/M codes for separate services to ensure payment.

Source: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Relative-Value-Files.html

Modifier 25 Overview

- **Modifier 25 may only be used with an E/M code**
  - Modifier 25 should be used when ***ALL** of the following are **TRUE**:*
    - E/M service was provided by the same physician and on same date as a procedure or other service
    - Patient's condition required a significant and separately identifiable E/M service above and beyond the usual work associated with the medical or surgical procedure
    - Documentation in the medical record supports the reporting of an E/M service

Modifier 25 Overview (cont'd)

Key Phrases:

- **Patient's condition required**
  - Medically necessary for the additional service(s) to be performed on the same day that another procedure or service was performed
- **Significant, separately identifiable E/M service above and beyond**
  - The additional service was clearly different from the procedure or service performed

Modifier 25 Overview (cont'd)

- **Why is it needed?**
  - Procedure Reimbursement Package
    - Procedures defined in the Resource-Based Relative Value Scale (RBRVS) reimbursement system include a certain amount of preoperative and postoperative care
    - Modifier 25 may be used to report additional work not associated with the procedure but required by the patient's clinical condition
    - The modifier "overrides" the coding edit to ensure the physician is reimbursed for the additional E/M service

Modifier 25 Overview (cont'd)

- **Helpful tips:**
  - If the physician diagnoses the patient's condition and begins performing a minor procedure or endoscopy on the same day, modifier 25 should be added to the E/M service.
  - If the purpose of the E/M service was to familiarize the patient with the procedure immediately before the procedure, modifier 25 does not apply.
  - If the patient is present for the procedure only, modifier 25 does not apply.
  - A separate diagnosis code is not required.

How to Use Modifier 25

- **Was the required, separately identifiable E/M service performed on the same day as minor surgery?**
  - Minor surgery includes procedures with 000 or 010 global days.
    - Examples include:
      - Wound closure/repair
      - Drainage of skin abscess
      - Biopsy of skin lesion
      - Biopsy of breast percutaneously

How to Use Modifier 25 (cont'd)

- **Codes with 000 global period**
  - Includes endoscopic or minor procedures
  - Preoperative and postoperative services provided on the day of the procedure included in the procedural payment amount
    - E/M Services provided for a separate condition or beyond the usual pre-/post-operative work on the same date would require modifier 25 for reimbursement
    - Different diagnoses are not required to support a separate E/M service

How to Use Modifier 25 (cont'd)

- **Codes with 010 global period**
  - Includes minor procedures.
  - Preoperative services provided on the day of the procedure and postoperative services provided during a 10-day period included in the procedural payment amount.
    - Procedural examples:
      - 10061 – incision and drainage of abscess, complicated or multiple
      - 11200 – removal of skin tags
      - 17003 – destruction of benign or premalignant lesions second through 14
      - E/M Services provided for a separate condition or beyond the pre-/post-operative work on the same date would require modifier -25 for reimbursement

How to Use Modifier 25 (cont'd)

- **Modifier 25 should NOT be used with:**
  - Surgical CPT codes
  - An E/M code when the encounter was for a planned procedure or service performed
  - An E/M service completed on a different date of service than the procedure/surgery
  - An E/M service completed when no other service was performed on the same day
  - An E/M service that results in the decision to perform a major procedure (with 90-day global period). Instead, use modifier 57, decision for surgery.

Unrelated Components

- **When determining the level of E/M visit to bill when modifier 25 is used:**
  - Only consider the content of the components associated with condition for the separate E/M service:
    - History
    - Exam
    - Medical Decision Making
    - Time
  - Do **not** consider the content or time of the procedure or the associated pre/post-procedural work when assigning the E/M level of service.

How to Use Modifier 25 (cont'd)

- **Procedural Examples:**
  - **96372** – Therapeutic, prophylactic, or diagnostic injection
  - **96413** – Chemotherapy administration, IV Infusion; 1 hour
    - Both of these codes have XXX global day status indicating global concept does not apply.
    - Services performed on the same date as the surgical procedure can be separately reported without a modifier.
    - However, Medicare Manual requires Modifier 25 on E/M with chemo services provided on the same day.

Chemotherapy Guidelines (CPT)

"Physician or other qualified health care professional work related to hydration, injection, and infusion services predominantly involves affirmation of treatment plan and direct supervision of staff."

"Chemotherapy administration codes 96401-96549 apply to parenteral administration of non-radionuclide anti-neoplastic drugs; and also to anti-neoplastic agents provided for treatment of noncancer diagnoses (eg, cyclophosphamide for auto-immune conditions) or to substances such as certain monoclonal antibody agents, and other biologic response modifiers. The highly complex infusion of chemotherapy or other drug or biologic agents requires physician or other qualified health care professional work and/or clinical staff monitoring well beyond that of therapeutic drug agents (96360-96379) because the incidence of severe adverse patient reactions are typically greater. These services can be provided by any physician or other qualified health care professional. Chemotherapy services are typically highly complex and require **direct supervision for any or all purposes of patient assessment, provision of consent, safety oversight, and intraservice supervision of staff**. Typically, such chemotherapy services require advanced practice training and competency for staff who provide these services; special considerations for preparation, dosage, or disposal; and commonly, these services entail significant patient risk and frequent monitoring. **Examples are frequent changes in the infusion rate, prolonged presence of the nurse administering the solution for patient monitoring and infusion adjustments, and frequent conferring with the physician or other qualified health care professional about these issues.** When performed to facilitate the infusion of injection, preparation of chemotherapy agent(s), highly complex agent(s), or other highly complex drugs is included and is not reported separately. To report infusions that do not require this level of complexity, see 96360-96379. Codes 96401-96402, 96409-96425, 96521-96523 are not intended to be reported by the individual physician or other qualified health care professional in the facility setting."

