Part B Insider (Multispecialty) Coding Alert

Part B Coding Coach: Test Yourself-When Does Modifier 25 Apply?

Stay off the OIG's hit list while collecting well-deserved reimbursement

If you don't know the how-to's of coding with modifier 25, you could be facing something much more costly than denied claims. The **Office of Inspector General** (OIG) has taken a special interest in the use of this common modifier, but careful attention in appending could prevent an unwanted visit from your auditor.

How savvy are you when it comes to modifier 25 (Significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service)? Test your knowledge with the following scenarios:

Meet Basic Requirements First

Scenario #1: An orthopedist examines an established patient suffering from pain in her left knee. The orthopedist does a full evaluation of the patient, with a history, exam and medical decision-making, and then decides to take an X-ray. She determines that the patient suffers from bursitis. Based on her workup, the orthopedist decides to give the patient a steroid injection.

Answer: List 9923x-25 in addition to 20610 (Arthrocentesis, injection, and/or injection; major joint or bursa [e.g., shoulder, hip, knee joint, subacromial bursa]).

Explanation: The first step in determining if you meet the basic requirements of modifier 25 is to establish that the service is significant and separately identifiable from the same-day procedure, notes **Alice G. Beaton, CPC**, of Footcare of Hampton Roads in Suffolk, VA.

To evaluate whether this is the case, use the "HEM" test, advises **Laureen Jandroep, OTR, CPC, CCS-P, CPC-H, CCS**, director and senior instructor for **CRN Institute,** an online coding certification training center based in Absecon, NJ. The E/M must include a history, exam and medical decision-making.

Based on the workup, the physician made the decision to administer the steroid injection - so this was not a scheduled minor procedure, explains **Barbara J. Cobuzzi, CPC, CPC-H, CHBME,** president of **CRN Healthcare Solutions** in Shrewsbury, NJ. Therefore you may bill the E/M with modifier 25. In this case, modifier 25 indicates to the carrier that the E/M led to the decision for the minor procedure.

Important: Check to be sure the physician performed a minor procedure, one with a 0-10 day global period (such as the injection), before separately reporting a distinct E/M with modifier 25.

Practices must recognize that all minor procedures have built into them a small degree of HEM, notes Cobuzzi. Modifier 25 indicates for the payer that the E/M goes beyond the included history and physical to a much more significant level.

Once you have concluded that a full and distinct E/M has taken place, assign a level of service. Reminder: The highest level of service that you can use for an E/M is the one for which at least two of the three "HEM" elements qualify.

Smart idea: If you've taken all these steps and you're still staring at a denial, documentation can be your best friend. Separate notes for the procedure and the E/M, while not required, can ensure that your "case is proven" in an appeal, according to Jandroep. She suggests that getting into the habit of even using a simple line to separate the procedure from the E/M can save a lot of billing headaches.

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Another Option: Cobuzzi advises practices to develop separate, simple forms for their most commonly performed procedures. That way, the physician's procedure note is always separate from that for the E/M, and appealing any denials is a breeze.

Recognize The 'Oh, By The Way' Factor

Scenario #2: An established patient who has been diagnosed with cellulitis and abscess of the foot arrives at a podiatry office for a prescheduled incision and drainage of a soft tissue abscess on the heel of his left foot. After the procedure, the patient indicates that he has also been experiencing pain in the right heel, especially upon rising in the morning. The podiatrist performs a problem-focused history, problem-focused exam and straightforward medical decision-making to determine that the patient is presenting with plantar fasciitis in the right foot. How would you code the E/M, procedure and diagnoses for this visit?

Answer: You should code the procedure first with 20000 (Incision of soft tissue abscess [e.g., secondary to osteomyelitis]; superficial) followed by the E/M code 99212-25. Code two separate diagnoses, linking 682.7 (Cellulitis and abscess of foot, except toes) to the procedure and 728.7 (Plantar fascial fibromatosis) to the E/M.

The "Oh, by the way" scenario, as Cobuzzi describes it, occurs when a patient is attending one pre-scheduled procedure, but presents with another complaint in a different body part that is unrelated to the current procedure.

Reality check: In this case, separate diagnoses for the procedure and E/M are appropriate. Both CPT and Medicare state that you do not need to have separate diagnoses to append modifier 25, although coding experts acknowledge that it certainly helps. If you code for the same diagnosis, just don't be surprised to see your claim come back initially. When you have separate documentation, you can appeal with confidence.

Know Your Globals

Scenario #3: A surgeon receives a request to evaluate a patient for acute right-upper quadrant pain and tenderness. Following a full evaluation, the surgeon decides to remove the gallbladder and schedules an immediate laparoscopic cholecystectomy.

Answer: Code both 47562 (Laparoscopy, surgical; cholecystectomy) and the examination that led to the decision to perform the surgery (i.e., 99243, Office consultation for a new or established patient...). In this case, however, modifier 57 would be required instead of modifier 25 because the follow-up surgery has a 90-day global period (it is a major procedure).

Modifier 25 is only appropriate for minor procedures. Think of modifier "25 as decision for minor surgery and 57 as decision for major surgery, Jandroep suggests.

You may have to make exceptions depending on your payer, according to Cobuzzi. Some payers may want to see modifier 57 to indicate decision for surgery, even for minor procedures (where modifier 25 should apply). If this is the case, "the best thing to do is get the policy in writing from the payer if you can," she recommends.

Always: Whether using modifier 25 or modifier 57, make sure to append the modifier to the E/M code and not the procedure code.
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Be careful: CPT includes "one related E/M encounter on the date immediately prior to or on the date of the procedure (including history and physical [H&P])," so to make the case for appending modifier 57, you must meet the following conditions:

1. The E/M service must have directly led to the podiatrist's decision to perform surgery.

2. The E/M service must occur on the same day of, or the day before, the surgical procedure.

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3. The surgery could not have been scheduled prior to the day of the E/M.

Tip: If you are not sure
whether your claim qualifies for modifier 25 or modifier 57, reference the Medicare Physician Fee Schedule database, which provides information on global periods, along with RVUs and other helpful coding information. Visit www.cms.hhs.gov/physicians/pfs, and click on the download for "2005 National Physician Fee Schedule Relative Value File."

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