Part B Insider (Multispecialty) Coding Alert

Modifiers: This Payer Now Rejects Most Modifier 25 Claims

Navigate the modifier maze with quick advice.

You've followed the modifier 25 guidance, double- and triple-checked the CCI edits, and triumphantly append modifier 25 to your E/M code, awaiting payment for both a procedure and an E/M service—only to find a denial on your desk a few days later. Unfortunately, this scenario is becoming quite common, with yet another payer jumping on the "no extra modifier 25 pay" bandwagon.

Background: 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) typically allows you to separately bill for an E/M service performed at the same time as another procedure or service, as long as the E/M is significant and separately identifiable, the procedure has a global period, and the same physician performs both services on the same date.

Unfortunately, however, not every payer accepts the modifier at face value. Last week, insurer Tufts Health Plan posted on its website, "Effective for dates of service on or after July 1, 2014, Tufts Health Plan will not compensate for evaluation and management services billed with modifier 25 on the same day as a procedure with a 0-day, 10-day or 90-day post-operative period if the member has been seen by the same provider in the last eight weeks for the same condition. Refer to the AMA's CPT® Coding Manual for a description of appropriate use of modifier 25."

Interpretation: The policy applies to any situation involving a procedure with the stated global periods and an E/M service if the second visit involves the same complaint as a previous visit within the last two months.

Remember edits: Don't forget that Correct Coding Initiative (CCI) edits bundled most minor procedures into established E/M services in 2013, so it's much more difficult to justify billing an E/M and a minor procedure.

Prior to the second quarter of 2013, the only reason to need a 25 was the definition of the minor procedure and the fact that it included a mini E/M service. As of Q2 2013, CCI added a further burden of separateness by bundling the established E/M with the scopes and other minor procedures like 69210 (Removal impacted cerumen requiring instrumentation, unilateral). This does not apply to new patient, ED and xxx global procedure services with E/M codes. They still just have the mini E/M associated with them, but are not bundled with the E/M codes.

Keep in mind that you should use the 25 modifier only when it is correct, when it applies based on both the definition of the minor procedure global definition and the bundling as of second quarter of 2013. Overuse of the 25 modifier is a red flag for audit, so you want to have documentation to back up whenever you report it.

Medicare Still Paying for 25

Although some private payers have adjusted their modifier 25 policies, keep in mind that CMS still allows payment for it, if you meet the criteria. "Different diagnoses are not required for reporting the E/M service on the same date as the procedure or other service with a global fee period," CMS says in MLN Matters article MM5025. "Modifier 25 is added to the E/M code on the claim."

Resource: To read the Tufts Health Plan announcement on modifier 25, visit www.tuftshealthplan.com/providers/provider.php?sec=news&content=modifier_25. To read MLN Matters article MM5025, visit www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/mm5025.pdf.

Codify
BY AAPC