

Outpatient Facility Coding Alert

Modifier Update: Remember These 5 Pointers Before Appending Modifier 25

Tip: It doesn't automatically apply to all E/M services.

Billing for both a procedure and E/M service can add dollars to your bottom line but can also increase your risk for audit. The OIG (Office of Inspector General) will expect to see modifier 25 on these claims, so it's important to report things correctly from both a revenue and compliance standpoint.

Refresher: Your working definition according to Medicare's Modifier 25 Fact Sheet is Significant, separately identifiable evaluation and management (E/M) service by the same physician on the day of a procedure.

And, although modifier 25 is most often viewed as an office modifier, it can also apply in certain outpatient situations.

Follow these five steps when you consider appending modifier 25:

1. Verify that the service was distinctly different. You have two possibilities for this step: either the provider sees a new patient or the provider sees an established patient with a new indication or a change in clinical condition. As always, you should also report the proper ICD-10 diagnosis explaining the condition □ which can help support your use of modifier 25.

2. Attest the date of service. When you submit modifier 25, the E/M service the modifier applies to should generally be on the same day as the other procedure or E/M service. In the hospital outpatient setting, however, the encounter may cross the midnight threshold, according to **Sarah L. Goodman, MBA, CHCAF, COC, CCP, FCS**, President, CEO, and principal consultant for SLG, Inc, in Raleigh, N.C.

3. Ascertain that the service was significant. The service your provider renders in addition to the E/M care should be medically necessary. The patient should have come to your clinic for a different reason or should have a documented, medically necessary reason for a separate visit.

4. Ensure that the service was not during the global period of an earlier procedure. If the visit and E/M service fall during a global period, you won't report modifier 25. Instead, you can append modifier 24 (Unrelated evaluation and management service by the same physician or other qualified health care professional during a postoperative period) for an unrelated service during the postoperative global period. Note that global periods do not apply to facility billing.

5. Document correctly to avoid the risk of audits. On several occasions, OIG Work Plans have identified the use of modifier 25 as an area of concern so has implemented a focused review program to keep a check on the modifier's usage. If you are contacted about a review, you're required to provide the OIG with the claims and substantiating documents that support your choice of modifier 25.

Scenario: An established patient with chronic sinusitis visited an ENT clinic. During the visit, the patient said that he had a hearing problem in his left ear. Upon examination, the physician found a substantial amount of impacted cerumen. He removed the cerumen and coded the service as 99213-25. Because this procedure was not preplanned, the physician can bill for the cerumen removal even though it is related to the E/M. Include diagnosis J32.9 (Chronic sinusitis, unspecified) on the claim.

