Codify
BY AAPC

Optometry Coding & Billing Alert

Answer 'Separate' or 'Inherent' Question Before You Use Modifier 25

When an optometrist 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.

In order to rightfully code an E/M-25, 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.

Include Evidence of Separate E/M in Notes

The basics: "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 **Catherine 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, 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.-

Example: An established patient with dry eye syndrome reports to the OD for a scheduled punctal plug insertion. After discussing the procedure with the patient and answering a few questions, the OD inserts a collagen plug in the patient's right lower puncta.

In this instance, the OD does not perform a significantly separate E/M. The patient reported with a set appointment for the plug insertion and already had a diagnosis. On the claim, report the following:

- 68761 (Closure of the lacrimal punctum; by plug, each) for the insertion

- modifier E4 (Lower right, eyelid) linked to 68761 to show the location of the plug insertion

- 375.15 (Tear film insufficiency, unspecified) linked to 68761 to represent the patient's condition.

Now check out this example: A patient complaining of eye pain reports to the optometrist. The OD performs a review of systems; a check of past, family and social history; a problem-focused history; and a problem-focused exam on the eye, which reveals a conjunctival foreign body (FB). The optometrist then removes the FB.

In this instance, the OD performed an E/M prior to performing the procedure.

On the claim, you should report the following:

- 65205 (Removal of foreign body, external eye; conjunctival superficial) for the removal

- 930.1 (Foreign body in conjunctival sac) linked to 65205 to represent the patient's condition

- 99212 (Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: a problem-focused history; a problem-focused examination; and straightforward medical decision- making) for the E/M

- modifier 25 linked to 99212 to show that the E/M and plug insertion were separate services

- 379.91 (Pain in or around eye) linked to 99212 to represent the patient's eye pain.

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 doctor asks a few incidental questions of the patient prior to the procedure, as is the case with most encounters, you should report the procedure code only.