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Part B Insider (Multispecialty) Coding Alert

Modifiers: Master These 3 Modifier 25 Issues to Get Claims Paid

Hint: Modifier 25 may apply to E/M performed with xxx global-day procedures.

Want to collect for both a procedure and an E/M service? Then modifier 25 (Significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service) must be your friend.

However, practices need to know how to use this modifier properly, or the MAC could ask for a refund. You can prevent paybacks by avoiding the following three problems that will land your claims on the MAC's hot list.

Problem 1: No Separate E/M HEM

You not only need to describe the procedure you performed--you also have to document the E/M service.

For example: Documentation shows that a physician provides an echocardiogram for a patient on the same day as an office visit, but offers no information about the separate E/M service (such as 99201-99215, Office or other outpatient visit for the evaluation and management of a new or established patient).

If a patient comes to see the physician due to multiple problems and the physician orders an echocardiogram for one of those problems, the E/M visit should separately identifiable from the ECG. The reason is that the physician addressed one or more problems that required separate medical decision-making.

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.

Here, "HEM" stands for "history, exam and medical decision-making." All procedures include some service related to patient evaluation and management, but a 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.

Problem 2: Modifier 25 With Single-Code Claims

Although the news that all procedures contain a minor related E/M service might surprise you, you probably know that modifier 25 submissions require a minimum of two codes. However, auditors tell the Insider that not all coders are aware of this, and that they occasionally see modifier 25 on claims when an E/M visit was the only service reported.

Without an accompanying initial service or procedure, you can't have a significant, separately identifiable service, experts say. When submitting claims consisting solely of an E/M code, make sure you don't include modifier 25.

Problem 3: Modifier 25 With xxx Procedures

According to CMS, physicians and qualified nonphysician practitioners (NPP) should use modifier 25 "to designate a significant, separately identifiable E/M service provided by the same physician/qualified NPP to the same patient on the same day as another procedure or other service with a global fee period." In other words, you should not use modifier 25 when the procedure that occurred on the same day as a procedure that has no global days.

The CMS definition, which is spelled out in MLN Matters article MM502, is still commonly misunderstood by many

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practices. Because many commonly billed procedures, such as EKGs, don't have a global period, modifier 25 should not be necessary for many claims. However, some payers do require the modifier even in these circumstances, so you should check with your payer to see whether you should include modifier 25.

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