

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

USE OF MODIFIER 25



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Inspector General

November 2005
OEI-07-03-00470

Office of Inspector General

<http://oig.hhs.gov>

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E X E C U T I V E S U M M A R Y

OBJECTIVE

To determine the extent to which use of modifier 25 meets Medicare program requirements.

BACKGROUND

Medicare payments for medical procedures include payments for certain evaluation and management (E/M) services that are necessary prior to the performance of a procedure. The Centers for Medicare & Medicaid Services (CMS) does not normally allow additional payments for separate E/M services performed by a provider on the same day as a procedure. However, if a provider performs an E/M service on the same day as a procedure that is significant, separately identifiable, and above and beyond the usual preoperative and postoperative care associated with the procedure, modifier 25 may be attached to the claim to allow additional payment for the separate E/M service. In calendar year 2002, Medicare allowed \$1.96 billion for approximately 29 million claims using modifier 25.

The Office of Inspector General (OIG) randomly selected 450 claims billed in calendar year 2002 using modifier 25 for medical review. OIG requested from the appropriate providers all medical records for services provided to the beneficiary on the date of service listed on the sampled claim. OIG was able to contact the providers who submitted 431 of these sampled claims; therefore, 19 claims were excluded from the analysis. OIG contracted with certified professional coders to determine whether the use of modifier 25 met program requirements. OIG also conducted structured interviews with all carriers focusing on their understanding, outreach, and oversight regarding modifier 25; conducted interviews with staff in CMS central and regional offices about their oversight of modifier 25 use; and reviewed examples of carrier outreach relating to modifier 25.

FINDINGS

Thirty-five percent of claims using modifier 25 that Medicare allowed in 2002 did not meet program requirements, resulting in \$538 million in improper payments. Medicare should not have allowed payment for these claims because the E/M services were not significant, separately identifiable, and above and beyond the usual preoperative and

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postoperative care associated with the procedure; or because the claims failed to meet basic Medicare documentation requirements.

Some additional claims did not meet program requirements, although the unnecessary use of modifier 25 may not have resulted in improper payments. A large number of claims submitted used modifier 25 unnecessarily, such as by attaching the modifier to an E/M claim when no other service was performed on the same day. While such use may not lead to improper payments, it does fail to meet program requirements.

Carrier oversight related to modifier 25 is limited. Carriers use different methods to provide outreach regarding the use of modifier 25. More than one-third of carriers have not conducted oversight related to modifier 25.

RECOMMENDATION

CMS should work with carriers to reduce the number of claims submitted using modifier 25 that do not meet program requirements.

CMS may want to:

- Reinforce the requirements that E/M services billed using modifier 25 be significant, separately identifiable, and above and beyond the usual preoperative and postoperative care associated with the procedure;
- Encourage carriers to emphasize that appropriate documentation of both E/M services and procedures must be maintained to support claims for payments using modifier 25 even though the documentation is not required to be submitted with the claims; and
- Emphasize that modifier 25 should only be used on claims for E/M services, and only when these services are provided on the same day as another procedure.

CMS should also encourage carriers to reexamine their modifier 25 outreach activities and include modifier 25 reviews in their medical review strategies where appropriate.

AGENCY COMMENTS

CMS concurred with the OIG recommendations and indicated that it recently made significant efforts to educate the provider community about the need for documentation to support services billed to the Medicare program. CMS noted that it will inform contractors of the OIG findings so they can take any appropriate actions. CMS will also modify the “Medical Claims Processing Manual” to clarify that appropriate documentation must be maintained to support claims for payments, even though providers are not required to submit the documentation with the claim. CMS indicated that it will explore the potential to place greater emphasis on modifier 25 outreach activities and include the modifier in contractor medical review strategies.

CMS did note that the majority of improper payments reported stemmed from instances in which the provider failed to furnish the documentation necessary to determine the medical necessity of the service, rather than uncertainty about the guidelines for using modifier 25. Nonetheless, CMS indicates it will explore options to reinforce or emphasize the requirements for using modifier 25.

