Part B Insider (Multispecialty) Coding Alert

Modifiers: E/M Services Call for Modifier 25, But Only When Necessary

You'll be putting your practice in the crosshairs if you misuse this modifier.

Knowing when to append a modifier can be tricky, but many coders will tell you that one of the most misunderstood is modifier 25 (Significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service). If you count yourself in that confused group, use these four criteria to determine whether modifier 25 is right for your next coding assignment.

1. Modifier 25 is for E/M Only

You can only consider reporting modifier 25 when coding an E/M service, says **Janet Palazzo, CPC,** of Regional Otolaryngology in Cherry Hill, N.J. If the procedures you're reporting don't fall under E/M services, it's possible the encounter qualifies for another modifier instead.

How it works: You would use modifier 25 to indicate you have documentation that supports an E/M was significant and separately identifiable from the work included in another service or procedure. By contrast, modifier 59 (Distinct procedural service) can be used only to distinguish one non-E/M procedure from another non-E/M procedure.

2. Extent of Service Makes a Difference

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."

You need to add modifier 25 because minor procedures (0- and 10-day global procedures) include a small E/M within the value of the minor procedure. Therefore, in order to be paid for an E/ M and the minor procedure, you have to tell the payer that the E/M was significant and separately identifiable from the minor procedure

When the patient's complaint can stand alone as a billable service, you might be able to use modifier 25. How can you tell? "Look at the documentation and cross out anything that is directly related to the procedure performed," says **Judith L. Blaszczyk RN, CPC, ACS-PM,** compliance auditor with ACE consulting in Leawood, Kan. "Look then at the remaining documentation to determine if it is indeed significant, separately identifiable and medically necessary," she adds.

Example: For example, a patient comes into a family practitioner with knee pain. The physician does a full work up on the patient and as a result of the complete history, exam and medical decision making, plans to do a steroid injection that day. Since this E/M was the decision for the minor procedure, a 25 modifier would be appropriate on the E/M service. When the patient returns in three months for another steroid injection, however, the small E/M that is done for the scheduled steroid injection is not billable and does not support or justify a 25 modifier unless some other condition is reviewed and creates medical necessity.

Pointer: Though you do not have to have different diagnoses to compliantly report modifier 25 with an E/M code, you should link the different diagnoses to the appropriate CPT codes when applicable. In the above example, you should link 719.06 (knee pain) to the E/M code as the primary diagnosis. Then, link 727.2 (bursitis) as the primary diagnosis code for the knee injection.

3. Global Period Length Offers Clues

Another common point of confusion is between 25 and modifier 57 (Decision for surgery). You should only use modifier 25 with procedures that have a 0- or 10-day global period. These kinds of procedures are what Medicare defines as "minor." In contrast, you'll use modifier 57 for procedures with a 90-day global period.

Do this for 25: Your modifier 25 claims should meet all of the following criteria:

The E/M occurs on the same day as the surgical procedure The procedure following the E/M is minor (has a zero- or 10-day global period) The E/M service is both significant and separately identifiable from any inherent E/M component that the procedure involves

The same physician (or one with the same tax ID) provides the E/M service and the subsequent procedure.

Follow 57 guidelines: Use modifier 57 if the claim meets all of the following criteria:

- The E/M occurs on the same day of or the day before the surgical procedure
- The E/M service directly prompted the surgeon's decision to perform surgery
- The surgical procedure following the E/M has a 90- day global period
- The same surgeon (or another surgeon with the same tax ID) provided the E/M service and the surgical procedure.

Because modifier 57 claims involve an E/M service that results in a decision for surgery, you would generally expect to see the same diagnosis code for both the E/M and the surgical procedure. The surgeon would most likely not make a decision for surgery based on a significant problem unrelated to the procedure.

4. Avoid Scrutiny, Don't Overuse 25

Some coders view modifier 25 as a "magic bullet," says Blaszczyk. 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.