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Medicare Payments for Evaluation and Management Services Provided on the Same Day as Eye Injections Were at Risk for Noncompliance With Medicare Requirements

REPORT HIGHLIGHTS

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Why OIG Did This Audit

- For June 2022 through May 2023 (audit period), Medicare paid $313 million for 3.3 million injections of drugs into the eye (i.e., intravitreal injections). Medicare also paid $124 million for 1.4 million evaluation and management (E&M) services billed with modifier 25 and provided on the same day as intravitreal injections.
- Prior OIG audits of individual providers found high improper payment rates for E&M services provided on the same day as intravitreal injections.
- This audit identified Medicare Part B payments to providers for E&M services that were provided on the same day as intravitreal injections and that were at risk for noncompliance with Medicare requirements.

What OIG Found

- For 42 percent of intravitreal injections provided during our audit period, providers billed for E&M services provided on the same day as injections using modifier 25, which allowed the claims to bypass system edits that are designed to prevent improper payments.
- To test provider compliance with Medicare requirements, we reviewed documentation for 24 sampled E&M services and found that documentation for 22 services did not support the use of modifier 25.
- CMS paid for E&M services billed with modifier 25 and provided on the same day as intravitreal injections that were at risk for noncompliance because CMS's internal controls were not adequate during our audit period to detect and prevent potentially improper payments. During our audit period, Medicare paid $124 million nationwide for these services.

What OIG Recommends

We made three recommendations to CMS, including that CMS update Medicare requirements for billing E&M services provided on the same day as intravitreal injections to help providers understand appropriate use of modifier 25, and conduct medical reviews of E&M services and recover payments of up to $124 million for those services that CMS determines should not have been billed with modifier 25 during our audit period. The full recommendations are in the report.

CMS concurred with one recommendation and did not indicate concurrence or nonconcurrence with two recommendations. CMS also described actions it had taken or planned to take to address all of our recommendations.

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INTRODUCTION

WHY WE DID THIS AUDIT

Medicare Part B pays providers for injections of drugs into the eye (i.e., intravitreal injections) that are reasonable and necessary to treat enrollees' conditions.[1] In addition, a provider may be eligible for a separate payment for evaluation and management (E&M) services provided on the same day as an intravitreal injection if the services are significant and separately identifiable from the injection.

Prior Office of Inspector General (OIG) audits of two providers identified high improper payment rates for E&M services provided on the same day as intravitreal injections.[2] Specifically, E&M services were not significant and separately identifiable from the injections. We conducted this audit to determine whether the issues identified in these two prior OIG audits existed nationwide from June 1, 2022, through May 31, 2023 (audit period).[3] (See Appendix B for a list of related OIG reports.)

OBJECTIVE

Our objective was to identify Medicare Part B payments to physicians for E&M services that were provided on the same day as intravitreal injections and that were at risk for noncompliance with Medicare requirements.

BACKGROUND

Medicare Program and the Role of Medicare Administrative Contractors

The Medicare program provides health insurance coverage to people aged 65 years and older, people with disabilities, and people with end-stage renal disease. The Centers for Medicare & Medicaid Services (CMS) administers the program. Medicare Part B provides supplementary medical insurance for medical and other health services, such as E&M services.

[1] An intravitreal injection is a procedure to place medication directly into the space in the back of the eye, called the vitreous cavity. The procedure is usually performed by a trained retina specialist in an office setting.

[2] OIG, *An Ophthalmology Clinic in California: Audit of Medicare Payments for Eye Injections of Eylea and Lucentis* (A-09-19-03022), Mar. 29, 2021; *An Ophthalmology Clinic in Florida: Audit of Medicare Payments for Eye Injections of Avastin, Eylea, and Lucentis* (A-09-19-03025), Sept. 7, 2021.

[3] This audit period correlated with the most recent claim data available at the start of our audit.

CMS contracts with Medicare Administrative Contractors (MACs) to process and pay Part B claims for defined geographic areas (jurisdictions). During our audit period, CMS contracted with 7 MACs to process and pay Medicare Part B claims for 12 jurisdictions.[4]

MACs help CMS in its efforts to detect and prevent improper payments and promote Medicare compliance. MACs' responsibilities include educating providers on Medicare requirements and billing procedures, applying system edits to claims to determine whether claims are complete and reimbursable, and performing medical reviews of claims to determine whether services provided to enrollees are medically necessary.[5]

Medical reviews include prepayment and postpayment reviews, which consist of collecting information for a selection of claims and reviewing enrollee medical records to ensure that Medicare pays only for services that meet all Medicare coverage, documentation, coding, and medical necessity requirements. MACs use the results of prepayment reviews to help ensure they make proper Medicare payments. MACs use the results of postpayment reviews to recover any improper payments for claims that were already paid. MACs perform prepayment and postpayment reviews that target problem areas identified by analyzing claims data.

Medical reviews that focus on specific providers are conducted as part of CMS's Targeted Probe and Educate (TPE) program; we refer to these reviews as "TPE reviews." TPE reviews typically evaluate 20 to 40 claims per provider for an item or a service and provide individualized education to providers based on the results of these reviews.[6] MACs analyze available data to identify for TPE reviews those providers: (1) that have historically high claim-denial rates, (2) that have billing practices that vary from their peers, or (3) for whom evidence suggests that there is a potential risk to the Medicare trust funds.

Evaluation and Management Services

A provider performs an E&M service to assess and manage an enrollee's health. The three key components for documenting an E&M service are history, examination, and medical decision-making.

