Codify
BY AAPC

Internal Medicine Coding Alert

3 Quick Tips to Achieve Ethical Modifier -25 Reimbursement

Inside: The best way to get your copy of our easy-to-use appeal letter

Modifier -25 may be a "last resort" modifier, but it can also help you accurately code an appropriate E/M service that an insurer normally bundles into a procedure. Follow these three steps to learn when - and when not - to use the modifier, and how to win an appeal if a carrier denies your claim.

1. The Right Times to Report Injections and E/Ms

In some circumstances, your internist can bill for both an injection and an office visit, even though Medicare bundles these services.

For instance, a new patient presents to receive a steroid injection for shoulder pain, but also has hypertension. The internist would bill for the injection and for the evaluation and exam of the hypertension, says **April Borgstedt, CPC**, an internal medicine coding specialist and president of Working for You Consulting in Broken Arrow, Okla.

How you should code: For the injection, you could report G0351 (Therapeutic or diagnostic injection [specify substance or drug]; subcutaneous or intramuscular) along with the appropriate E/M code (for example, 99203, Office or other outpatient visit for the E/M of a new patient ...). Be sure you attach modifier -25 (Significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service) to the E/M to show that it's a separate service, Borgstedt says.

If your office is billing a private carrier, you may have to use CPT's injection code 90782 (Therapeutic, prophylactic or diagnostic injection [specify material injected]; subcutaneous or intramuscular). Remember that Medicare no longer accepts this code. Ask your private payer for its injection and modifier -25 policies.

Check Your ICD-9 Codes

Before you separate out the E/M with modifier -25, be sure the physician performed an exam that will satisfy coding and medical-necessity guidelines, Borgstedt adds.

For example, if the patient is new to your office, your internist's E/M service should meet all three key elements: history, exam and medical decision-making.

In addition, link the appropriate ICD-9 codes to the procedures and E/M. For example, tie shoulder pain's diagnosis code 729.5 (Pain in limb) to G0351, and the hypertension code (for example, 401.0, Essential hypertension; malignant) to the E/M code.

Heads-up: Coding guidelines and insurer's policies may not require different diagnosis codes for the procedure and E/M when you use modifier -25, but doing so increases your chances of getting paid with some carriers, Borgstedt says.

Special note: Private insurers often require a separate condition or reason for the E/M service. But make sure you don't artificially come up with diagnosis codes to support the separate E/M charge, says **Marcella Bucknam, CPC, CCS, CPC-H, CCS-P,** HIM program coordinator at Clarkson College in Omaha, Neb. The medical documentation should always support what the physician bills and the codes you use, she says.

2. Some Payers Differ on Ancillary Services

When the internist performs an office visit and then also provides an ancillary service, such as a chest x-ray or lab test, to determine a diagnosis or the treatment plan, you typically don't need to use modifier -25 to separate the E/M service, Borgstedt says.

For example, along with an exam, the internist or nurse performs a urinalysis, which is an ancillary service, for a patient with suspected diabetes. In this case, you could report the appropriate E/M code (such as, 99212, Office or other outpatient visit for the E/M of an established patient...) along with 81002 (Urinalysis, by dip stick or tablet reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein, specific gravity, urobilinogen, any number of these constituents; non-automated, without microscopy) without using modifier -25.

Quick tip: You should use the modifier to unbundle an E/M the internist provided at the same time as a procedure that has a global fee service, Borgstedt says.

Watch out: Not all private insurance companies follow CPT coding guidelines, Bucknam says. This means if an insurer requires that you attach modifier -25 to any E/M billed on the same day as a lab or x-ray, you should do it.

Handy tool idea: If your office deals with several different commercial carriers, you're also probably dealing with several different sets of coding policies. To keep track of these policies, develop a chart that links each of the commercial insurance companies to their respective policies on modifiers for quick, easy use, Bucknam says.

3. Use Our Appeal Letter to Fight Rejections

If you think your insurance carrier unfairly denied your modifier -25 claim and you want to appeal, you need a tried-and-true appeal letter to get your deserved reimbursement.

What to do: Try one of Internal Medicine Coding Alert's templates for appealing modifier -25 denials. Simply send an e-mail to kirkj@eliresearch.com for your free template.