

Modifier Coding Alert

Modifier Madness: Capture Deserved Separate E/M Payment with Modifier 25

Identify second service as above and beyond to use 25 to generate deserved revenue.

Payers are cracking down more and more on modifier 25 claims, and if your coding isn't solid, the claim won't stand up, even in an appeal. If you don't know the rules for when you can legitimately attach modifier 25 to seek separate E/M payment, you could be costing your practice lots of money.

Read on to learn to recognize when modifier 25 is appropriate and ensure you bring in every dollar your physicians deserve.

Bring Modifier 25 to the Table

Anytime your physician provides more than one service at a single encounter, you must consider whether you need a modifier. According to CPT®, when your provider sees a patient and treats more than one complaint, you may need to use modifier 25 (Significant, separately identifiable evaluation and management service by the same physician or other qualified health care professional on the same day of the procedure or other service) to report that "the patient's condition required a significant, separately identifiable E/M service above and beyond the other service provided or beyond the usual pre- and post-operative care associated with the procedure that was performed."

You just need to learn how to determine what "above and beyond" entails. Review the notes to learn if:

- your physician performed a problem-oriented E/M service on the complaint
- you can code the complaint separately
- there's a separate diagnosis for the complaint
- the diagnosis is the same, but your doctor performed extra work beyond the pre- and post-operative work related to the procedure code.

If the documentation meets these criteria, you can report the appropriate E/M code with modifier 25 attached along with the preventive medicine code or the minor surgical procedure code that represents the separately identifiable ☐ and payable ☐ service your provider performed.

"In order to bill an additional E/M with modifier 25, the coder must answer the question 'Did my provider perform a service above and beyond and in essence unrelated?,'" says **Linda Eickmann Duckworth, CHC, CPC**, managing consultant and compliance officer at Medical Revenue Solutions, LLC in Oak Grove, Mo. "If the answer is yes, then code the E/M with modifier 25." If the 'over and above' is related to the same diagnosis, it's important to have, within the body of the note, clear illustration that the visit was needed in order for the other service to take place (i.e. a full body analysis and in-depth history before a biopsy is taken on the same day.)

Examples: "Common examples would include a full preventive service or an office visit that addresses issues separate from the immunizations such as an injury, diabetes follow up, or dermatitis," added Duckworth.

Know When 25 Won't Apply

You might frequently use modifier 25 but there are conditions when its use isn't appropriate. One condition is if the only service being performed in your physician's office for a patient is an E/M, there's no call for a modifier.

Another thing to watch for is whether modifier 25 is necessary with the E/M service, warns **Becky Boone, CPC, CUC**,

certified reimbursement assistant for the University of Missouri Department of Surgery in Columbia. Some office procedures do not, and should not, require you to attach modifier 25 to the E/M and incorrectly attaching modifier 25 could cause problems with the claims.

Example: Some urodynamic codes have global code 'XXX' meaning the global concept doesn't apply to the code. In other words, these services and procedures include only the service or procedure itself, and any (minor) built-in E/M service. Some urodynamic codes have '0' global because the procedure is minor with no pre- or post-operative periods. "XXX doesn't require modifier 25 for the E/M code," explains Boone.

Alternative: Modifier 59 (Distinct procedural service) may be the better choice if there's no other more appropriate modifier that better explains the situation. You wouldn't use 25 if you need to distinguish one service or procedure from another non-E/M related service or procedure performed on the same date.

Tip: Simple office labs provided during an E/M encounter don't typically call for modifier 25 because they aren't thought of as having an E/M component to them that needs to be reported separately. There are times, however, that your payer may dictate whether the 25 modifier is required. For example, when your physician provides an injection administration is to the patient on the same day as an E/M, some Medicaid contractors will require modifier 25 on the office labs.

Peruse CPT® Guidelines for Help

If you're in doubt about when to attach modifier 25 to an E/M procedure or service, look at the CPT® guidelines that precede the non-E/M codes for instruction on including E/M services.

Example: In front of the vaccine administration codes, CPT® states, "If a significantly separately identifiable E/M service (e.g., office or other outpatient services, preventive medicine services) is performed, the appropriate E/M service code should be reported in addition to the vaccine and toxoid administration codes."