[4] Five of the seven MACs processed and paid claims for two jurisdictions. The remaining two MACs each processed and paid claims for one jurisdiction.

[5] An edit is programming within the standard claims processing system that selects certain claims; evaluates or compares information on the selected claims or other accessible sources; and, depending on the evaluation, takes action on the claims, such as paying them in full, paying them in part, or suspending them for manual review.

[6] The TPE program's process typically includes up to three rounds of prepayment or postpayment probe reviews, each of which may be followed by one-on-one education for a provider that is found to be noncompliant (CMS, *Medicare Program Integrity Manual*, Pub. No. 100-08, chapter 3, § 3.2.5).

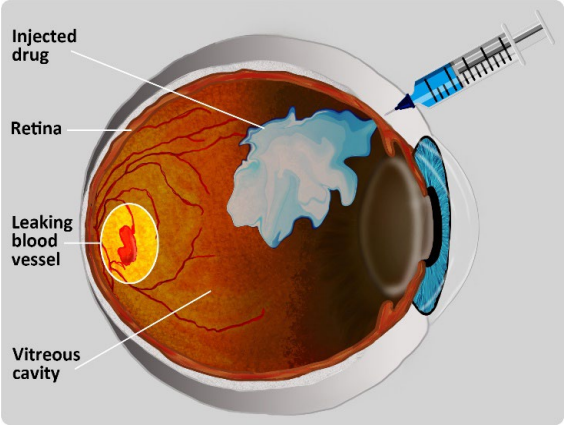
- The history component includes some or all of the following elements: the chief complaint, history of present illness, review of systems, and review of an enrollee's family and social history.[7]

- The examination component consists of a provider's assessment of an enrollee's body areas or organ systems.

- The medical decision-making component includes establishing a diagnosis for an enrollee and selecting a management option (e.g., a treatment plan or course of action).[8]

Intravitreal Injections

Figure 1: Intravitreal Injection for Wet AMD



Intravitreal injections are used to administer drugs to treat a variety of retinal conditions, such as wet age-related macular degeneration (AMD). Wet AMD, one of the most common conditions treated with intravitreal injections, occurs when abnormal blood vessels begin to grow underneath the retina and leak blood or fluid that blurs central vision. The drugs used for the intravitreal injections reduce the abnormal growth and leakage, which helps stabilize vision loss and, in some cases, can improve sight. Figure 1 shows an intravitreal injection to treat wet AMD.

The recommended frequency of intravitreal injections varies from every few weeks to every few months, and duration of treatment varies by case. Enrollees often require multiple doses over many months, and repeat treatments are often needed for continued benefit.

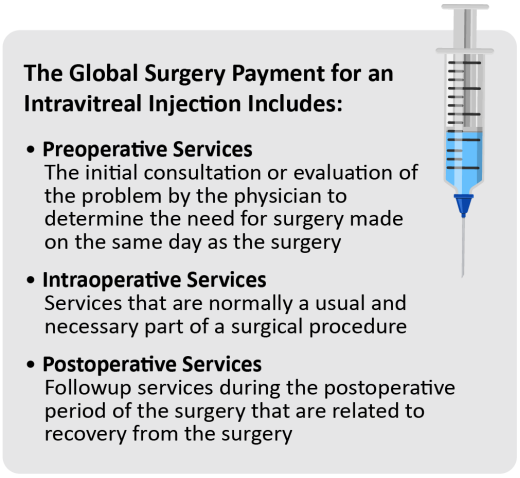
[7] The chief complaint is a concise statement describing the symptom, problem, condition, diagnosis, or other factor that is the reason for the visit, usually stated in the enrollee's own words. The review of systems is a review of the body systems (e.g., cardiovascular, respiratory, and gastrointestinal) by asking questions to identify symptoms that the enrollee has experienced.

[8] The history and examination components help the provider in determining the correct diagnosis and selecting a management option.

Medicare Coverage of E&M Services Provided on the Same Day as Intravitreal Injections

Medicare Part B covers reasonable and necessary ophthalmology services, such as intravitreal injections and the drugs used to treat eye diseases (Social Security Act (the Act) § 1862(a)(1)(A)). Medicare pays for an intravitreal injection (which is considered minor surgery) as part of a global surgery payment that includes the preoperative, intraoperative, and postoperative services furnished by the provider.[9] (See Figure 2.)

Figure 2: The Global Surgery Payment



Generally, an E&M service provided on the same day as an intravitreal injection is included in the payment for the intravitreal injection. The initial consultation with the provider or the provider's evaluation of the problem to determine the need for surgery is always included in the payment for an intravitreal injection.[10]

An E&M service is separately reportable on the same date of service as a minor surgery (e.g., an intravitreal injection) under limited circumstances. Medicare may make a separate payment for an E&M service if it was significant, separately identifiable, and above and beyond the other service provided or beyond the usual preoperative and postoperative care associated with the intravitreal injection.[11] To identify such a service, Medicare requires that modifier 25 be included on the claim.[12]

Appending modifier 25 to a Current Procedural Terminology (CPT®) code on a claim allows the claim to bypass automated system edits in a MAC's claims processing system that are designed

[9] The Act § 1848(c)(1)(A)(ii); 42 CFR §§ 410.20(a) and 414.40(b)(1). The Medicare Physician Fee Schedule indicates that an intravitreal injection is considered a minor surgical procedure.

[10] The Act § 1848(c)(1)(A)(ii); 42 CFR § 414.40(b)(1); *Medicare National Correct Coding Initiative Policy Manual* (NCCI Policy Manual), chapter I, § D. See also, CMS's *Medicare Claims Processing Manual,* Pub. No. 100-04 (Claims Processing Manual), chapter 12, §§ 40.1(A), 40.1(B), and 40.1(C).