OFFICE OF INSPECTOR GENERAL RESPONSE

OIG appreciates CMS’s comments on the draft report and recognizes its efforts to educate the provider community and contractors regarding the need for documentation to support services billed to Medicare. However, OIG believes it is important to note that additional improper payments may have been made, and that without proper documentation OIG was unable to determine if services were provided and whether these payments were appropriate.

► T A B L E O F C O N T E N T S

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OBJECTIVE

To determine the extent to which use of modifier 25 meets Medicare program requirements.

BACKGROUND

Evaluation and management (E/M) services that are necessary for the performance of a medical procedure (for example, assessing the site/condition of the problem area, explaining the procedure, and obtaining informed consent) are included in Medicare payments for the procedure.¹ However, if a provider performs an E/M service on the same day as a procedure that is significant, separately identifiable, and above and beyond the usual preoperative and postoperative care associated with the procedure, the provider may attach modifier 25 to the E/M service claim² to facilitate billing and to allow separate payment for the E/M service.³ In calendar year 2002, Medicare allowed \$1.96 billion for approximately 29 million services billed using modifier 25.

Required Documentation

Although providers are not required to provide supporting documentation when submitting claims using modifier 25,⁴ they must furnish “such information as may be necessary in order to determine the amounts due” to receive Medicare payment.⁵ Medical record documentation should include:

- Clinical information confirming that the E/M service billed was above and beyond the E/M services included in the procedure,⁶

¹ “CPT Assistant,” Vol. 8, Issue 9, September 1998.

² Within a single claim, multiple line items for individual services and procedures may be billed. OIG uses the term “claim” generically to refer to claims and claim line items.

³ CMS’s “Internet-Only Manual, Educational Resource Web Guide,” CMS Manual System, Publication 100-4, Medicare Claims Processing, Chapter 12, § 40.2 Billing Requirements for Global Surgeries, A-Procedure Codes and Modifiers, 8-Significant Evaluation and Management on Day of Procedure.

⁴ Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule for Calendar Year 2000, 56 Fed. Reg. 59502–59603 (1990).

⁵ Social Security Act, § 1833 (e). “No payment shall be made to any provider of services or other person under this part unless there has been furnished such information as may be necessary in order to determine the amounts due . . .”

⁶ “CPT Assistant,” Vol. 8, Issue 9, September 1998.

- Information to support that the provider submitting the claims for payment is the same provider that furnished both the medical procedure(s) and the E/M service,⁷ and
- Information indicating that a single beneficiary received both the medical procedure(s) and the E/M service billed.

Modifier 25 should be used only with the E/M service portion of the Medicare claim. Procedures submitted in conjunction with an E/M service do not need modifier 25 in order to be paid.⁸ Therefore, even if used appropriately for every encounter a provider has with every patient (one surgical procedure and one E/M service), modifier 25 should be used on no more than 50 percent of items billed.

Guidance and Outreach

Guidance to providers regarding the use of modifier 25 is available through a variety of sources, such as newsletters, bulletins, and letters from contractors and the Centers for Medicare & Medicaid Services (CMS). However, the governing source for determining appropriate payment is CMS's "Internet-Only Manual."⁹ Chapter 12, section 40.2 of the manual states:

Modifier 25 is used to facilitate billing of evaluation and management services on the day of a procedure for which separate payment may be made. It is used to report a significant, separately identifiable evaluation and management service performed by the same physician on the day of a procedure. The physician may need to indicate that on the day a procedure or service that is identified with a [Current Procedural Terminology] code was performed, the patient's condition required a significant, separately identifiable evaluation and management service above and beyond the usual preoperative and postoperative care associated with the procedure or service that was performed.

In addition, CMS allows providers to use the Current Procedural Terminology (CPT) Manual, published by the American Medical Association, as a source of information regarding the use of modifier 25. The CPT Manual contains detailed descriptions of the procedure codes

⁷ Social Security Act, § 1833 (e).

⁸ CMS's "Internet-Only Manual," Pub. 100-4, Medicare Claims Processing, chapter 12.

⁹ Department of Health and Human Services, CMS, "Internet-Only Manual," retrieved March 7, 2005, from <http://www.cms.hhs.gov/manuals/cmsindex.asp>.

and modifiers that providers use to submit claims for reimbursement to Medicare.

