Eli's Rehab Report

Take 3 Steps to Fewer Modifier -25 Denials

If you can prove that you've met specific documentation requirements, you can report both a procedure and an E/M service on the same day. Follow these three simple steps from the experts to determine whether your modifier -25 claims are airtight.

1. Prove Whether Service Is Separately Identifiable. CMS policy dictates that all procedures, from simple injections to common diagnostic tests, include an inherent E/M component. Therefore, CMS will not pay you for an additional E/M service unless it is significant and separately identifiable it must go above and beyond the E/M service you would normally provide as a part of the procedure.

To demonstrate that your service is separately reportable, you must append modifier -25 (Significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service), which allows separate payment for an E/M service that you perform on the same day as a procedure or other service.

Some practices define "significant" to mean that the E/M visit must be at least a level-four or -five code (such as 99204 or 99215), but the September 1998 CPT Assistant states, "To use modifier -25 correctly, the chosen level of E/M service needs to be supported by adequate documentation for the appropriate level of service Modifier -25 is not restricted to any particular level of E/M service."

So, you should append modifier -25 to your E/M code if the physician believes that he or she performed an E/M service completely independent of the procedure.

No HEM, No E/M

"I always say, if you don't have an HEM (history, exam, and medical decision-making), you don't have an E/M," says **Laureen Jandroep, OTR, CPC, CCS-P CPC-H, CCS**, director and senior instructor for the CRN Institute, an online coding certification training center. "There should be clear documentation of the HEM, in addition to any notes about procedures performed."

To demonstrate that your E/M service qualifies as an independent evaluation, physically separate the E/M notes from the procedure documentation in the medical record, says **Susan Callaway, CPC, CCS-P**, an independent coding specialist and educator in North Augusta, S.C.

The physician should document the HEM in the patient's chart and record the procedure notes on a different sheet attached to the chart. Using this documentation method, a reviewer can clearly identify the two services, each of which is individually supported by
your documentation.

2. Modifier -25 Claims Do Not Require a Separate Diagnosis. The requirement that an E/M service must be "separately identifiable" is CMS' attempt to differentiate E/M services included as part of a larger procedure from those that go beyond the usual pre- or postprocedure evaluation and care.

Payers and providers sometimes interpret this to mean that a second, distinct diagnosis is required to bill a separate E/M service, but this is incorrect, Callaway says.

Likewise, there is no requirement that the E/M service must be unrelated to the other service or procedure provided. CPT

specifically states, "The E/M service may be prompted by the symptom or condition for which the procedure and/or service was provided. As such, different diagnoses are not required for reporting of the E/M services on the same date." In all cases, though, if a second (related or unrelated) diagnosis is available, you should report it.

Example A: A patient arrives for prescheduled electromyographic (EMG) testing of upper-extremity weakness and pain. During the visit, the patient states that the pain is worsening, making it increasingly difficult to perform daily activities. Concerned by these developments, the physician takes an updated history, writes a prescription for pain management and counsels the patient on possible diagnoses and treatment management options.

The documentation supports a level-three (99213) E/M service (with modifier -25 appended) in addition to the EMG (95861, Needle electromyography; two extremities with or without related paraspinal areas).

Because the E/M service resulted from the same complaint that prompted the EMG, however, you would link the same diagnosis (such as 729.5, Pain in limb) to both codes. Without modifier -25, the payer would most likely bundle your E/M service into the EMG procedure.

Example B: Suppose a primary-care physician refers a patient to the PM&R practice for increasing lower-extremity weakness. During the visit, the physiatrist learns that the patient's weakness occurred first on the left side and then progressed to the right during the previous week. The physiatrist further discovers that recently the patient has developed some urinary stream slowness, but with sensation intact. The patient also exhibits decreased strength in both legs and has a slightly "wide-based" gait, but without significant loss of balance.

Based on the physiatrist's E/M service, she has concerns about central nervous system diseases and determines that additional evaluation (including diagnostic testing) is required.

In this case, the physiatrist's E/M service is essential in determining the most effective diagnostic tests, and an E/M code is clearly appropriate in addition to any diagnostic tests the physiatrist might perform. The diagnoses may be different for the E/M and the testing, but the signs and symptoms diagnoses used for each may be similar.

3. Avoid Confusion With Modifier -57. Like modifier -25, modifier -57 (Decision for surgery) appends to E/M services but is rarely used by physiatrists. Modifier -57 is appropriate only if, during the patient evaluation, the physician determines that a major surgical procedure, that is, a procedure with a 90-day global period, is necessary.

A surgeon will typically make this determination. Modifier -57 indicates to the payer that the E/M service should not be included in the global package.