March 30, 2018

Weekly **Auditing and Compliance** Tip

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To Modify or Not to Modify

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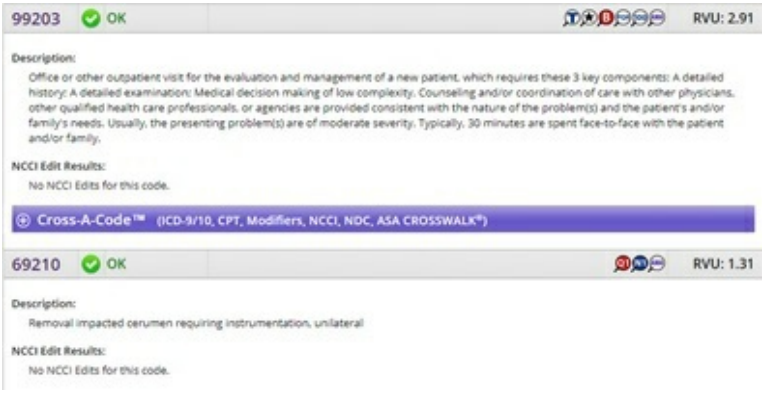
If you work in a medical office, you are probably familiar with Comparative Billing Reports or CBRs. You know, those friendly letters insurance carriers send to educate the providers that their billing habits fall outside of the average. For the past several years, many of these CBRs have been telling us we are overutilizing modifiers like -25 and -59. When you read these letters, you may think, "But we have to use them to get paid." Have you ever really researched to find out why your claims are outliers? If not, you are most likely also receiving documentation requests from the insurance carriers prior to being paid for claims that include them. Let's look at ways to ensure the modifiers are being appended correctly.

When learning to code, we are all taught we should append modifiers when more than one service is rendered on the same day. What we aren't always taught is the true "why" of modifier usage or how they actually "modify" our claim. All procedures are assigned a value based on the work required to perform the procedure. This value includes pre-operative services routinely performed by the provider. When we append the E&M modifier -25 (for 0-10 global services) we are indicating the provider rendered *"Significant, Separately Identifiable E&M services on the Same Day of the Procedure."* What it should also say is "For Which there is an NCCI edit."

The first step to avoid claim delays and minimize the number of modifier related CBRs is to run NCCI checks for your common procedures with E&M codes. You may be surprised to learn that there are no edits for many of these when done with a new patient visit. For example, if we check the edits for 99203 and 69210 (impacted cerumen removal), we will find this:



The discussion about modifier overutilization came up with an Orthopaedic practice. It was suggested they run each of their office procedures thru a code editor with a new patient E&M. They got the same result as in the example above for every one of them. They then ran fracture care codes (90 day global) and found the ones most commonly reported did not need modifier -57. As a result, they eliminated the use of the modifiers on new patient claims for payors who follow NCCI.

Once we know an edit exists, look at the visit's intent. If the established patient visit is for a new problem, it is possible the provider documented a significant, separately identifiable E&M service above and beyond the work required as part of the procedure. If so, then it is appropriate to append the modifier. However, if the intent of the visit was to perform the procedure, an E&M should not typically be billed. Back to the Orthopaedic world for an example. Mr. Smith comes in with knee pain. The provider diagnoses him with osteoarthritis of the knee and schedules him to come in for a series of viscosupplementation injections. Mr. Smith returns the next week for the first injection in the series. The provider verifies there have been no significant changes in Mr. Smith's condition and performs the injection. No

E&M should be billed for this date because the intent of the visit was to do the procedure. The work of the E&M was done the previous week. However, if Mr. Smith had a new complaint of shoulder pain when he returned for the injection, and the provider documented an appropriate E&M service related to the shoulder pain, the

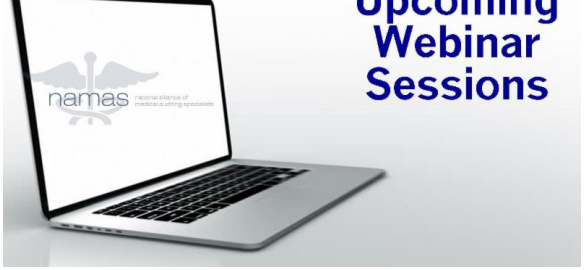
E&M for the shoulder pain can be reported with modifier -25.

So far, our discussion focus has been modifier -25, but these steps also apply to the procedure modifier -59. First, is there an edit between the codes being reported that requires a modifier. If not, no modifier. If so, the documentation needs to be audited to see if it supports *"a different session, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same individual."* If any of these are clearly supported by the documentation, a modifier can be appended. Modifier -59 is a "last resort" modifier. When another modifier (i.e. anatomical modifiers) is appropriate, it should be used rather than -59. Several years ago, CMS released the -X{EPSU} modifiers. These modifiers are intended to be used instead of modifier -59. The value in these new modifiers is they help us identify when it is truly appropriate to unbundle procedures. It is likely you will find if one of these X modifiers do not apply, modifier -59 is not appropriate. They are:

- XE Separate Encounter, A Service That Is Distinct Because It Occurred During A Separate Encounter,
- XS Separate Structure, A Service That Is Distinct Because It Was Performed On A Separate Organ/Structure,
- XP Separate Practitioner, A Service That Is Distinct Because It Was Performed By A Different Practitioner, and
- XU Unusual Non-Overlapping Service, The Use Of A Service That Is Distinct Because It Does Not Overlap Usual Components Of The Main Service.

Using your code book to know what the complete code descriptions are will also help eliminate some of the questions. For example, the operative report indicates the provider performed a meniscectomy and chondroplasty on the right knee. When we check these codes for edits, we find that 29877 (chondroplasty)

can't be billed with 29881 (meniscectomy). If we go to our code book to see why, we find that the description for the meniscectomy states "including debridement/shaving of articular cartilage (chondroplasty), same or separate compartment(s), when performed." No matter how badly the provider would like to bill these codes together, no unbundling modifier is appropriate.



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Speaker: Scott Kraft, CPC, CPMA

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Speaker, Dr. Warner

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In short, these are things you can implement today:

1. Check CCI to know if an edit exists before appending a modifier
2. When a modifier is required, audit the documentation to verify it is supported
3. When in doubt, refer to your complete code descriptions
4. A final point that must be mentioned, not all carriers are created equal. This information is based on NCCI edits developed with CMS. Some payors have their own requirements, so know your payors.

This Week's Audit Tip Written By:

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- https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM8863.pdf
- https://www.palmettogba.com/palmetto/webTool.nsf/vTool/mod25
- https://www.cms.gov/Medicare/coding/NationalCorrectCodInitEd/index.html

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