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# Optometry Coding & Billing Alert

## E/M Services: Answer 'Separate' or 'Inherent' Question Before You Use Modifier 25

**Not all pre-procedure services constitute a separate E/M.**

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. The most vital element on successful modifier 25 claims is concrete evidence that the procedure and E/M were truly separate.

You can only consider reporting modifier 25 when coding an E/M service, says **Janet Palazzo, CPC,** coder for a practice in Cherry Hill, N.J.

Exception: Medicare and most other carriers treat the eye codes (92002-92014, Ophthalmological services: medical examination and evaluation ...) the same as E/M codes. Therefore, if there is a separately identifiable service, you can report it with an eye code and append modifier 25 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 medicalnecessity criteria.

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

In this instance, the optometrist 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 optometrist performs a review of systems; a check of past, family and social history; a  problemfocused 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 optometrist 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

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- 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 problemfocused 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. 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.

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.

**Avoid Scrutiny -- Don't Overuse 25**

Some coders view modifier 25 as a "magic bullet," says **Judith L. Blaszczyk RN, CPC, ACS-PM,** compliance auditor with ACE consulting in Leawood, Kan. She has heard from some coders that "always add a 25 modifier to their E/Ms done on the same day as a procedure because that is the only way they can get them paid," Blaszczyk adds.

That kind of coding is improper and incorrect, says Palazzo. "Any practice that applies modifier 25 indiscriminately to their E/Ms will be an outlier to other practices in the volume of claims billed with modifier 25 and will be sending up red flags," says Blaszczyk.

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