[11] The Act § 1848(c)(1)(A)(ii); 42 CFR § 414.40(b)(1); NCCI Policy Manual, chapter I, §§ E and D. See also, CMS's Claims Processing Manual, chapter 12, §§ 40.1(A), 40.1(B), and 40.1(C).

[12] A modifier is a two-character code reported with a Current Procedural Terminology code and is used to give Medicare additional information needed to process a claim.

to prevent improper payment for services that should not be billed on the same day.[13, 14, 15] These edits could prevent payments for E&M services billed for the same Medicare enrollee on the same day as a minor surgery, such as an intravitreal injection.[16] A modifier may be appended to a CPT code only if the clinical circumstances justify use of the modifier. A modifier may not be appended to a CPT code solely to bypass an edit if the clinical circumstances do not justify its use, but there is a risk that a provider may use modifier 25 solely to bypass edits. An intravitreal injection and an E&M service must be appropriately and sufficiently documented in an enrollee's medical record to support the claim for these services.[17]

Prior Office of Inspector General Audits

Prior OIG audits of two providers found high improper payment rates for E&M services billed with modifier 25 and provided on the same day as intravitreal injections.[18] For these audits, an independent medical review contractor reviewed a sample of physicians' medical records related to the claims and determined that these records did not contain evidence that the E&M services were significant and separately identifiable from the injection procedures. According to the independent medical review contractor, the medical records showed that the components of the physician evaluation were related to and included in the intravitreal injection procedures.

[13] The Secretary of Health and Human Services adopted the CPT, fourth edition, as the standard medical data code set (which is maintained and distributed by the American Medical Association (AMA) for physician services and other health care services) for the period on and after Oct. 1, 2015 (45 CFR §§ 162.1002(a)(5) and 162.1002(c)(1)).

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[16] NCCI Policy Manual, chapter I, § E(1). CMS's Claims Processing Manual lists the E&M CPT codes that the MACs use in establishing edits for identifying services included in the payment for a minor surgery (chapter 12, § 40.3(B)). In this report, "billed on the same day" refers to two services that were billed with the same date of service for the same Medicare enrollee.

[17] The Act § 1833(e). See also, CMS's Claims Processing Manual, chapter 12, §§ 30.6.6(B), 40.2(A)(8), and 40.4(A).

[18] See footnote 2.

Specifically, the audits found the following:

- For one audit (A-09-19-03022), Medicare improperly paid for 95 of 95 sampled E&M services billed with modifier 25 and provided on the same day as intravitreal injections that we reviewed. The provider stated that it was unaware it was using modifier 25 incorrectly and that E&M services could not be billed separately from intravitreal injections. The provider stated that it relied on the billing company to determine how the services should be billed.

- For the other audit (A-09-19-03025), Medicare improperly paid for 57 of 73 sampled E&M services billed with modifier 25 and provided on the same day as intravitreal injections that we reviewed. The provider stated that it believed that the E&M services billed were appropriate because they were for examination of the eye that was not receiving an intravitreal injection. However, the independent medical review contractor determined that the medical records did not support the use of modifier 25. Additionally, the independent medical reviewer stated that some of the E&M services were for the purpose of deciding to treat the enrollee's other eye (i.e., the one not receiving an intravitreal injection) with an intravitreal injection on a future date. Medicare global surgery rules prevent the reporting of a separate E&M service for the work associated with the decision to perform a minor surgical procedure.[19]

HOW WE CONDUCTED THIS AUDIT

For our audit period, Medicare paid approximately $313 million for 3.3 million intravitreal injections provided to enrollees nationwide. Medicare also paid approximately $124 million for 1.4 million E&M services billed with modifier 25 and provided on the same day as intravitreal injections for these same enrollees. In addition, the enrollees were held responsible for approximately $31 million in coinsurance associated with these services.[20] We analyzed claims data to determine the percentage of intravitreal injections paid by Medicare nationwide for which providers also billed for E&M services provided on the same day as the injections. We also interviewed officials from CMS and the Medicare Part B MACs to obtain an understanding of CMS's internal controls and reimbursement requirements for E&M services billed with modifier 25 and provided on the same day as intravitreal injections.

To test provider compliance with Medicare requirements for E&M services billed with modifier 25 and provided on the same day as intravitreal injections, we selected a random sample of 24 E&M services (2 services from each of the 12 MAC jurisdictions), totaling $2,121, that were provided to the same Medicare enrollees on the same day as intravitreal injections.

[19] NCCI Policy Manual, chapter I, § E(b).

[20] Enrollees were held responsible for $31,168,592 in coinsurance. Medicare requires enrollees to pay a coinsurance amount equal to 20 percent of the amount allowed by Medicare for a Part B service and pays the provider the remaining 80 percent. However, not all enrollees pay out of pocket for coinsurance. Some enrollees have secondary insurance coverage (e.g., Medicaid) that will pay the coinsurance.

We reviewed documentation for the 24 sampled services to determine whether it supported the use of modifier 25 (i.e., whether the supporting documentation included significant and separately identifiable E&M services that were above and beyond the usual care associated with the intravitreal injections).

Although we did not use a medical reviewer to determine whether E&M services were medically necessary, MACs confirmed our determinations of whether the documentation for the 24 sampled E&M services supported the use of modifier 25. In addition, we requested that the providers for the 24 sampled E&M services respond to a questionnaire that contained questions related to the providers' understanding of the use of modifier 25 when billing for an E&M service provided on the same day as an intravitreal injection.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Appendix A contains the details of our audit scope and methodology.