Chemotherapy Administration (NCCI)

"*The drug and chemotherapy administration HCPCS/CPT codes 96360-96375, 96377 and* ***96401-96425 have been valued to include the work and practice expenses of CPT code 99211*** *(E&M service, office or other outpatient visit, established patient, level I). Although CPT code 99211 is not reportable with chemotherapy and non-chemotherapy drug/substance administration HCPCS/CPT codes, other non-facility-based E&M CPT codes (e.g., 99202- 99205, 99212-99215) are separately reportable with modifier 25 if the physician provides a significant and separately identifiable E&M service."*

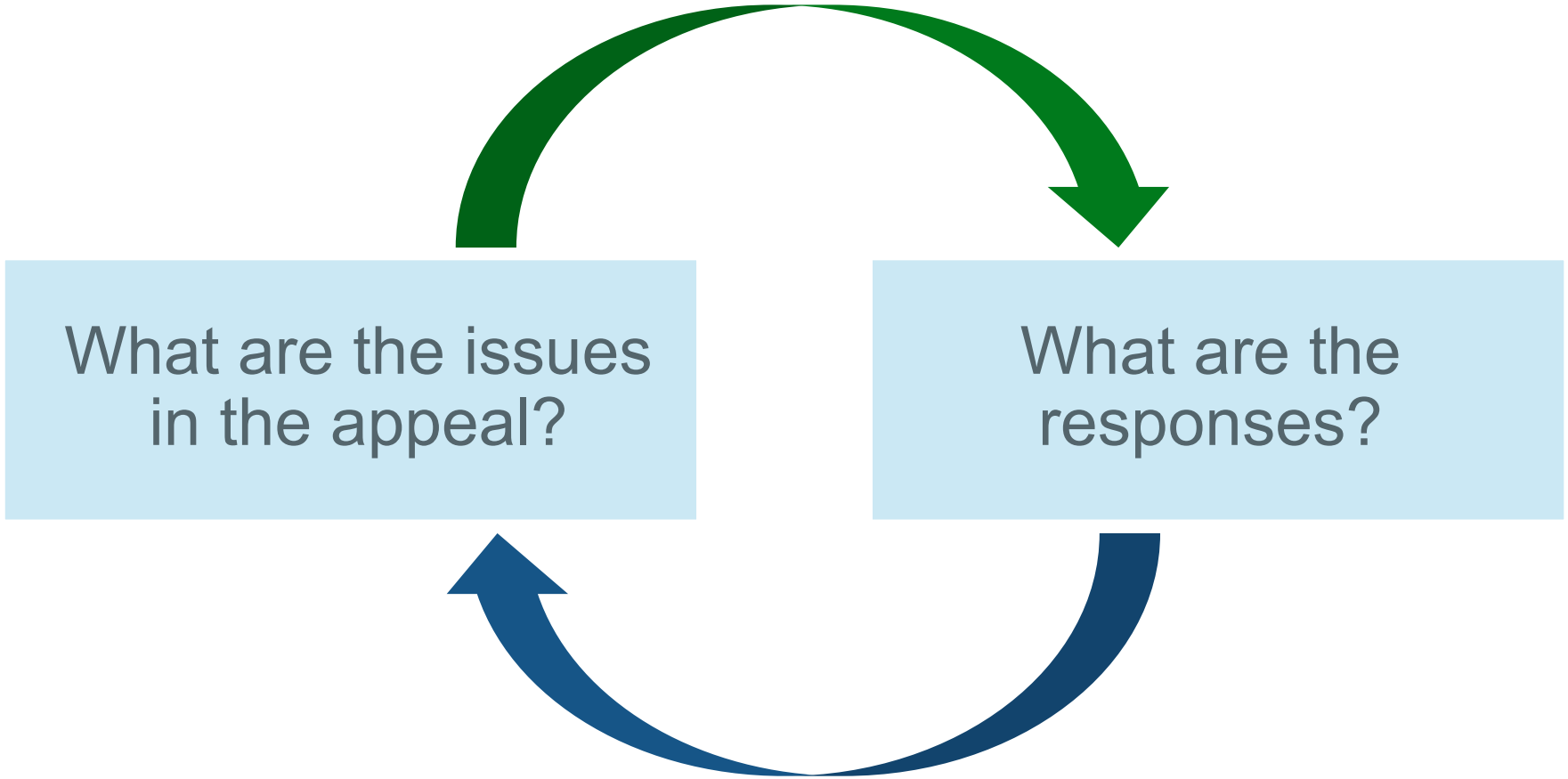
1) National Code Correct Initiative Manual, Ch. 11, Chemotherapy Administration

Appeals and Responses

Levels of Appeal

- Redetermination
- Reconsideration
- Administrative Law Judge
- Medicare Appeals Council
- Other

Appeals: Issues and Responses



Appeals: Issues and Responses (cont'd)

- Organization of the Responses
  - Procedural
  - Financial
  - Clinical
    - Clinical categories from appeal
  - Coding
- Presentation at appeal/setting for each bucket
- Limitations of arguments

Takeaways from the Decision

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