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Dermatology Coding Alert

Attention Dermatology Coders: 3 Questions to Ask Yourself About Modifier -25

If you want to make sure that you get reimbursed for your modifier -25 claims, start by making sure that you can separately identify your E/M procedures from your other procedures.

Modifier -25 (Significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service) can get your practice paid for E/M services that the dermatologist performs on the same day as another separate procedure of service - but first you have to prove it.

Here are three easy questions to ask yourself - with answers from the experts - to set you on the road to no-hassle modifier -25 reimbursements.

1. Does your E/M procedure stand alone? CMS specifies that all procedures have an E/M component. But Medicare will not pay for any additional E/M procedure unless it is completely separate and identifiable from the service the physician would normally provide. For example, an established patient comes in with lesions on both arms. The dermatologist evaluates the patient and decides to perform a biopsy of one of the skin lesions (minor surgery). The patient is then diagnosed with dermal lesions of the arms (709.9). The key is the documentation of the medical record. For the E/M service, documentation should include the history of the new problem, the examination of the problem, and any related areas, and the medical decision-making, which would include the determination to proceed with the biopsy.

Documentation of the biopsy should also be listed, preferably under a separate heading from the E/M service. This note should include the methodology employed to perform the procedure, as well as the findings. Consider it a miniature version of a hospital operative report.

Because this is a new problem for this patient and the dermatologist must evaluate the patient and the problem before he or she can make a decision to do surgery, you need to report the evaluation with an E/M and then append a modifier -25 to the E/M service (709.9) and also bill the skin biopsy code 11100 (Biopsy of skin, subcutaneous tissue and/or mucous membrane [including simple closure], unless otherwise listed; single lesion), advises **Tammy Young, LPN, HIA, CPC, CPC-H**, a healthcare consultant in Dickson, Tenn.

When the pathology report comes back, your nurse may call and schedule the patient for additional work. At that time, the patient is scheduled for a shave removal procedure (11300-11303, Shaving of epidermal or dermal lesion, single lesion, trunk, arms or legs; lesion diameter 0.5 cm or less). At the second visit you would only report the dermal shaving, Young says. You would not bill an E/M service because the condition is not a new problem or symptom and the dermatologist has previously evaluated the patient for it, she adds. **Note:** Becuase the biopsy has \"0\" days for a global period, you don\'t need to worry about additional modifiers for the shave biopsy.

If there is a separately identifiable problem the dermatologist manages during this visit, then you would report an E/M code with the -25 modifier. Continuing with the example above. Let\'s say that now the patient is complaining about a new rash. The patient is evaluated, (history, examination and decision-making). You would code this examination as an E/M service. You will still code for your procedure as planned, but now add the E/M with a modifier -25 and a diagnosis that indicates that patient was evaluated for a rash.

Tip: When asking yourself if a procedure stands alone, physically separate the E/M notes from the procedure documentation in your medical record. If a reviewer could look at your medical notes and clearly see that the physician completed two separate and independently identifiable procedures, then you can append modifier -25. This is accomplished easily by simply adding the \"Procedure\" heading to your note and documenting the procedure under that

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heading. Remember, for an E/M, separate and identifiable means a reviewer can determine the three components of history, exam and medical decision-making from your procedure.

2. Do you have to have additional diagnoses? You may believe that for an E/M service to be separately identifiable, the service must have a separate diagnosis. But CPT states that an E/M service may be prompted by a symptom or condition that requires a procedure, but the procedure must be separate from any procedure completed for the initial symptoms or conditions. You don\'t have to have another diagnosis.

For instance, a patient may present with a problem of acne flare-up. The dermatologist may interview the patient to determine what could have caused the change (i.e., stress, new cleanser, sun or chemical exposure) to determine a change in treatment.

During this process, there may be an inflamed area that needs draining. If all elements are documented properly, an E/M service could be billed in addition to the CPT code for acne surgery (10040) or incision and drainage of abscess (10060). The diagnosis may be the same, depending on the documentation provided for the encounter, says **Karen Hurley, CMM, CPC**, president of HPMSI in Waldorf, Md. But in all cases, if you have an additional diagnosis, you should always report it. ICD-9 guidelines direct the coder to list the symptom for the visit, and if a more definitive diagnosis is known following the procedure, to use the definitive diagnosis on the procedure.

3. Are you confusing modifiers -25 and -57? Modifier -57 (Decision for surgery), like modifier -25, applies to E/M services, but when should you use which modifier? You should use modifier -57 only if a physician decides that the patient needs a surgical procedure the same day as the E/M service or the next day, and the procedure that will be performed has a global period of 90 days. Modifier -25 is used when the procedure is done on the same day and the global period for the procedure is zero or 10 days.

Skin grafting, for example has a global period of 90 days, while the shave codes (11300-11313) have zero, and benign excision codes (11400-11446) have 10.

If a patient is evaluated for a potential skin graft on Monday, and the skin graft is planned for the same day or the following day, the modifier -57 will be required on the E/M code. Compare this to the excision of a benign lesion. If the patient is evaluated on Monday and the procedure is done immediately following on the same date, then modifier -25 is used. However, if the patient is evaluated on Monday and brought back the next day, only the procedure is charged on the following day, and no modifier is necessary.

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