Dermatology Coding Alert

Modifier Basics: Follow 3 Rules to Capture Separate E/M Pay

Avoid modifier 25 scrutiny with proper 'separately identifiable' documentation.

Reporting a separate E/M every time your dermatologist performs a procedure is asking for an audit. Unlock the secrets to legitimate pay for separately identifiable E/M services using modifier 25 (Significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service) with these three guidelines.

1. Ensure Your Dermatologist Performed a Separate Service

You should use modifier 25 when your dermatologist's documentation supports that he performed an E/M service that was significant and separately identifiable from the work included in another service or procedure.

Tip: "Look at the documentation and cross out anything that is directly related to the procedure performed," says **Judith L. Blaszczyk RN, CPC, ACS-PM,** compliance auditor with ACE consulting in Leawood, Kan. "Look then at the remaining documentation to determine if it is indeed significant, separately identifiable and medically necessary."

Official guidance: CPT's Appendix A states that a significant and separately identifiable service "is defined or substantiated by documentation that satisfies the relevant criteria for the respective E/M service to be reported."

Remember: You can only consider reporting modifier 25 when coding an E/M service. If the procedures you're reporting don't fall under E/M services, it's possible the encounter qualifies for another modifier instead.

Example: A new patient comes to your practice with a red, itchy rash on her arm. The dermatologist makes an initial diagnosis of nonspecified contact dermatitis (692.9, Contact dermatitis and other eczema; unspecified cause). After thorough examination, the dermatologist applies patch tests the same day and asks the patient to return in 48, 72, and 96 hours for readings.

You should report 95044 (Patch or application test[s] [specify number of tests]) for the patch tests. You should also bill for the E/M services the dermatologist provides to the patient.

You should determine the most appropriate E/M code (99201-99215) to report based on the scope of the examination and the key components the dermatologist covers with the patient.

Append modifier 25 to your E/M code to notify the payer that the dermatologist performed an initial evaluation that led him to complete patch testing on this patient.

Bottom line: Using modifier 25 is "essentially telling the insurance company: 'During this visit I determined XYZ needed to be done and I happened to have time to do it that day.' If you can't say this (or something like it) then the E/M service shouldn't be billed," says **Suzan Berman CPC, CEMC, CEDC,** senior manager of coding education and documentation compliance in the Physician Services Division at the University of Pittsburgh Medical Center.

2. Don't Confuse Modifiers 25 and 57

The difference between 25 and modifier 57 (Decision for surgery) is a common point of confusion, because both involve your dermatologist performing a procedure and distinct E/M service for the same patient on the same day.

The quickest distinction is that you would use 25 for a distinct E/M with a minor procedure, and 57 for a distinct E/M with a major follow-up procedure.

How it works: You should only use modifier 25 with procedures that have a 0- or 10-day global period, Berman explains. These kinds of procedures are what Medicare defines as "minor." In contrast, you'll use modifier 57 for procedures with a 90-day global period. Note, however, that some payers are now requesting 57 on 10-day globals, according to **Jetton Torrix, CCS-P, CPC-H,** course director of Knowledge Source Seminars in North Port, Fla. and Cross Country Education instructor, so check with your individual payers.

Watch out: Some coders view modifier 25 as a "magic bullet" and they always add a 25 modifier to E/Ms done on the same day as a procedure because that is the only way they can get them paid. Don't fall into that trap. "Any practice that applies modifier 25 indiscriminately to their E/Ms will be an outlier to other practices in the volume of claims billed with modifier 25and will be sending up red flags," Blaszczyk says.

3. Stop Omitting 25 Because of Same Dx

Proper modifier 25 use does not require a different diagnosis code. In fact, the presence of different diagnosis codes attached to the E/M and the procedure does not necessarily support a separately reportable E/M service.

"The guidelines changed years ago that you do not need to have a different diagnosis to use modifier 25," says Torrix.

"But it still seems to be easier to get paid if the diagnoses are different," she adds.

Go to the source: The information about modifier 25 in the CPT manual clearly indicates that you do not have to have two different diagnosis codes to use the modifier. The CPT manual states: "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."

How it works: "The proof [of separately reportable services] is in the documentation of the E/M service," Berman says.

Your dermatologist's documentation should clearly establish that the visit's purpose was not to perform the procedure. If you receive denials on modifier 25 claims simply because you use the same diagnosis code for the E/M and the procedure, you should appeal assuming your dermatologist's documentation supports reporting separate services.