FINDINGS

Medicare Part B payments to providers for E&M services that were provided on the same day as intravitreal injections were at risk for noncompliance with Medicare requirements. For 42 percent of intravitreal injections paid by Medicare nationwide, providers billed for E&M services provided on the same day as the injections even though Medicare allows E&M services and intravitreal injections to be billed on the same day under only limited circumstances.[21] These providers used modifier 25, which allowed claims to bypass automated system edits that are designed to prevent payment for E&M services billed on the same day as intravitreal injections. Our data analysis suggests that providers may have been using the modifier incorrectly.

To test provider compliance with Medicare requirements for E&M services provided on the same day as intravitreal injections and billed with modifier 25, we reviewed supporting documentation for 24 sampled E&M services. Documentation for 22 of the sampled services did not support the use of modifier 25.[22] Specifically, the documentation did not support that significant and separately identifiable E&M services that were beyond the usual preoperative

[21] CMS did not specify a threshold for defining "limited circumstances" for E&M services billed on the same day as intravitreal injections. Medicare may make a separate payment for an E&M service only if the service was significant, separately identifiable, and above and beyond the other service provided or beyond the usual preoperative and postoperative care associated with the intravitreal injection.

[22] The MACs agreed with our determinations for these 22 sampled E&M services.

and postoperative care associated with the intravitreal injections were provided on the same day as the intravitreal injections.

CMS made payments for E&M services provided on the same day as intravitreal injections and that may have been incorrectly billed with modifier 25 because CMS's internal controls were not adequate during our audit period to detect and prevent potentially improper payments. Specifically, Medicare requirements for using modifier 25 did not clarify under which circumstances E&M services could be billed on the same day as intravitreal injections. In addition, during our audit period, the MACs did not perform any prepayment or postpayment medical reviews of claims for E&M services billed with modifier 25. Furthermore, CMS and the MACs did not furnish provider education that focused on billing for E&M services provided on the same day as intravitreal injections.

Because CMS did not have adequate internal controls, payments for E&M services provided on the same day as intravitreal injections were at risk for noncompliance. During our audit period, Medicare paid approximately $124 million for these services.[23]

MEDICARE REQUIREMENTS

Payment must not be made to a provider for a service unless "there has been furnished such information as may be necessary in order to determine the amounts due such provider" (the Act § 1833(e)).

Under limited circumstances, an E&M service is separately reportable on the same date of service as minor surgery. In general, an E&M service performed on the same date of service as a minor surgical procedure (e.g., an intravitreal injection) is included in the payment for the procedure. The decision to perform a minor surgical procedure is part of that procedure and must not be reported separately as an E&M service. However, a significant and separately identifiable E&M service unrelated to the decision to perform the minor surgical procedure is separately reportable with modifier 25 (*Medicare National Correct Coding Initiative Policy Manual* (NCCI Policy Manual), chapter I, § D).[24]

Because a minor surgical procedure includes preprocedure, intraprocedure, and postprocedure work inherent in the procedure, the provider must not report an E&M service for this work. Furthermore, Medicare global surgery rules prevent the reporting of a separate E&M service for the work associated with the decision to perform a minor surgical procedure whether the patient is a new or an established patient (NCCI Policy Manual, chapter I, § E(b)).

[23] During our audit period, Medicare paid $123,955,176 for these services.

[24] *The responsibility for the content of any "National Correct Coding Policy" included in this product is with the Centers for Medicare and Medicaid Services and no endorsement by the AMA is intended or should be implied. The AMA disclaims responsibility for any consequences or liability attributable to or related to any use, nonuse or interpretation of information contained in this product.*

The American Medical Association's (AMA's) *CPT 2023 Professional* states:[25]

> It may be necessary to indicate that on the day a procedure or service . . . was performed, the patient's condition required a significant, separately identifiable [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. A significant, separately identifiable [E&M] service is defined or substantiated by documentation that satisfies the relevant criteria for the respective [E&M] service to be reported. . . . This circumstance may be reported by adding modifier 25 to the appropriate level of [E&M] service. Note: This modifier is not used to report an E&M service that resulted in a decision to perform surgery.

PAYMENTS FOR E&M SERVICES PROVIDED ON THE SAME DAY AS INTRAVITREAL INJECTIONS WERE AT RISK FOR NONCOMPLIANCE WITH MEDICARE REQUIREMENTS

Providers Billed for E&M Services Provided on the Same Day as Intravitreal Injections for 42 Percent of Intravitreal Injections Provided to Enrollees and Paid by Medicare

For 1,380,670 (42 percent) of 3,296,895 intravitreal injections provided to enrollees nationwide and paid by Medicare during our audit period, providers billed for E&M services on the same day as these injections. These providers used modifier 25, which allowed claims to bypass automated system edits that are designed to prevent payments for E&M services provided on the same day as intravitreal injections. Because an E&M service is separately reportable on the same date of service as an intravitreal injection under only limited circumstances, our data analysis suggests that providers may have been using the modifier incorrectly.

Documentation Did Not Support Use of Modifier 25 for Most of the Sampled Services

Of the 24 randomly sampled E&M services billed with modifier 25 and provided on the same day as intravitreal injections, the documentation for 2 services supported the use of the modifier. The medical records showed that each of these E&M services was associated with the decision to perform the intravitreal injection procedure and was above and beyond the usual care associated with such a procedure. For example, one provider billed for an E&M service for an examination of both eyes and an intravitreal injection into the right eye. During the examination, the provider identified signs related to a separate diagnosis for the left eye. The provider addressed the additional diagnosis by providing education to the enrollee on the condition and prognosis, describing monitoring techniques to use at home, identifying risk factors to avoid, and notifying the enrollee to contact the provider immediately if symptoms increased.

