Pain Management Coding Alert

Modifier Coding: Ensure You Follow This 'Do' and 'Don't' to Reach Modifier 25 Success

The key: Know that 'separate' designation is justified.

You might routinely turn to 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 better explain your physician's services, but don't use it every time you see multiple services during an office visit. Double check two important things before submitting claims or you could risk denials or other problems.

Remember: Modifier 25 can only be reported when the physician performs an E/M service in addition to a separate procedure or service during the same encounter. When you're able to report both services, append modifier 25 to the pertinent E/M code.

Don't Automatically Include Modifier 25

Seeing that the physician performed a procedure and E/M service during the same encounter doesn't mean modifier 25 always applies.

"The -25 modifier doesn't need to be appended to every E/M service just because something else was done during the visit," says **Suzan (Berman) Hauptman MPM, CPC, CEMC, CEDC**, manager of physician compliance auditing for West Penn Allegheny Health System in Pittsburgh, Pa.

Tip: Modifier 25 is used primarily for minor surgical procedures - those with 0- or 10-day global periods. It's not appropriate to report modifier 25 with major surgical procedures that have 90-day global periods. Medicare also allows modifier 25 reporting for procedures with an "XXX" global period.

"I think practices trip over this because they're afraid the other service will interfere with the payment of the E/M service," Hauptman says.

Caution: Don't rely on only the fee slip communication when appending modifier 25. "Make certain that there's documentation in the medical record to support the procedure as well as the separate E/M service," Hauptman advises.

Plus: You can connect the same diagnosis with both the procedure and the E/M service as long as the documentation supports medical necessity for both and that the E/M service meets the required criteria of "separately identifiable" and "significant."

For example, the physician administers a therapeutic lumbar epidural injection (62311) as treatment of the patient's chronic pain (338.2x). The physician also performs chronic opioid medication management during the same visit. You can report both services with the same diagnosis code. If the physician completes separately identifiable/significant work in the chronic medication management (beyond that associated with the procedure), you can bill for both the injection procedure and the E/M service with modifier 25 appended.

Do Confirm Medical Necessity

"I find that the biggest problem with modifier 25 is inappropriate use, meaning it's used with an E/M code when there wasn't sufficient medical necessity to perform an E/M to perform the minor procedure," says **Catherine Brink, BS, CMM, CPC, CMSCS**, president of Healthcare Resource Management, Inc., in Spring Lake, N.J. "In other words, there's insufficient documentation to support the E/M code."

For example, physicians often complete a limited personal historical inquiry about the reason for a patient's examination, acquisition of informed consent, and other factors prior to performing radiographic procedures. Chapter 9 of Medicare's NCCI Manual confirms that "if the medical decision making that evolves from the procurement of the information from the patient is limited to whether or not the procedure should be performed, whether comorbidity may impact the procedure, or involves discussion and education with the patient, an evaluation/management code is not reported separately." If you only have documentation of the determination that the patient has indications for the procedure but no contraindications or other details, it would not be compliant to bill an E/M service with modifier 25.

Second snag: "Another side to this is not appropriately using the -25 modifier when an E/M is performed, and then a minor procedure is the result of the medical decision making," Brink adds.

Include 25: A patient is referred to pain management for facet joint injections. The physician schedules the patient for the facet injections following an evaluation. The documentation for the "evaluation" includes primarily only the pre-procedure work associated with confirmation of the appropriate procedure, ensuring there aren't any contraindications present, obtaining consent, etc. Because the documentation is confirming the decision to perform the procedure, appending modifier 25 is appropriate.

Skip 25: The May 2012 issue of CPT® Assistant includes this example of when not to report the E/M service with modifier 25: "A patient complained of left knee pain. At a previous visit, the physician evaluated the knee, ordered a prescription of a nonsteroidal anti-inflammatory drug and scheduled a follow-up visit in two weeks later for performance of an arthrocentesis if not improved. The patient returned, wherein the physician performed an arthrocentesis and injection of the left knee joint and scheduled a follow-up visit for one month later." It would not be appropriate to report the E/M service at the two-week follow-up visit because the focus of the visit was related to the performance of an arthrocentesis. Only code 20610 for the arthrocentesis would be reported."