Medicare contractors that pay Part B claims, which are called carriers, issue guidance to providers regarding modifier 25 through carrier websites, newsletters, and workshops. Carriers also conduct outreach activities to help educate providers about Medicare policies, including modifier 25. Carriers may communicate directly through e-mails or letters, conduct local provider education and training programs, publish newsletters, and conduct provider communication meetings.

Oversight

CMS requires carriers to conduct oversight of claims in their respective jurisdictions. Carriers prioritize their claims oversight activities based on the degree of risk to the Medicare program and available resources, and prepare an annual medical review strategy that they submit to CMS. Each carrier may choose whether modifier 25 is included in its annual review strategy. CMS allocates funds to conduct the reviews based on each carrier's past review volume. Carriers are asked to then prioritize their workloads and perform reviews within that target budget amount.

METHODOLOGY

Literature Review

The Office of Inspector General (OIG) reviewed reports and other documents related to modifier 25 published by CMS, Medicare carriers, OIG, the Government Accountability Office, and other organizations (such as provider groups, journals, and industry newsletters).

Interviews

OIG conducted structured interviews with staff in CMS central and regional offices regarding their oversight of modifier 25 use. OIG also conducted structured interviews with medical review and provider education staff at all 24 carriers contracting with Medicare at the time of the review. Carrier interviews focused on the carriers' understanding of the definition of modifier 25 and the outreach and oversight they had conducted related to this modifier.

Electronic Claims Review and Sample Selection

OIG obtained all 2002 Medicare Part B provider claims from the CMS National Claims History file. From this file, OIG identified all allowed claims for services billed with modifier 25 and merged these claims with

the Physician Identification Master Record. OIG then determined each provider's proportion of modifier 25 use, based on all claims each provider submitted, which was used later in determining the sample for medical review.

OIG divided claims submitted with modifier 25 into two groups: those that had no other claim for the same beneficiary on the same day for the same provider and those that did.

Physicians who submitted claims included in the first group used modifier 25 unnecessarily because no other claims were submitted for the beneficiaries on the dates of those services.

From the second group, OIG excluded all providers submitting fewer than 25 claims using modifier 25 and those whose proportion of modifier 25 use was less than 1 percent, due to the low risk these providers pose.

OIG grouped the remaining 24.8 million claims into six strata based on the provider's proportion of modifier 25 use and volume of claims. OIG then randomly selected 75 claims from each of the six strata to create a sample of 450 claims. The appendix provides an overview of the six strata.

Medical Record Request

For each of the 450 sampled claims, OIG requested the provider identified to provide all medical records for services rendered to the beneficiary on the date of service listed. OIG achieved a 92 percent (415/450) response rate to the request for medical records. This response rate was spread across all six strata.

For the remaining 35 providers, either OIG received no response to the requests for medical records or requests were returned because of invalid addresses. OIG attempted to identify alternative addresses for these providers by consulting Medicare contractors, the Unique Provider Identification Number Registry Web site, State licensing boards for the provider's State of practice, and State licensing boards in contiguous States. OIG then mailed a request to each address identified. When telephone numbers were available, OIG also attempted to contact these providers by telephone.

Through these efforts, OIG was able to obtain valid addresses for 14 of the remaining 35 providers. OIG made at least four attempts to contact each of these providers, two or more of which were made via certified mail to each valid address identified. OIG received return receipts for these 14 providers, indicating that they received the

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request. OIG did not receive the requested documents from 13 of these providers. One provider submitted documentation after the completion of the data collection and review, and was therefore included in the 14 providers who did not respond to the OIG request. Two providers refused to provide medical records because they no longer maintained the records in question. One provider had retired and forwarded all medical records to his patients; the other was a physical therapist providing services to the patients of a provider OIG was unable to contact.

OIG was unable to obtain valid addresses or telephone numbers for 18 providers and unable to contact 1 additional provider. These 19 providers were not included in the analysis. Providers for 431 of the 450 sampled claims had the opportunity to respond and were included in the analysis.

