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Internal Medicine Coding Alert

Is E/M 'Separate' or 'Inherent'? Find Out Before Filing With Modifier 25

Remember, not all pre-procedure services constitute a separate E/M

If your internist performs an E/M service and a procedure on the same patient during the same encounter, you may be able to report the E/M using modifier 25 (Significant, separately identifiable E/M service by the same physician on the same day of the procedure or other service). Or you may not.

The key: You must prove that the E/M is a separate service and is not an inherent component of the procedure. Follow this advice to find out when to report an E/M with modifier 25, and when to leave the E/M off the claim.

Find Evidence of Separate E/M in Notes

In a nutshell: "Coders should use modifier 25 when a significant, separately identifiable E/M service is performed by the same physician at the same face-to-face encounter as a procedure or other service," says C**atherine Brink, CMM, CPC,** president of Healthcare Resource Management of Spring Lake, N.J.

The most vital element on successful modifier-25 claims is concrete evidence that the procedure and E/M were truly separate, Brink says. All procedure codes have an inherent E/M component built into them, and the physician must go beyond that to justify a separate E/M. In addition, the E/M service must also meet medical- necessity criteria.

For example, a patient reports to the internist for treatment of a foot laceration. The physician performs an exam on the foot and places three sutures. Notes indicate a limited foot exam.

In this case, insurers aren't likely to accept a code for a significant, separately identifiable E/M service since the internist limited his exam to the foot. So you should just report the procedure code on this claim.

Exam Must Go Beyond Limited to Support Separate E/M

Now check out this detailed scenario, courtesy of Brink, in which the internist performs a procedure and a separate E/M:

A new patient presents with dull aching pain in his right elbow. The pain has persisted for three weeks, and despite taking Motrin for the pain, he's gotten no relief. The patient is a tennis player, and he reports that the elbow gets worse after he plays tennis or when he makes a fist.

The internist performs a review of systems; past, family and social history; an expanded problem-focused history and an expanded problem-focused exam on the right elbow, which reveals trigger point at lateral epicondyle of the humerus. When the physician depresses the elbow, the patient has pain radiating to the outer side of his arm and forearm aggravated by dorsiflexion and supination of the wrist. When his middle finger is extended against resistance, the pain is worse. The patient has no numbness or tingling in the elbow.

During the course of moderate medical decision-making (MDM), the internist makes a diagnosis of lateral epicondylitis (tennis elbow) and injects 1 mg of cortisone into the elbow. The internist advises the patient to use a tennis elbow strap when lifting with his right arm and while playing tennis.

In this instance, the internist performed a significant E/M service before deciding to inject the elbow. On the claim, therefore, you should report the following:

- 20552 (Injection[s]; single or multiple trigger point[s], one or two muscle[s]) for the injection

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- 99202 (Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components: an expanded problem-focused history; an expanded problem-focused examination; straightforward medical decision-making) for the E/M
- modifier 25 attached to 99202 to show that the injection and the E/M were separate services
- 726.32 (Enthesopathy of elbow region; lateral epicondylitis) to represent the patient's injury.
- J0835 (Injection, consyntropin, per 0.25 mg) x 4 units for the cortisone supply.

You Could Have Same Dx for E/M, Procedure

As evidenced in the above example, you don't need a diagnosis code for a separate problem to code an E/M with modifier 25, says **Leslie Bowers,** coder at Bay Ocean Medical.

Sometimes, the circumstances justify a procedure and a separate E/M for the same complaint.

A good rule for modifier 25 claims is "if an E/M service was necessary for the physician to make a medical decision to perform the procedure -- and he had to take a history, perform an exam and come to a medical decision to perform the procedure -- then a separate E/M can be charged," Brink says.

But when the internist asks a few incidental questions of the patient prior to the procedure, you should report the procedure code only.

Experts Agree: Solid Documentation Paves Way to Modifier 25 Payment

Without proper documentation of the separate E/M, your modifier 25 claim could land in the denial pile, Brink says.

You don't necessarily have to submit separate reports for the procedure and E/M, but you do need "designated procedure documentation and E/M visit documentation," Bowers says.

Here's what CPT Assistant from January 2004 says about modifier 25 claims: "Generally, separate documentation of each service (e.g., E/M and procedure) is recommended so that each service is readily and individually identifiable as such. Each may be documented separately in progress or other appropriate notes. Separate pages for each service are not required."

Try this: When you check documentation for your modifier 25 claim, Brink recommends that you make sure there is medical necessity for the separate E/M. Remember, the encounter must satisfy three of three E/M components to report a new patient E/M service, and it must satisfy two of three components to report an established patient E/M.

Once you confirm that the notes clearly indicate a medically necessary E/M service separate from the procedure the internist performed, your modifier 25 claim is ready for submission.

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