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Optometry Coding & Billing Alert

Modifiers: Master Modifier 25 Following These Expert Tips

Haphazardly using 25 on all claims will lead to payer scrutiny.

With payers cracking down on modifier 25 claims, you need to ensure you know exactly how and when to separately report an E/M service along with a procedure.

Solidify your claims by learning these four tips that guide when you can legitimately report a separate E/M service using modifier 25 (Significant, separately identifiable evaluation and management service by the same physician or other qualified health care professional on the same day of the procedure or other service).

Tip 1: Save 25 for E/M Codes

You should use modifier 25 when your optometrist's documentation supports that he performed an E/M service that was significant and separately identifiable from the work included in another service or procedure.

Remember: You can only consider reporting modifier 25 when coding an E/M service. If the procedures you're reporting don't fall under E/M services, it's possible the encounter qualifies for another modifier instead.

Watch out: Some coders view modifier 25 as a "magic bullet" and they always add a 25 modifier to E/Ms done on the same day as a procedure because they feel that is the only way they can get paid for both services. Don't fall into that trap. You will set your practice up for several denials, and worse, payer audits.

Tip 2: Identify E/M HEM Before Adding 25

Your optometrist not only needs to describe the procedure he performed he must also document the E/M service provided.

If a patient comes to see the physician because of several skin problems, and the physician orders a diagnostic test to further evaluate one of these problems, the E/M visit should be separately identifiable from the diagnostic test and reported with modifier 25. In some cases, the physician may address more than one problem, each requiring a separate history, examination and medical decision-making (HEM).

You should use modifier 25 only with services that are "significant, separately identifiable" and "above and beyond the usual preoperative and postoperative care associated with the procedure."

Best bet: When using modifier 25, you should remember this maxim: If you don't have a HEM, you can't bill an E/M.

All procedures include some service related to preoperative patient evaluation and management, but a completely separate E/M should include its own HEM. In other words, the physician needs to determine whether the problem is significant enough to require additional work to perform the key components of the problem-oriented E/M service.

"I tell my students 'You can't bill an E/M unless you have a HEM,' meaning a clearly documented note," says **Laureen Jandroep, CPC, CPC-I, CMSCS, CHCI**, senior instructor at CodingCertification.org in Oceanville, N.J. "It is recommended that the physician actually have separate pages for the procedure documentation and the E/M documentation."

Tip: Look at the documentation and cross out anything that is directly related to the procedure performed. Then, review the remaining documentation to determine if it is indeed significant, separately identifiable and medically necessary.

Official guidance: CPT®'s Appendix A states that a significant and separately identifiable service "is defined or

substantiated by documentation that satisfies the relevant criteria for the respective E/M service to be reported."

"The OIG is very specific when they state the additional service(s) provided must not be part of the normal service included in the procedure (i.e., they must be beyond the usual pre- and post-operative care associated with the procedure)," says Alice Kater, CPC, PCS, coder for a practice in South Bend, Ind.

Tip 3: Stop Omitting 25 Because of Same Dx

Proper modifier 25 use does not require a different diagnosis code, says **Gaye Pratt, RMM, RMC**, business office manager for Vincent P. Miraglia, MD, in Stuart, Fla. 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.

"It doesn't hurt to have separate diagnosis codes if the visit warrants it," Pratt says. "If you are required to send notes, it needs to have documentation supporting the additional diagnosis codes."

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 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."

Your optometrist's documentation should clearly establish that the visit's 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 optometrist's documentation supports reporting separate services.

Check the Global Period

The Correct Coding Initiative (CCI) manual for 2013 revised the wording associated with reporting modifier 25 in conjunction with minor surgical procedures, effective January 1, 2013. The description of minor surgical procedures (with new verbiage underlined) states:

"If a procedure has a global period of 000 or 010 days, it is defined as a minor surgical procedure. **E/M services on the same date of service as the minor surgical procedure are included in the payment for the procedure**. The decision to perform a minor surgical procedure is included in the payment for the minor surgical procedure and should not be reported separately as an E/M service.

"HOWEVER, a significant and separately identifiable E/M service unrelated to the decision to perform the minor surgical procedure is separately reportable with modifier 25. The E/M service and minor procedure do not require different diagnoses.

"If a minor surgical procedure is performed on a new patient, the same rules for reporting E/M services apply. The fact that the patient is "new" to the provider is not sufficient alone to justify reporting an E/M service on the same date of service as a minor surgical procedure."

"E/M billing with modifier 25 has always been a target in the past, but this most recent description seems a little more threatening and goes beyond the definitions found in AMA CPT®," says **Barbara J. Cobuzzi, MBA, CENTC, CPC-H, CPC-P, CPC-I, CHCC**, president of CRN Healthcare Solutions, a consulting firm in Tinton Falls, N.J. "It is getting more and more difficult to support the 25 with E/M and the minor procedures with this updated verbiage."

What it means: The description change and greater payer attention don't mean you should never report an E/M, modifier 25, and minor procedure on the same claim again. You should, however, take a closer look at the specific clinical scenario and your documentation before doing so, to verify that the E/M encounter can stand on its own.

"I interpret that as the visit is way beyond the small E/M that is associated with a minor procedure," Cobuzzi explains. "This is a significant and separately identifiable E/M because, based on the modifier's terminology, it is way more than the small history, exam, and MDM associated with a minor procedure."

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