Part B Insider (Multispecialty) Coding Alert

Part B Coding Coach: Don't Fear Modifier 25 Audits--Arm Yourself With Top-Notch Documentation

Hint: If E/M services go 'above and beyond' pre-op work, you can report

The **Centers for Medicare & Medicaid Services** (CMS) recently warned that modifier 25 claims may soon receive extra scrutiny. But you can prepare successfully for audits, including ensuring your physicians- documentation is up to par, with the following do's and don-ts.

Do Clear Up Any Modifier Modification Confusion

Thanks to a new transmittal from CMS, you have clear guidelines to follow when you-re considering the 25 modifier (Significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service).
Clarification #1: CMS has added the word -usual,- so the guidelines for modifier 25 now read: -a significant, separately identifiable E/M service that is above and beyond the usual pre- and post-operative work for the service.-

The addition is meant to emphasize that any extra E/M service must be -above and beyond- the typical pre-op or post-op work, says **Quinten Buechner** with **ProActive Consultants** in Cumberland, WI.

Clarification #2: Transmittal 954, issued May 19 by CMS, specifically indicates that you don't need a different diagnosis for the E/M service and surgery to be able to use modifier 25. Remember, however, that many private carriers demand separate diagnoses before paying for the E/M service as well as the procedure--even though this contradicts CPT guidelines.

Clarification #3: As before, you-ll now also need to make sure that you have appropriate documentation that proves the medical necessity of the separate same-day E/M service your physician provided. You don't need to submit this documentation with the claim, but it must be available upon request.

Don't Be An Error-Rate Statistic

The guidelines for using modifier 25 haven't actually changed, says **Stacie L. Buck, RHIA, CCS-P, LHRM**, vice president of Southeast Radiology Management in Stuart, Fla. -CMS is issuing clarification in light of the findings in the OIG's report on modifier 25.- The Office of Inspector General (OIG) found a 35-percent error rate for modifier 25--and $538 million in improper payments--in its sample of claims from 2003.

But it's safe to say your modifier claims will be under more scrutiny. -I strongly believe providers will see more and more claims with 25 subjected to pre and post payment review because of the OIG findings,- Buck adds.

Do Be Proactive: Stress -Significance- in Documentation

Rule of Thumb: All procedures, from simple injections to common diagnostic tests, include an -inherent- E/M component, according to CMS guidelines. Therefore, any E/M service you report separately must go -above and beyond- the minimal evaluation and management that normally accompanies such a procedure.

If there isn't an identifiable medical question that's being asked and answered--such as, -Is this procedure still the correct treatment?---then the physician likely hasn't provided a separately identifiable E/M service.

When you are considering whether you should append modifier 25 to an E/M service code when your physician performs an E/M service and another procedure or service, follow these three tips:

1. Make sure your claim in-cludes E/M services that are significant and separately identifiable. The E/M should be above and beyond the usual preoperative and postoperative care associated with the procedure.

2. Focus on compiling complete documentation of both the procedure and the separate E/M.

3. Don't append modifier 25 if an E/M is the only service your physician provides the patient that day.

Best practice: Ask your physician to document the E/M and the procedure in separate paragraphs or even on separate pages in the medical report so you can easily identify their separate nature. -Physicians and coders need to make sure that the documentation clearly supports both services and that all guidelines are followed,- Buck advises.

Do Double-Check Whether Doc Planned Ahead

When making your modifier decision, follow this train of thought:

1. If your physician performs a separate identifiable service or procedure along with an E/M service, report both services and append modifier 25 to the E/M code.

2. If the physician plans beforehand, at a previous patient encounter, to do a procedure on another day or encounter and on that day does a limited pre-op evaluation, just prior to surgery, then don't bill for a separate E/M.

3. But if your physician doesn't know if an operation will be necessary and must rule out other options before surgery, then you can bill for the E/M examination performed be-fore the doctor reached the decision to proceed with surgery on that same day.

Example: A patient with an implanted cranial neurostimulator returns to the office for regular follow-up, indicating a notable loss of benefit with increased tremor. The neurosurgeon determines that the neurostimulator leads are not working, and removes the pulse generator the same day. Report the generator removal with code 61888 (Revision or removal of cranial neurostimulator pulse generator or receiver), and report the appropriate level established patient office visit code with modifier 25 appended.

Don't Fall For 99211 Trap

The exception is 99211 (Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician), which you cannot ever report with any of the injection codes because the work RVUs are already included and factored in to the injection code. So, if you have an E/M service, higher than a level one, that you can show is separate from the injection service, you may use modifier 25 and report both services.