[25] Providers are required to use CPT codes when billing Medicare (45 CFR §§ 162.1002(c)(1) and (a)(5)).

For the remaining 22 randomly sampled E&M services billed with modifier 25 and provided on the same day as intravitreal injections, the documentation did not support the use of the modifier. Specifically, the supporting documentation did not show that significant and separately identifiable E&M services were provided on the same day as the intravitreal injections. The medical records showed that each of these E&M services was associated with the decision to perform the intravitreal injection procedure and was not above and beyond the usual care associated with such a procedure. The MACs agreed with our determinations for these 22 sampled E&M services.

Example of an E&M Service That Was Not Significant and Separately Identifiable

Medicare paid $103 to a provider for an E&M service provided on the same day as an intravitreal injection into an enrollee's right eye, for which Medicare paid $91. The medical record showed that the reason for the visit was to follow up on wet AMD in the enrollee's right eye. The medical record did not support that the E&M service was separately identifiable from and unrelated to the intravitreal injection performed. Specifically, the medical record showed that the E&M service was for the purpose of deciding to treat the enrollee's right eye with an intravitreal injection. Therefore, the use of modifier 25 was not supported. As a result, Medicare improperly paid $103 for the E&M service.

Based on our review of provider documentation and statements from providers of the sampled E&M services, we determined that providers generally did not know how to use modifier 25 appropriately. Specifically, the providers did not understand Medicare requirements for billing E&M services provided on the same day as intravitreal injections; e.g., they did not understand that the decision to perform a minor surgical procedure is part of the minor surgical procedure and should not be billed separately.

For the 22 sampled E&M services for which the documentation did not support the use of the modifier, provider statements in response to our questionnaire indicated the following:

- For 15 sampled E&M services, providers did not clearly understand how to use modifier 25 or whether they could bill for E&M services provided on the same day as intravitreal injections. For example, one provider stated that modifier 25 was included on the claim for the sampled E&M service when the intravitreal injection was "performed on the same day as [the] exam." However, the E&M service is included in the payment for the intravitreal injection; modifier 25 must not be included on the claim unless the E&M service is significant and separately identifiable from the intravitreal injection and above and beyond the usual care associated with the injection. In addition, another provider stated that it "performed a full eye examination of both eyes" and performed an injection into the left eye. The provider stated that it "believe[d] that this qualifies for the use of modifier 25." This provider billed for an E&M service for a comprehensive examination of both eyes and an intravitreal injection into the left eye. According to the MACs, an exam resulting in an intravitreal injection into one eye with no other procedures conducted would be considered preprocedure work inherent in the

intravitreal injection and is included in the payment for the intravitreal injection.[26] Therefore, the E&M service billed for the comprehensive eye exam was not separately identifiable from the intravitreal injection and was not above and beyond the usual care associated with the injection.

- For five sampled E&M services, providers understood that an E&M service provided on the same day as an intravitreal injection must be billed with modifier 25 to indicate on the Medicare claim that the E&M service was a significant, separately identifiable E&M service above and beyond the intravitreal injection or beyond the usual preoperative and postoperative care associated with the intravitreal injection. Although these providers correctly cited Medicare requirements and stated that they understood them, the providers' supporting documentation did not show that the E&M services were significant and separately identifiable and above and beyond the usual care associated with the intravitreal injections that had been provided on the same day. For example, one provider's medical record showed that the only procedure performed on the date of service was the intravitreal injection. The provider did not document in the medical record a significant and separately identifiable E&M service that was above and beyond the usual care associated with the injection.

- For two sampled E&M services, the providers did not respond to our questionnaire to explain why they included modifier 25 on the claims for the sampled services. For example, one provider's medical record showed that the only procedure performed on the date of service was the intravitreal injection. The provider did not explain why modifier 25 was included on the claim for the E&M service.

CMS'S INTERNAL CONTROLS FOR E&M SERVICES WERE NOT ADEQUATE TO DETECT AND PREVENT POTENTIALLY IMPROPER PAYMENTS

During our audit period, CMS's internal controls were not adequate to detect and prevent potentially improper payments for E&M services provided on the same day as intravitreal injections. Specifically, Medicare requirements for the use of modifier 25 did not specifically clarify under which circumstances E&M services could be billed on the same day as intravitreal injections. In addition, during our audit period, the MACs did not perform any prepayment or postpayment reviews of claims for E&M services billed with modifier 25. Furthermore, CMS and the MACs did not provide education that specifically focused on E&M services provided on the same day as intravitreal injections.

CMS Did Not Have Clear Medicare Requirements for Providers' Use of Modifier 25

CMS did not have clear Medicare requirements for providers' use of modifier 25 when submitting claims for E&M services provided on the same day as intravitreal injections.

[26] According to CMS, the Medicare payment for a comprehensive eye examination is the same whether one or two eyes are examined.

Specifically, CMS did not provide a definition of a "significant and separately identifiable" E&M service that is above and beyond the usual care associated with an intravitreal injection.

CMS stated that it uses AMA's description of modifier 25.[27] CMS also stated that because modifier 25 is not a CMS-defined code, CMS does not have the authority to make changes to the definition. However, CMS has the authority to clarify the appropriate use of modifier 25 within its requirements. If CMS does not clarify to providers how to bill for E&M services provided on the same day as intravitreal injections—e.g., by providing examples of the appropriate use of modifier 25 when billing for E&M services on the same day as intravitreal injections—there is a higher risk of noncompliance with Medicare requirements.