Medical Record Review

OIG contracted with certified professional coders who used the medical records received from providers to determine whether the use of modifier 25 met program requirements. One of two coders reviewed each sampled record using a data collection instrument specifically designed for this study. This data collection instrument was based on the CMS definition of modifier 25 in the “Internet-Only Manual,” Chapter 12, section 40.2. CMS approved the instrument prior to use. After the initial coding review, a second coder reviewed each completed data collection instrument to be sure that the initial coder addressed each question correctly and clearly explained the results from a coding perspective. The project manager, a registered nurse with 18 years’ experience, also conducted a quality assurance evaluation of all reviews to ensure that the answers to questions were complete, consistent, and clearly communicated. In addition, interrater reliability testing was conducted on a 5-percent sample of the reviews. This means that for 5 percent of the records reviewed, the source medical record was rereviewed by a second coder in addition to the review done by the primary reviewer. Results of the second review were then compared with the original review to ensure that the coders were in agreement.

Standards

This study was conducted in accordance with the “Quality Standards for Inspections” issued by the President’s Council on Integrity and Efficiency and the Executive Council on Integrity and Efficiency.

FINDINGS

Thirty-five percent of claims using modifier 25 that Medicare allowed in 2002 did not meet program requirements, resulting in \$538 million in improper payments

In 2002, Medicare should not have allowed payments for 35 percent of claims for E/M services billed using modifier 25. These claims totaled

\$538 million in improper payments that Medicare and/or beneficiaries made. The payments were improper because the services were deemed (1) noncovered because they did not meet the requirements for use of modifier 25 or (2) undocumented due to failure to meet basic Medicare documentation requirements under section 1833(e) of the Social Security Act (the Act).¹⁰ These claims were distributed across strata, provider specialty types, and the Medicare carriers that allowed the claims. See Table 1 below for a summary of the improper payments.

Table 1: Improper Payments for Claims Using Modifier 25

| Basis for Improper Payment | | Sample | | | Weighted Projection | |
|----------------------------|---|--------------------|-----------------------|-------------------|-----------------------|----------------------|
| | | Number of Services | Services (Proportion) | Allowed Amount | Services (Proportion) | Allowed Amount |
| Noncovered | Failed to meet modifier 25 requirements | 9 | 0.02 | \$469.75 | | |
| Undocumented | Failed to document E/M service and/or procedure | 116 | 0.27 | \$6,868.20 | | |
| | Missing identifying information | 19 | 0.04 | \$1,202.72 | | |
| | Did not respond to request | 14 | 0.03 | \$1,127.51 | | |
| Total | | 158 | 0.36 | \$9,668.18 | 0.35* | \$538 million |

Source: OIG medical review of claim line items billed with modifier 25 and allowed by Medicare in 2002 and 2005.

* This percentage is projected and may therefore vary slightly from the sample proportion.

¹⁰ These projected statistics use weights derived by dividing the population of an individual stratum by the number of sampled claims in that stratum. For the point estimate of 35 percent, the confidence interval at 95 percent is 28 to 40 percent. For the estimated dollar amount of \$538 million, the confidence interval at 95 percent is \$431 million to \$643 million.

Noncovered

Medical reviewers determined that Medicare should not have allowed 2 percent (9/431) of the sampled claims reviewed because the E/M services for which payments were made did not meet the requirement that the services be significant, separately identifiable, and above and beyond the usual preoperative and postoperative care associated with the procedure. Therefore, these services were not covered.

For example, documentation for one of the records reviewed indicated that a Medicare beneficiary had returned for a nail debridement procedure after a previous visit. The patient's condition had been evaluated prior to the day of the procedure. The provider documented some E/M services the day of the procedure, but did not document any E/M services above and beyond the services necessary to perform the debridement on the day of the procedure. Therefore, payment for the separate E/M service should not have been allowed.

Undocumented

Providers failed to furnish documentation that met Medicare program payment requirements for 34 percent (149/431) of the sampled claims. These claims did not meet the requirements of section 1833(e) of the Act, which states that, to receive Medicare payment, providers must furnish "such information as may be necessary in order to determine the amounts due." The providers who submitted these claims failed to document E/M services and/or procedures, provided documentation that was missing identifying information, or failed to respond to OIG request(s) for documentation.

