Internal Medicine Coding Alert

Get Paid for Two E/M Visits or an E/M Service and Procedure Performed on the Same Day

Because internal medicine practices are often the primary source of their patients medical care, they are frequently presented with some rather unusual coding and billing situationsparticularly with regard to separate services delivered to the same patients on the same day.

We continue to come across this problem, begins a letter from staffers in the billing department at Cumberland Internal Medicine in Vineland, NJ. An established patient came into the office for a follow-up to allergic rhinitis and was seen by his primary care doctor. We used 99215 as his office-visit code. Later that evening, the same patient had a heart attack and was seen by our on-call doctor for this problem and was admitted to the hospital. Since we already saw the patient that day, what is the appropriate way to bill this service, since both doctors are in our group and deserve to be paid?

The key problem here is that both of the services provided are evaluation and management services, and they were performed on the same day, by physicians from the same medical group.

Traditionally, many payers have refused to pay for two E/M services given to the same patient on the same day, the rationale being that the services are somehow related and the second should be included in the first.

In this particular case, however, the distinct ICD-9 codes linked to the different E/M codes should be enough to get each claim paid, states **Catherine Brink, CMM, CPC,** president of Healthcare Resource Management in Spring Lake, NJ.

I would assume that the payer, seeing the ICD-9 for the allergic rhinitis (477.x) linked to the office-visit E/M (99215) and the ICD-9 for the heart attack (410.x, acute myocardial infarction), would realize that these were two separate, distinct services, notes Brink.

In addition, the coders should be sure that they indicate the different places of service: the office for the rhinitis visit, and the hospital for the admission for the heart attack.

In this case, both physicians deserve to be paid for the services rendered, and accurate and thorough coding of the diagnoses and services should be enough for the claims to be paid, she says. In this case, no modifiers would apply.

Using Modifier -25 with Same Diagnosis Code

Procedures performed on the same day as a separate E/M service also present a problem because many payers consider the procedure to be included in the E/M payment.

CPT provides a solution. The -25 modifier (significant, separately identifiable evaluation and management service by the same physician on the same day) can be applied to the E/M code to indicate that the code for the procedure should be paid separately. (See article on use of the -25 modifier in the August 1998 issue of IMCA.)

However, it is not always easy to get the procedure and service paid.

My question is, can you bill an E/M code and procedure with the same diagnosis and still use modifier -25?, writes **Jill Nakano,** office administrator for West Hawaii Medical Group in Kailua-Kona, HI.

Nakanos question refers to the language describing a significant, separately identifiable E/M service. Since both codes

are linked to the same diagnosis code, some payers automatically consider the procedure to be bundled into the E/M service.

According to a change in the Health Care Financing Administrations guidelines in 1999, this is incorrect, explains Brink.

Medicare will now recognize a -25 modifier on an E/M code when both that code and a separate procedure performed on the same day to the same patient by the same physician have the same ICD-9 code.

For example, she says, a patient comes into the office complaining of joint pain in the elbow. The physician performs an examination and determines the patient is suffering from tendinitis (726.90, enthesopathy of specified site). The physician gives the patient an injection to reduce the inflammation.

Naturally, since the injection is a starred procedure (20550, injection, tendon sheath, ligament, trigger points or ganglion cyst) the physician wants to bill for this, says Brink.

Prior to 1999, Medicare would only accept the -25 modifier on the office visit if it was billed with another ICD-9 code (i.e., joint pain, elbow 719.4x), says Brink.

However, this policy encouraged incorrect coding. In this case, the ICD-9 code for elbow pain is not the most specific code available. Even the 1998 ICD-9 instructs coders that an additional fifth-digit is required for this code and that simple 719.4 is not acceptable. The most specific diagnosis would be tendinitis, and now Medicare will recognize this code (729.60) for both the procedure and the office visit.

Note: Billing with the -25 modifier is appropriate because the physician did not expect to perform the injection. It was performed as a result of the examination for an unknown problem. Therefore, the evaluation and management services performed were not part of the normal E/M services included in the injection procedure. However, as always, it is imperative that the physician document the evaluation and management service: the history, exam, and medical-decision making involved.

Brink is quick to note that not all payers follow Medicares guidelines, although many do. The modifiers, particularly modifier -25, are very payer-specific, she says.

It is important to check with other third-party payers to determine whether they will accept the use of a -25 modifier when the diagnosis code is the same for both the E/M visit and the procedure. They may require additional documentation in order to process the claim.