MACs Did Not Perform Medical Reviews of Claims for E&M Services Billed With Modifier 25

During our audit period, the MACs did not perform any prepayment or postpayment medical reviews of claims for E&M services billed with modifier 25, including E&M services provided on the same day as intravitreal injections. CMS suspended most Medicare Part B medical reviews, including medical reviews of E&M services, to reduce provider burden and ensure that enrollees had access to medically necessary services during the COVID-19 public health emergency.[28] Four of the seven MACs stated that before our audit period, they performed prepayment and postpayment medical reviews of intravitreal injections and E&M services but did not specifically review E&M services that were provided on the same day as intravitreal injections. If the MACs had reviewed claims for these services, they might have detected and prevented potentially unallowable claims billed nationwide.

CMS and MACs Did Not Provide Education That Focused on Billing for E&M Services Provided on the Same Day as Intravitreal Injections

CMS and the MACs did not provide education that focused on billing for E&M services provided on the same day as intravitreal injections. CMS offered educational materials that included guidance for documenting E&M services and information on using modifiers for procedures (e.g., intravitreal injections) covered by global surgery payments. Examples were the Medicare Learning Network (MLN) booklets *Evaluation and Management Services Guide* and *Global Surgery*.[29] In addition, the MACs offered online training and provided educational materials (e.g., web-based articles) that included information on E&M services and global surgical procedures. However, during our audit period, neither CMS nor the MACs provided training or

[27] CMS provided the following AMA document describing the use of modifier 25: *Reporting CPT Modifier 25*. Accessed on Apr. 2, 2025. In this document, AMA acknowledged that there is confusion about appropriate use of modifier 25.

[28] CMS prohibited MACs from conducting medical reviews of claims for E&M services from Mar. 26, 2020, through May 11, 2023 (the period of the COVID-19 public health emergency).

[29] MLN, *Evaluation and Management Services Guide* (MLN006764), September 2024; *Global Surgery* (MLN907166), November 2024. Accessed on Apr. 2, 2025.

educational materials on billing E&M services with modifier 25 when provided on the same day as intravitreal injections.

CONCLUSION

During our audit period, providers for 42 percent of intravitreal injections provided to enrollees nationwide billed for E&M services with modifier 25 and that were provided on the same day as the injections. Because E&M services should be billed separately in only limited circumstances, this finding indicates that many providers did not know how to use modifier 25 appropriately, and the results of our review of 24 sampled E&M services as well as statements from providers support this conclusion. Implementing adequate internal controls, such as providing clear Medicare requirements for providers' use of modifier 25 when submitting claims for E&M services provided on the same day as intravitreal injections, could help clarify the appropriate use of modifier 25 and prevent improper payments related to the incorrect use of this modifier.

Because CMS did not have adequate internal controls, payments for E&M services provided on the same day as intravitreal injections were at risk for noncompliance with Medicare requirements. During our audit period, Medicare paid approximately $124 million nationwide for these services, and enrollees were held responsible for approximately $31 million in coinsurance associated with these services.

RECOMMENDATIONS

We recommend that the Centers for Medicare & Medicaid Services do the following:

- Update Medicare requirements for billing E&M services provided on the same day as intravitreal injections to help providers understand the appropriate use of modifier 25 (e.g., clarify the definition of a "significant and separately identifiable" E&M service and identify the circumstances that allow for an E&M service to be billed on the same date of service as an intravitreal injection).

- Conduct medical reviews of E&M services that were provided on the same day as intravitreal injections to determine whether these payments were improper and, consistent with relevant laws and the agency's policies and procedures, recover payments of up to $123,955,176 for E&M services that CMS determines should not have been billed with modifier 25 during our audit period, and instruct those providers to refund to enrollees any coinsurance amounts that may have been incorrectly collected from them or from someone on their behalf.

- Provide more education to providers on billing E&M services provided on the same day as intravitreal injections and the appropriate use of modifier 25 to help prevent improper payments for those services. For example, CMS could: (1) emphasize that the decision to perform an intravitreal injection is part of the minor surgical procedure and a separate E&M service should not be billed for that work; (2) provide a clear definition

of a "significant and separately identifiable" E&M service that is "above and beyond" the usual care associated with an intravitreal injection; and (3) provide examples of E&M services that would be considered significant and separately identifiable and above and beyond the usual care associated with an intravitreal injection.

CMS COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft report, CMS concurred with our second recommendation and did not explicitly state its concurrence or nonconcurrence with our first and third recommendations. However, CMS stated that it has already met the requirements of the third recommendation and asked that we remove the recommendation from our report. CMS described actions that it had taken or planned to take to address all of our recommendations. After reviewing CMS's comments, we maintain that our recommendations are valid.

CMS also provided technical comments on our draft report, which we addressed as appropriate. CMS's comments, excluding the technical comments, are included as Appendix C.

The following sections summarize CMS's comments and our response.

CMS COMMENTS

- Regarding our first recommendation (related to updating Medicare requirements for billing E&M services provided on the same day as intravitreal injections), CMS stated that it will consider updating the requirements to clarify the appropriate use of modifier 25 as part of its ongoing efforts to more accurately value and pay for global packages.

- Regarding our second recommendation (related to conducting medical reviews of E&M services provided on the same day as intravitreal injections), CMS concurred; it stated that it will evaluate a sample of E&M services provided on the same day as intravitreal injections and will recover payments found to be improper in accordance with its policies and procedures. CMS also stated that "providers are notified of associated cost sharing amounts as part of the overpayment recovery process so that the providers can refund any cost sharing amounts that may have been incorrectly collected."

