Codify by AAPC

Internal Medicine Coding Alert

Reader Questions: Stop Omitting 25 Because of Same Diagnosis

Question: I was recently told in a class that you do not need different diagnosis codes to use modifier 25 for reporting an E/M service on the same date as a procedure. But I've been told many times in the past by certified coders that when I bill more than one procedure that I need to add modifier 25 to the E/M and point the primary diagnosis to the E/M and point a secondary diagnosis to the other procedure. Can you clear up my confusion?

Answer: Proper modifier 25 (Significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service) use does not require a different diagnosis code. In fact, the presence of different diagnosis codes attached to the E/M and the procedure does not necessarily support a separately reportable E/M service. Your key to separately reporting the E/M service lies in whether your doctor performed and documented work beyond what is considered to be part of the procedure.

How it works: When using modifier 25, the diagnosis associated with the E/M service can be the same as the diagnosis associated with the same-day procedure, or the diagnosis associated with the E/M service can be different than the diagnosis associated with the same-day procedure.

Go to the source: The information about modifier 25 in the CPT manual clearly indicates that you do not have to have two different diagnosis codes to use the modifier. The CPT manual description of modifier 25 states: "The E/M service may be prompted by the symptom or condition for which the procedure and/or service was provided. As such, different diagnoses are **not** required for reporting of the E/M services on the same date." (Emphasis added)

Both CPT and Medicare rules will allow the same diagnosis for the E/M service with modifier 25 and the procedure on the same day, and Medicare will reimburse for both with the same diagnosis, assuming both are reasonable and necessary and otherwise meeting Medicare coverage criteria. The catch is that your internist's documentation should clearly establish that the E/M involved work over and above that typically associated with the procedure done at the same encounter and that the encounter's sole purpose was not to perform the procedure. If you receive denials on modifier 25 claims simply because you use the same diagnosis code for the E/M and the procedure, you should appeal, assuming your internist's documentation supports reporting separate services.

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