Dermatology Coding Alert

Think You Know How to Use Modifier -25?

Answer 3 questions to make sure

If you want to recoup reimbursement for your modifier -25 claims, make sure you can separately identify your dermatologist\'s E/M services from other procedures he performs for the same patient on the same day.

Here are three easy questions to ask yourself -- with answers from the experts -- to help guide you on the road to hassle-free use of modifier -25 (Significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service).

1. Does your E/M service stand alone?

CMS specifies that all procedures have an inherent evaluation and management component. Private payers also assume that there\'s some inherent E/M visit built into the reimbursement for procedure codes, because most dermatologists do a certain amount of \"visiting\" with the patient before any procedure.

This is why you need to be careful of overuse of modifier -25. Don\'t append modifier -25 just because your dermatologist spoke with the patient before doing the procedure, says **Brenda W. Messick, CPC,** a coding specialist in Atlanta.

For proper Medicare coding with modifier -25, the E/M service needs to be separate and identifiable from the minor procedure, and you need separate documentation for both services.

For example: A patient presents at your dermatology practice for a routine checkup. The dermatologist does more than just walk into the room and perform a checkup. The patient has a lesion on her arm that the dermatologist decides to excise.

You should include all the needed E/M documentation, including the plan to excise the lesion. Then you want separate documentation for the excision to show that you have reason to report a complete E/M separately. The repair documentation procedural note can be on the same sheet, or it can be on a separate piece of paper. You can provide the mini-operative report of the repair that tells how the dermatologist prepared the patient, what type of anesthetic he used, how many sutures he applied, and other relevant details.

Tip: When asking yourself if a procedure stands alone, 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 services, you can append modifier -25 for Medicare minor procedures.

For CPT payers, reporting works a little differently. CPT only bundles the E/M service performed subsequent to the decision for surgery. So, an E/M may be appropriate if the documentation supports a thorough history and physical exam prior to the decision for surgery, coding experts say.

2. Do you need to have additional diagnoses?

You may think that in order for an E/M service to be separately identifiable, the service must have a separate diagnosis. Not true.

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 your physician performed for the initial symptoms or conditions. You don\'t necessarily have to have another diagnosis.

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For example, if a patient presents with a minor wart and otherwise has no complaints, you might be left with only wart removal as a diagnosis code. However, even according to Medicare\'s more restrictive rules, an E/M might apply if the dermatologist performed a more complicated exam from concerns based on the patient\'s previous history.

Warning: Never append modifier -25 to the procedure code, only to the E/M code. You may encounter situations, such as the one described above, in which the same diagnosis will be the reason for both the E/M visit and the procedure, says **Tina Landskroener, CCS-P,** of Total Healthcare Compliance in Las Vegas.

3. Have you considered modifier -57?

Modifier -57 (Decision for surgery) applies to E/M services also, but you should not use this routinely for procedures the dermatologist performs with E/M visits.

For Medicare, you should use modifier -57 only if the dermatologist decides that the patient needs a surgical procedure the day before or the day of the procedure, and the procedure has a global period of 90 days. Modifier -57 is allowed by Medicare to represent the work required to reach the decision for surgery for a major procedure. Modifier -25, on the other hand, is used to represent a separately identifiable E/M service that was performed during the 0- to 10-day global period of a minor procedure.

For example, the dermatologist evaluates a malignant lesion on the patient\'s back that measures 1.2 cm and performs the necessary excision. In this case, you\'d report 11602 (Excision, malignant lesion including margins, trunk, arms, or legs; excised diameter 1.1 to 2.0 cm) to represent the procedure, and append modifier -57 to represent the physician\'s decision for surgery associated with this major procedure, such as a complex repair (13100, Repair, complex, trunk; 1.1 cm to 2.5 cm).

For a laceration repair (12011, Simple repair of superficial wounds of face, ears, eyelids, nose, lips, and/or mucous membranes; 2.5 cm or less), you could append modifier -25 to the E/M if the dermatologist performed a separately identifiable service in addition to the procedure.

Reimbursement tip: Every carrier is different, and not all of them follow the coding standards for using modifier -25. \"Sometimes it\'s best to contact those carriers that keep denying you and find out how they want it billed. If a carrier ever tells you anything that is directly against an accepted CPT/ICD-9/HCPCS coding standard, then ask for it in writing,\" says **Jamie Darling, CPC,** of Graybill Medical Group in Escondido, Calif.

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