- Regarding our third recommendation (related to providing more education to providers on billing E&M services provided on the same day as intravitreal injections), CMS stated that it has conducted extensive national education on this topic since 2018. CMS stated that based on this education, it believes that it has already met the requirements of this recommendation and asked that we remove the recommendation from our report.

OFFICE OF INSPECTOR GENERAL RESPONSE

After reviewing CMS's comments, we maintain that our recommendations are valid.

Regarding our first recommendation, we continue to recommend that CMS take action to update Medicare requirements for billing E&M services provided on the same day as intravitreal injections to help providers understand the appropriate use of modifier 25. By implementing this recommendation, CMS may lower the risk of noncompliance with Medicare requirements.

Regarding our third recommendation, we continue to recommend that CMS provide more education to providers that is specifically focused on billing E&M services provided on the same day as intravitreal injections and the appropriate use of modifier 25. Our audit showed that providers did not know how to use modifier 25 appropriately when billing E&M services provided on the same day as intravitreal injections.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

From June 1, 2022, through May 31, 2023 (audit period), Medicare paid $313,206,565 for 3,296,895 intravitreal injections provided to enrollees nationwide. Medicare also paid $123,955,176 for 1,380,670 E&M services billed with modifier 25 and provided on the same day as intravitreal injections for these same enrollees.[30] In addition, the enrollees were held responsible for $31,168,592 in coinsurance associated with these services. We analyzed claims data to determine the percentage of intravitreal injections paid by Medicare nationwide for which providers also billed for E&M services provided on the same day as the injections.

To test provider compliance with Medicare requirements for E&M services billed with modifier 25 and provided on the same day as intravitreal injections, we selected a random sample of 24 E&M services (2 services from each of the 12 MAC jurisdictions), totaling $2,121, that were provided to the same Medicare enrollees on the same day as intravitreal injections. We reviewed documentation for the 24 sampled services to determine whether it supported the use of modifier 25 (i.e., whether the supporting documentation included significant and separately identifiable E&M services that were above and beyond the usual care associated with the intravitreal injections).

Although we did not use a medical reviewer to determine whether E&M services were medically necessary, MACs confirmed our determinations of whether the documentation for the 24 sampled E&M services supported the use of modifier 25.

Our review enabled us to establish reasonable assurance of the authenticity and accuracy of the data obtained from CMS's National Claims History (NCH) file, but we did not assess the completeness of the data. We assessed the reliability of the data obtained from the NCH file by: (1) considering prior data reliability assessments on data from the NCH file; and (2) performing electronic testing of the data, such as verifying that the data met the parameters of our request. We determined that the data were sufficiently reliable for purposes of this audit.

We did not perform an overall assessment of the internal control structures of CMS or the MACs. Rather, we limited our review to those controls that were significant to our objective. Specifically, we reviewed CMS's oversight mechanisms for processing and reviewing Medicare claims for E&M services provided on the same day as intravitreal injections, and for preventing improper payments for those services. For example, we interviewed CMS and MAC officials and obtained an understanding of their system edits and their policies and procedures for documenting and billing E&M services provided on the same day as intravitreal injections.

We conducted our audit from September 2023 through February 2025.

[30] *CPT copyright 2023 American Medical Association. All rights reserved.*

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal laws, regulations, and guidance;
- interviewed officials from CMS and the Medicare Part B MACs to obtain an understanding of CMS's internal controls and reimbursement requirements for E&M services billed with modifier 25 and provided on the same day as intravitreal injections;
- obtained from CMS's NCH file the paid Medicare Part B claims for E&M services provided to Medicare enrollees during our audit period;
- analyzed Medicare Part B claims data for intravitreal injections as well as for E&M services billed with modifier 25 and provided on the same day as intravitreal injections provided to Medicare enrollees during our audit period;
- selected for review a simple random sample of 24 E&M services that were provided on the same day as intravitreal injections;[31]
- requested from the providers for the 24 sampled E&M services: (1) supporting documentation for the sampled services and (2) responses to a questionnaire that contained questions related to the providers' understanding of the appropriate use of modifier 25 when billing for an E&M service provided on the same day as an intravitreal injection;
- reviewed documentation for the 24 E&M sampled services to determine whether it supported the use of modifier 25 (i.e., whether the supporting documentation included significant and separately identifiable E&M services that were above and beyond the usual care associated with the intravitreal injections);
- requested that the Medicare Part B MACs review the sampled services to confirm our determinations; and
- discussed the results of our audit with CMS officials.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions

[31] We did not select a sample of E&M services for the purpose of estimating the total amount of improper payments during our audit period but rather to test provider compliance with Medicare requirements for E&M services provided on the same day as intravitreal injections and billed with modifier 25.

