Part B Insider (Multispecialty) Coding Alert

Part B Coding Coach: Hone Your Modifier 25 Policy With These Guidelines

Private payors may drop the modifier requirement for medicine/service claims

You finally have a fail-safe policy to stop the nagging doubt over whether you should append modifier 25 to the E/M service on a claim that also involves a medicine code.

CPT: Many Medicine + E/M Claims Don't Require 25

When you perform an office visit that is separate and distinct from a medicine service (meaning a procedure listed in the Medicine section of CPT), -the E/M code does not typically require modifier 25 (Significant, separately identifiable E/M service by the same physician on the same day of the procedure or other service),- says **Richard H. Tuck, MD**, a nationally recognized coding speaker. -You will not find any language to that effect in CPT or CPT Assistant.-

But your office may be in the habit of automatically entering 25 on all claims for same-day office visits with associated medicine services. Physicians have been increasingly using modifier 25 because payors have recognized the modifier and paid claims coded in that manner, Tuck says. -Thus, the modifier has become used more frequently than rules necessarily dictate.-

Tuck says the following medicine services are among those that CPT does not require to have modifier 25 on the E/M service code (such as 99201-99215, Office or other outpatient visit for the E/M of a patient -):

- evaluation of patient's use of an inhaler (94664, Demonstration and/or evaluation of patient utilization of an aerosol generator, nebulizer, metered dose inhaler or IPPB device)

- airway inhalation treatment (94640, Pressurized or nonpressurized inhalation treatment for acute airway obstruction or for sputum induction for diagnostic purposes [e.g., with an aerosol generator, nebulizer, metered dose inhaler or intermittent positive pressure breathing (IPPB) device]).

CMS Echoes CPT Policy

Recently, the **Centers for Medicare & Medicaid Services** (CMS) backed this less-use policy via a much-needed clarification.

New guidance: You should only use modifier 25 when the physician provides a significant and separately identifiable E/M service on the same day as a procedure with a global period (as of Aug. 20), says **Jim Collins, CPC, CHCC**, president of **Compliant MD Inc**. in Matthews, N.C.

CMS Transmittal 954 states modifier 25 -shall be used when the E/M service is above and beyond the usual preand postoperative work of a procedure with a global fee period performed on the same day as the E/M service.-

Otherwise, -E/M services provided on the date of the procedure are inclusive unless a separately identifiable E/M service is provided on the same day,- says **Kathy Pride**, **CPC, CCS-P,** director of consulting and training for **QuadraMed** in Reston, Va.

You can identify codes that have no global period by looking at column -O- of the 2006 National Physician Fee Schedule Relative Value File. If the column designates the code with an -XXX,- which means -The global concept does not apply to

the code,- CMS does not require you to use modifier 25 on an associated E/M service code.

Most codes listed in the medicine section of CPT contain no global period. So according to CMS, you would not need modifier 25 on the E/M service code for all the above-noted medicine codes. Other commonly used pulmonology codes containing -XXX- global days in the medicine section are (* indicates the National Correct Coding Initiative bundles the code into an E/M service; modifier required):

- vaccines, toxoids (90476-90749)
- immunization administration (90465-90474)
- pulmonary function tests (94010-94453, 94680-94750, 94770-94772)
- pulmonary stress tests (94620-94621)
- aerosol inhalation treatment (94642)
- ventilator management (94656-94657)*
- positive airway pressure, CPAP (94660)*
- negative pressure ventilation, CNP (94662)*
- chest-wall manipulation (94667-94668).

Don't forget: Code 94762 (Noninvasive ear or pulse oximetry for oxygen saturation; by continuous overnight monitoring [separate procedure]) can be billed on the same day as an E/M service (99211-99215, Office or other outpatient visit for the evaluation and management of an established patient ...), but 94760 (Noninvasive ear or pulse oximetry for oxygen saturation; single determination) and 94761 (... multiple determinations) cannot be billed on the same day as an E/M service, regardless of modifier use.

Exception: CPT states certain medicine codes do require modifier 25 on the E/M service code. These include injectables (90760-90779). -If a significant, separately identifiable Evaluation and Management service is performed, the appropriate E/M service code should be reported using modifier 25 in addition to 90760-90779,- according to CPT's introductory notes to the hydration, therapeutic, prophylactic and diagnostic injections and infusions subsection.

Expert Recommends Prudence

You-ll have to wait and see whether the CMS guidance on medicine codes other than injectables trickles down to private payors. If a payor doesn't require modifier 25 on these claims, -you-re really making extra work for yourself by including it,- Tuck says.

The modifier 25 clarification may help slightly, says **Chip Hart** with the Winooski, Va.-based **Physician's Computer Company**. -Offices will have a CMS rule to point to.-
But if insurers play by their own rules and require modifier 25 on service claims involving a medicine service, it might not be worth a fight. -If claim submission doesn't work without modifier 25, re-submit the claim using the modifier before picking up the phone, says **Charles A. Scott, MD.**

For more: You can find the CMS clarification online at www.cms.hhs.gov/Transmittals/downloads/R954CP.pdf.