

Internal Medicine Coding Alert

Get Paid for Both a Procedure and Office Visit on the Same Day

Editors Note: In upcoming issues, Internal Medicine Coding Alert will keep you up-to-date on specific modifiers and how they can be used by internal medicine practices. The following article covers modifier -25.

CPT modifier -25 (significant, separately identifiable evaluation and management [E/M] service by the same physician on the same day of a procedure or other service) can often be used in internal medicine practices when the physician sees the patient for a regular office visit, then performs an unrelated procedure. In another instance, the modifier may be used if the physician performs a scheduled procedure, then is asked about an unrelated medical problem.

The key to correctly using this modifier on the E/M code in each of these situations is an understanding, on the part of both the care provider and coder, of what is a significant, separately identifiable service and of what is needed to properly document it.

When Can You Use -25?

1. Patient seeks treatment for illness or problem unrelated to purpose of visit. Modifier -25 can most often be used when the physician performs a separate procedure on the same day of an office visit, says **Emily Hill, PA-C**, managing partner of Strategic Healthcare Services, a medical practice management consulting company in Southport, NC.

It is not two procedures on the same day, it is a visit and a procedure, a 99000 code and a procedure, she explains.

An example would be a patient presenting for evaluation of diabetes and hypertension, who, in addition, seeks treatment for a lesion on her hand, explains **Mabel Restuccio, CPC**, principal of Restuccio Healthcare Group, a practice management consulting firm in Cordova, TN. The visit was for diabetes and hypertension, but the lesion is bothering the patient, she asks the doctor to examine it, he does, and decides to remove the lesion in the office during the visit.

The physician would document the history, exam, and medical decision-making for the diabetes and hypertension, bill the appropriate level of service for the visit with a -25 modifier attached (e.g., 99214-25) and bill the appropriate code for the removal of the lesion (**CPT 11055**-paring or cutting of benign hyperkeratotic lesion, 11305-11308-shaving of epidermal or dermal lesion, single lesion, scalp, neck, hands, feet, genitalia), says Restuccio.

2. Patient comes in for a procedure then informs the physician about a separate problem. This is a scenario in which the patient, in the office for a scheduled procedure, then says to the doctor, Oh, by the way I have this other problem. . . , says Hill. If the physician addresses the separate problem that same day, then the evaluation and management service would be coded with the -25 modifier and the scheduled procedure would coded in the regular manner, she says. The coding would be the same in this situation as above, except that you will most likely have two separate diagnosis codes. These codes should be linked properly to the CPT codes, and the history, exam, and medical decision-making should be documented.

3. Patient comes in for a visit, which leads to a procedure. Sometimes a patient will come in with a problem that necessitates treatment. The procedure was not scheduled but resulted from information obtained through the E/M service, says Hill.

An example would be a patient who presents with unexplained ankle pain (pain in upper or lower extremity, 729.5). The physician, after the history and physical, may determine that a splint should be provided for ankle support, says Restuccio.

The physician would bill the appropriate level of service for the evaluation of the problem, typically a 99212, with the modifier -25 attached, she notes. In addition, the proper code for the application of the splint (29515) and the supply code corresponding to the splint (HCPCS L4350) would be used, she says.

Tips on Getting Paid

Many practices fear that the use of modifiers will trigger audits. And, in some cases, they do catch the attention of payers. However, if you take the time to follow simple guidelines and precautions, audits won't be a problem, says Hill.

1. Ensure proper documentation. If a separate E/M service is performed that day, the history, exam, and medical decision-making should be clearly documented. On the chart, an auditor should clearly see that there is an E/M service and a separate procedure. Hill recommends writing the history, exam, and medical decision-making for the procedure in a distinctly separate place on the chart and labeling it a procedure note.

For the heads-down auditor, who wants to look and see if they see two services on the same day, documenting the procedure in a separate place shows it much clearer to them, she says. They see [the documentation for] some E/M service and then they see procedure note.

2. Designate the person responsible for assigning the modifier. Is it a requirement in your office that the physician mark the modifier on the encounter form, or is the coder supposed to know to apply it? That's the question most practices need to answer in order to maximize use of this modifier, says Hill. What happens is the doctors don't mark it because they don't know about it, and then the coders don't write it down because they aren't sure whether they should or not.

Hill recommends that practices make the providers responsible for adding the modifier, since they are the ones who know exactly what services were performed.

I usually say you should encourage physicians to mark it, but what they need to understand is, if they are going to mark that, then they are attesting to the fact that they have documented both (the service and the procedure), she says. The doctor should know that he can't mark both, if there isn't documentation for both.

3. Know when not to use the modifier. Although many practices aren't using the modifier, those that do are often discovering that claims sail right through. Unfortunately, codes that have the modifier attached when it shouldn't be, or those without sufficient documentation, may sail right back to your office.

Some practices use modifier -25 incorrectly, says Restuccio. For example, if a problem has previously been evaluated, and the patient presents for the procedure a day or two later, only the procedure should be reported.

It is not appropriate to use modifier -25 in this instance, she emphasizes. Some physicians say they use it to cover pain management, but pain management is an integral part of the procedure itself and should not be billed separately.

Note: The Office of the Inspector General of the Department of Health and Human Services has announced that it is placing the use of modifier-25 under increased scrutiny. The OIG's work plan for fiscal year 1998 includes a statement that the office will determine whether physicians are improperly using modifier -25 on Medicare Part B claims to increase reimbursement.