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Part B Insider (Multispecialty) Coding Alert

Part B Coding Coach: 4 Questions to Ask Yourself About Modifier -25

If you want to recoup reimbursement for your modifier -25 claims, make sure that you can separately identify your physician's E/M services from other procedures he or she performed for the same patient on the same day.

Here are four easy questions to ask yourself - with answers from the experts - to help guide you on the road to hassle-free use of modifier -25 (Significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service).

1. Does your E/M service stand alone?

CMS specifies that all procedures have an E/M component. Private payers also assume that there's an inherent E/M visit built into the reimbursement for procedure codes, because most physicians do a certain amount of "visiting" with the patient before any procedure. This is why you need to be careful of overuse. Don't append modifier -25 just because your physician spoke with the patient before doing the procedure.

To get paid for modifier -25, the E/M service needs to be completely separate and identifiable from the procedure. For example, a woman who has had several miscarriages visits a reproductive endocrinologist (RE) for an endometrial biopsy (58100, Endometrial sampling with or without endocervical sampling, without cervical dilation, any method) to assess her uterine lining.

During the visit, the woman voices concern about a lump in her breast, prompting the RE to also perform a problem-focused exam of her breast, with history and medical decision-making. You report 58100, as well as E/M code 99213 (Established patient, office or other outpatient visit) with modifier -25 appended to the E/M, says a coding expert from an endocrinology practice in the Atlanta area.

The separate service or procedure may stem from a problem brought up by the patient or the doctor. Sometimes an easy way to tell that there are two separate services is that one service is unrelated to the reason why the patient was scheduled. For instance, in the example above, the woman was scheduled for an endometrial biopsy but also received a problem-focused exam of her breast that was totally unrelated to the procedure she was scheduled for.

Tip: When asking yourself if a procedure stands alone, separate the E/M notes from the procedure documentation in your medical record. If a reviewer could look at your medical notes and clearly see that the physician completed two separate and independently identifiable services, you can append modifier -25.

2. Do you need to have additional diagnoses?

You may think that in order for an E/M service to be separately identifiable, the service must have a separate diagnosis. Not true. CPT states that an E/M service may be prompted by a symptom or condition that requires a procedure but that the procedure must be separate from any procedure your physician completed for the initial symptoms or conditions. You don't necessarily have to have another diagnosis.

For instance, a postmenopausal woman presents for a review of her hormone replacement therapy. After considering the patient's course of treatment, the physician decides she needs another DEXA scan (76075, Dual energy x-ray absorptiometry, bone density study, one or more sites; axial skeleton) to determine if there's been any improvement in bone density. The diagnosis may be the same, depending on the documentation provided for the encounter. If documentation indicates the same diagnosis, you report E/M code 99213 and procedure code 76075 with the diagnosis code V07.4 (Postmenopausal hormone replacement therapy) for both. Append modifier -25 to 99213.

Important: Modifier -25 is always applied to the E/M code, never to the procedure code.

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You may encounter situations, such as the one described above, in which the same diagnosis will be the reason for both the E/M visit and the procedure, says **Tina Landskroener, CCS-P**, of Total Healthcare Compliance in Las Vegas. However, it's ideal if the procedure code has a different diagnosis than the E/M code. This makes justifying the modifier that much better for carriers, she says. In all cases, if you have an additional diagnosis, you should always report it.

3. Are you confusing modifiers -25 and -57?

Modifier -57 (Decision for surgery) applies to E/M services also, but you should not use this for procedures the physician performs with E/M visits. You should use modifier -57 only if a physician decides that the patient needs a surgical procedure the same day as the E/M service or the next day, and the procedure that will be performed has a global period of 90 days. Modifier -25 is used when the procedure is done on the same day and the global period for the procedure is zero to 10 days.

For example, skin grafting has a global period of 90 days. If a patient is evaluated for a potential skin graft on Monday, and the dermatologist plans the skin graft for the same day or the following day, modifier -57 will be required on the E/M code. Compare this with the excision of a benign lesion (11400-11446), which has a global period of 10 days. If a patient is evaluated on Monday and the procedure is done immediately following on the same date, modifier -25 is used. However, if the patient is evaluated on Monday and brought back the next day, only the procedure is charged on the following day, and no modifier is necessary.

4. Are you using modifier -25 unnecessarily?

Some minor services in your practice will be automatically bundled with the E/M service. For instance, Medicare specifies that if the physician performs an E/M service and a blood draw on the same day, the blood draw will be bundled with the E/M, says **Jamie Darling, CPC**, of Graybill Medical Group in Escondido, Calif. You would not need to report an extra code or modifier in this situation.

In addition, you will be paid when you report some services without appending modifier -25. For example, if a patient has an E/M and a urinalysis lab test (81000-81099) on the same day, both are billable without a modifier, Darling says.

"One easy trick I learned was this: If it can be done in another department, it doesn't need a -25," Darling says. So if, for instance, a patient presents complaining of chest pain (786.50) and the physician sends him for a chest x-ray in another department, you would not need to add modifier -25 to bill the E/M and the x-ray (if you're in a private clinic, you probably won't bill for the x-ray at all).

Reimbursement tip: Every carrier is different, and not all of them follow the coding standards for using modifier -25. "Sometimes it's best to contact those carriers that keep denying you and find out how they want it billed. If a carrier ever tells you anything that is directly against an accepted CPT/ICD-9/HCPCs coding standard, then ask for it in writing," Darling says.

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