It is important to note that some of the undocumented claims might have fallen into the noncovered category had OIG received more complete documentation. For example, if a provider performed only a procedure but billed for both the procedure and an E/M service, the E/M service should not have been allowed. However, OIG could not determine if missing documentation was the result of the provider simply not supplying it, thus failing to meet the requirements of section 1833(e) of the Act, or because an E/M service did not meet program requirements. OIG grouped all cases involving missing documentation into the undocumented category.

Failure to document E/M service and/or procedure. Medical reviewers found that providers did not document the E/M services and/or procedures for 27 percent (116/431) of the sampled claims received from providers. For

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example, documentation for one of the records reviewed indicated that a Medicare beneficiary presented for a flu shot. The provider submitted a claim for the flu shot and an E/M service, the latter using modifier 25. Both claims were allowed. The provider furnished documentation that a flu shot was provided, but no documentation to support the claim for a separate E/M service.

Another provider documented the E/M service provided to a beneficiary but did not document that the procedures were performed. In this instance, Medicare allowed the E/M service that was documented and four physical therapy procedures that were not documented. These physical therapy procedures were listed in the record as planned treatment, but there was no documentation that these procedures were actually performed. Without documentation of the procedures, Medicare should not have allowed these claims because it is impossible to determine if the procedures were provided and if the E/M service met program requirements.

Missing identifying information. Four percent (19/431) of the records reviewed were missing identifying information, such as the beneficiary or physician name, or a physician signature. Section 1833(e) of the Act states that providers must furnish information necessary to determine the amount of payment due. Without identifying information, reviewers cannot determine if the same provider furnished or the same beneficiary received both the procedure and the E/M service. Therefore, these records failed to meet basic documentation requirements and made it impossible to determine whether the use of modifier 25 met CMS requirements.

Providers did not respond to requests for documentation. Despite repeated requests, providers failed to furnish the documentation required to support payment for the E/M services and associated procedures for 3 percent (14/431) of the sampled claims. Therefore, Medicare should not have paid these claims because it is impossible to determine if the services were provided.

Some additional claims did not meet program requirements, although the unnecessary use of modifier 25 may not have resulted in improper payments

The primary study objective was to determine the extent to which the use of modifier 25 meets Medicare program requirements. However, in

developing the sample, OIG identified a large number of claims on which modifier 25 was used unnecessarily. While unnecessary use of modifier 25 does not always lead to improper payments, such use fails to meet program requirements.

In 2002, Medicare allowed 9 percent of all claims (2.6 million) using modifier 25 in which the provider billed for only one service on a single day. Because modifier 25 is to be used only with an E/M service that the same provider furnished on the same day as a procedure, the use of modifier 25 was unnecessary. These 2.6 million claims, submitted by 192,974 providers, were distributed among many specialty types and multiple carriers.¹¹

Twenty-eight percent of all providers in the sample population used modifier 25 on more than 50 percent of their claims, thus using it unnecessarily. Modifier 25 should only be used with the E/M service portion of a Medicare claim and not on the procedure portion of the claim. Therefore, even if used properly for every encounter a provider has with every beneficiary, modifier 25 should be used on no more than 50 percent of services billed. Claims submitted for some providers included the modifier on every item billed to Medicare in 2002—both procedures and E/M services.

Carrier oversight related to modifier 25 is limited

Carriers have many ways of communicating information to providers regarding modifier 25.

Carriers may communicate directly through e-mails or letters, conduct local provider education and training programs, publish newsletters, and conduct provider communication meetings. The majority of carriers reported using one or two of these channels.

¹¹ The number of providers was calculated by counting Unique Physician Identification Numbers listed on these claims.

F I N D I N G S

Thirty-eight percent (9/24) of carriers reported that they have never conducted any review of modifier 25. These carriers indicated that the use of modifier 25 had not “risen to a level” to warrant inclusion in their medical review strategy, or that resource limitations prohibited them from doing so.

The remaining 15 carriers reported having conducted some type of review for modifier 25 at least once since 1998. Twelve carriers found improper use, and 10 of these reported high error rates. For example, one carrier reported an error rate of 39 percent, while another reported a 44 percent error rate. Despite these results, carriers indicated to us that modifier 25 reviews are not a priority.