based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

APPENDIX B: RELATED OFFICE OF INSPECTOR GENERAL REPORTS

Report Title	Report Number	Date Issued
An Ophthalmology Clinic in Florida: Audit of Medicare Payments for Eye Injections of Avastin, Eylea, and Lucentis	A-09-19-03025	9/7/2021
An Ophthalmology Clinic in California: Audit of Medicare Payments for Eye Injections of Eylea and Lucentis	A-09-19-03022	3/29/2021
Questionable Billing for Medicare Ophthalmology Services	OEI-04-12-00280	9/15/2015
The Medicare Contractor for Jurisdiction 1 Overpaid a Provider That Incorrectly Billed for Aflibercept	A-06-14-00055	6/30/2015
Wisconsin Physicians Service Insurance Corporation Overpaid a Provider That Incorrectly Billed for Aflibercept	A-06-14-00051	6/22/2015
CGS Administrators, LLC, Overpaid Providers That Incorrectly Billed for Aflibercept	A-06-14-00053	5/14/2015
Medicare Paid $22 Million in 2012 for Potentially Inappropriate Ophthalmology Claims	OEI-04-12-00281	12/22/2014
Fletcher Allen Health Care Did Not Always Bill Correctly for Evaluation and Management Services Related to Eye Injection Procedures	A-01-11-00515	5/21/2012
Medicare Payments for Drugs Used To Treat Wet Age Related Macular Degeneration	OEI-03-10-00360	4/20/2012
Review of Medicare Part B Avastin and Lucentis Treatments for Age-Related Macular Degeneration	A-01-10-00514	9/6/2011
Use of Modifier 59 to Bypass Medicare's National Correct Coding Initiative Edits	OEI-03-02-00771	11/25/2005

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

DATE: March 20, 2025

TO: Amy J. Frontz
Deputy Inspector General for Audit Services

FROM: Stephanie Carlton
Acting Administrator

SUBJECT: Office of Inspector General (OIG) Draft Report: Medicare Payments for Evaluation and Management Services Provided on the Same Day as Eye Injections Were at Risk for Noncompliance with Medicare Requirements, A-09-23-03014

The Centers for Medicare & Medicaid Services (CMS) appreciates the opportunity to review and comment on the Office of Inspector General's (OIG) draft report. CMS is committed to ensuring that global surgery payments, such as those for intravitreal injections, are made in accordance with Medicare rules.

Intravitreal injection is considered a minor surgery, and CMS pays for surgical procedures with a global surgery payment. A global payment rate includes payment for evaluation and management (E&M)—the process by which the healthcare provider evaluates the problem and determines that the surgery is medically necessary, as well as for the procedure itself. Generally, a healthcare provider should not separately bill an E&M service for the same patient on the same day as an intravitreal injection. However, if the E&M service is related to a medical issue distinct from the intravitreal injection, or if it goes beyond the usual preoperative and postoperative care associated with the intravitreal injection, the healthcare provider may be permitted to bill it separately using a modifier on the claim.

CMS works to educate healthcare providers about proper coding practices for global surgery payments. Since 2018, CMS has issued more than 20 Medicare Learning Network (MLN) educational products and messages to educate healthcare providers about payment policy on global surgery packages and proper coding practices. For example, in November 2024, CMS issued a product on proper billing for global surgery procedures, including when it is appropriate to use a modifier for E&M services.[1]

In addition, CMS is required to collect data to use in valuing global surgical services by section 1848(c)(8)(B) of the Social Security Act, as added by the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). Furthermore, MACRA mandated that CMS collect additional data to assess the accuracy of global surgical package valuation. CMS has begun this iterative process by requiring healthcare providers of certain procedures to provide additional

[1] https://www.cms.gov/files/document/mln907166-global-surgery-booklet.pdf

information on post-operative visits. This work is part of CMS' ongoing effort to more accurately value and pay for global packages, and may include other global packages in the future.

OIG's recommendations and CMS' responses are below.

OIG Recommendation

CMS should update Medicare requirements for billing E&M services provided on the same day as intravitreal injections to help healthcare providers understand the appropriate use of modifier 25 (e.g., clarify the definition of a "significant and separately identifiable" E&M service and identify the circumstances that allow for an E&M service to be billed on the same date of service as an intravitreal injection).

CMS Response

CMS will consider updating requirements to clarify the appropriate use of modifier 25 as part of our ongoing efforts to more accurately value and pay for global packages.

OIG Recommendation

CMS should conduct medical reviews of E&M services that were provided on the same day as intravitreal injections to determine whether these payments were improper and, consistent with relevant laws and the agency's policies and procedures, recover payments of up to $123,955,176 for E&M services that CMS determines should not have been billed with modifier 25 during our audit period, and instruct those healthcare providers to refund to enrollees any coinsurance amounts that may have been incorrectly collected from them or from someone on their behalf.

CMS Response

CMS concurs with this recommendation. CMS will evaluate a sample of E&M services that were provided on the same day as intravitreal injections and will recover payments found to be improper in accordance with our policies and procedures. Providers are notified of associated cost sharing amounts as part of the overpayment recovery process so that the providers can refund any cost sharing amounts that may have been incorrectly collected.

OIG Recommendation

CMS should provide more education to healthcare providers on billing E&M services provided on the same day as intravitreal injections and the appropriate use of modifier 25 to help prevent improper payments for those services. For example, CMS could: (1) emphasize that the decision to perform an intravitreal injection is part of the minor surgical procedure and a separate E&M service should not be billed for that work; (2) provide a clear definition of a "significant and separately identifiable" E&M service that is "above and beyond" the usual care associated with an intravitreal injection; and (3) provide examples of E&M services that would be considered significant and separately identifiable and above and beyond the usual care associated with an intravitreal injection.

CMS Response

CMS has conducted extensive national education on this topic since 2018, issuing nine Medicare Learning Network (MLN) publications and 15 messages educating healthcare providers about global surgery package payment and codes required for post-operative visits. Additionally, CMS issued seven MLN publications and four messages specific to modifier 25. Based on this education,

CMS believes we have already met the requirements of this recommendation and ask that it be removed.

CMS thanks OIG for their efforts on this issue and looks forward to working with OIG on this and other issues in the future.

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