R E C O M M E N D A T I O N

In 2002, Medicare allowed \$538 million in improper payments for services billed using modifier 25. At the time of the review, carrier oversight was limited despite evidence of problems with modifier 25. Without changes, future Medicare expenditures related to modifier 25 remain at risk.

CMS should work with carriers to reduce the number of improper claims submitted using modifier 25. CMS may want to:

- Reinforce the requirements that E/M services billed using modifier 25 be “significant, separately identifiable” and “above and beyond the usual preoperative and postoperative care associated with the procedure;”
- In its outreach to providers, encourage carriers to emphasize that appropriate documentation of both E/M services and procedures must be maintained to support claims for payments using modifier 25 even though documentation is not required to be submitted with the claims; and
- Emphasize that modifier 25 should only be used on claims for E/M services, and only when these services are provided on the same day as another procedure.

CMS should also encourage carriers to reexamine their modifier 25 outreach activities and include modifier 25 reviews in their medical review strategies where appropriate.

AGENCY COMMENTS

CMS concurred with the OIG recommendations and indicated that it had recently made significant efforts to educate the provider community about the need for documentation to support services billed to the Medicare program. CMS noted that it will inform contractors of the OIG findings so they can take any appropriate actions. CMS will also modify the “Medical Claims Processing Manual” to clarify that appropriate documentation must be maintained to support claims for payments, even though providers are not required to submit the documentation with the claim. CMS indicated that it will explore the potential to place greater emphasis on modifier 25 outreach activities and include the modifier in contractor medical review strategies.

R E C O M M E N D A T I O N

CMS did note that the majority of improper payments reported stemmed from instances in which the provider failed to furnish the documentation necessary to determine the medical necessity of the service, rather than from uncertainty about the guidelines for using modifier 25. Nonetheless, CMS indicates it will explore options to reinforce or emphasize the requirements for using modifier 25. The full text of the agency's comments can be found in the "Agency Comments" section of this report.

OFFICE OF INSPECTOR GENERAL RESPONSE

OIG appreciates CMS's comments to the draft report and recognizes its efforts to educate the provider community and contractors regarding the need for documentation to support services billed to Medicare. However, OIG believes it is important to note that additional improper payments may have been made, and that without proper documentation OIG was unable to determine whether services were provided and the appropriateness of some payments. OIG made changes to the report in response to CMS's technical comments.

A P P E N D I X

Stratification of Medical Review Sample Based on Claims Submitted Using Modifier 25 That Medicare Allowed in 2002

| Stratum Based on Volume of Claims and the Proportion of a Provider's Allowed Claims Submitted Using Modifier 25 | | Number of Claims in Sample Universe | Percentage of Claims in Sample Universe | Allowed Dollars for Claims in Sample Universe | Stratum |
|---|--|-------------------------------------|---|---|---------|
| 100 Percent | Top 10 percent based on number of claims | 64,841 | 0.3% | \$4 million | 1 |
| | Remaining 90 percent | 55,767 | 0.2% | \$3.6 million | 2 |
| 50 percent to less than 100 percent | Top 10 percent based on number of claims | 2.9 million | 12% | \$168.2 million | 3 |
| | Remaining 90 percent | 4.1 million | 16.5% | \$262.7 million | 4 |
| 20 percent to less than 50 percent | | 8.8 million | 35% | \$576.9 million | 5 |
| 1 percent to less than 20 percent | | 8.9 million | 36% | \$623.7 million | 6 |
| Total | | 24.8 million | 100% | \$1.6 billion | |

Source: OIG, stratification of 2002 Medicare modifier 25 claims, 2005.

Note: All providers submitting fewer than 25 claims using modifier 25 and those whose proportion of modifier 25 use was less than 1 percent were excluded because they posed a low risk.

► AGENCY COMMENTS



DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

OCT 18 2005

Administrator
Washington, DC 20201

TO: Daniel R. Levinson
Office of Inspector General

FROM: Mark B. McClellan, M.D., Ph.D.
Administrator

SUBJECT: Office of Inspector General's Draft Report: "Use of Modifier 25"
(OEI-07-03-00470)

Thank you for the opportunity to review and comment on the Office of Inspector General's (OIG) draft report entitled, "Use of Modifier 25." We appreciate the OIG's efforts to ensure Medicare's payments for services coded with Modifier 25 are appropriate.

Medicare uses the Current Procedural Terminology (CPT) coding system of the American Medical Association (AMA) to identify the services or procedures performed by physicians and practitioners. The AMA CPT manual explains that a physician may need to indicate that on the day a procedure or service was performed, the patient's condition required a significant, separately identifiable evaluation and management (E/M) service above and beyond the other service provided, or beyond the usual preoperative and postoperative care associated with the procedure that was performed. The E/M service may be prompted by the symptom or condition for which the procedure and/or service was provided. As such, different diagnoses are not required for reporting of the E/M services on the same date. This circumstance may be reported by adding modifier 25 to the appropriate level of E/M service.

The Centers for Medicare & Medicaid Services (CMS) policy regarding CPT modifier -25 are in the Medicare Claims Processing Manual, publication 100-04, chapter 12, section 30.6.6 (B). CMS policy for use of modifier 25 mirrors the CPT instructions. The manual also states that carriers are to pay for an E/M service if the physician bills the service with the CPT modifier 25, without any other requirement for documentation unless certain conditions otherwise require this additional documentation.

The manual also states if a carrier has conducted a specific medical review process and determined, after reviewing the data, that an individual or a group has high use of modifier 25 compared to other physicians; has done a case-by-case review of the records to verify that the use of modifier 25 was inappropriate; and has educated the individual or group; the carrier may impose prepayment screens or documentation requirements for that provider or group.

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The OIG's draft report indicates that, in 2002, "Medicare should not have allowed \$538 million in improper payments for 35 percent of claims for E/M services billed using modifier 25." The OIG found the services should not have been separately billed with modifier 25 because the services were not significant, separately identifiable, and above and beyond the usual preoperative and postoperative care associated with the procedure; or because they failed to meet basic Medicare documentation requirements.

OIG Recommendation:

Reinforce the requirements that E/M services billed using modifier 25 be significant, separately identifiable, and above and beyond the usual preoperative and postoperative care associated with the procedure.

CMS Response:

We are concerned by the improper payments described in this report. As noted above, however, our instructions and the AMA's instructions clearly indicate modifier 25 should only be used for a significant, separately identifiable E/M service that is above and beyond the pre and postoperative work of the procedure. According to the OIG report, 2 percent of the sampled claims did not meet these criteria. The majority of the improper payments identified by the OIG were instances where the provider failed to furnish documentation necessary to determine the medical necessity of the service. Therefore, it does not appear the improper payments are primarily due to uncertainty about the guidelines for using modifier 25. Nonetheless, we will explore options to reinforce or emphasize the requirements for using modifier 25.

OIG Recommendation:

Encourage carriers to emphasize that appropriate documentation of both E/M services and procedures must be maintained to support claims for payments using modifier 25 even though the documentation is not required to be submitted with the claims.

CMS Response:

With respect to the lack of appropriate documentation found by the OIG, we agree with the recommendation that CMS should encourage carriers to emphasize that appropriate documentation must be maintained. It should be noted that CMS has recently put a significant effort into educating the provider community about the need for documentation. We will inform our contractors of these findings so they may take any appropriate actions in this regard. We will also modify chapter 12, section 30.6.6 (B) of the Medical Claims Processing Manual to clarify that appropriate documentation must be maintained to support claims for payments, even though the documentation is not required to be submitted with the claim.

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OIG Recommendation:

Emphasize that modifier 25 should only be used on claims for E/M services, and only when these services are provided on the same day as another procedure.

CMS Response:

We also agree with the recommendation that CMS should encourage carriers to reexamine their modifier 25 outreach activities and include modifier 25 reviews in their medical review strategies. The only way to identify the lack of appropriate documentation found by the OIG is to review the medical records for these cases. Therefore, we intend to explore the potential to place greater emphasis on this area.



A C K N O W L E D G M E N T S

This report was prepared under the direction of Brian T. Pattison, Regional Inspector General for Evaluation and Inspections in the Kansas City regional office, and Gina C. Maree, Assistant Regional Inspector General. Other principal Office of Evaluation and Inspections staff who contributed include:

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