Denials Involving Modifier "-25" Revisited

Here's some advice on the appropriate use of this modifier.

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Welcome to Codingline Particulars, a regular feature in Podiatry Management focusing on foot and ankle coding, billing, and practice management issues.

In the past several years, I have discussed the move by some payers to disregard modifier "-25" regardless of its appropriate use. In the past year, there appears to be a dramatic increase on the part of many payers to avoid reimbursing valid evaluation and management services when minor procedures are performed on the same day. While there always have been providers inappropriately billing E/M services, the way to safeguard the process is to request medical records and review whether the "-25" modifier has been appropriately applied. To refresh your memory, CPT describes the modifier as: "Significant, Separately Identifiable Evaluation and Management Service by the Same Physician on the Same Day of the Procedure or Other Service: It may be necessary to indicate that on the day a procedure or service identified by a CPT code was performed, the patient's condition required a significant, separately identifiable E/M service above and beyond the other service provided or beyond the usual preoperative and postoperative care associated with the procedure that was performed. A significant, separately identifiable E/M service is defined or substantiated by documentation that satisfies the relevant criteria for the respective E/M service to be reported (see Evaluation and Management Services Guidelines for instructions on determining level of E/M service). 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. This circumstance may be reported by adding modifier 25 to the appropriate level of E/M service. Note: This modifier is not used to report an E/M service that resulted in a decision to perform surgery. See modifier -57. For significant, separately identifiable non-E/M services, see modifier -59."

There have been few modifications to the above description since its introduction in 2000. A CPT Assistant (May 2000) clarification noted, "The physician may need to indicate that on the day a procedure or service identified by a CPT code was performed, the patient's condition required a significant, separately identifiable E/M service above and beyond the other service provided or beyond the usual preoperative and postoperative care associated with the procedure that was performed. This circumstance may be reported by adding the -25 modifier to the appropriate level of E/M service, or the separate five-digit modifier 09925 may be used." Like the above current "-25" modifier description, CPT Assistant included, "Note: This modifier is not used to report an E/M service that resulted in a decision to perform surgery. See modifier '-57.'"

How does one define and quantify "significant, separately identifiable E/M service above and beyond the other service provided"? While the relevant criteria for the respective E/M service level is evident in the official instructions/guidelines on evaluation and management use, determining medical necessity is a little harder. Medical necessity for an E/M service is based on relevant new history or examination and/or medical decision-making. In the case of a new patient, presuming the doctor has documented something, everything in the encounter from the gathering of patient demographics to the "building" of the clinical record based on the patient work-up is new,

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relevant, and significant. In the case of an established patient, the medical necessity of an evaluation and management service claim and the level of E/M is a factor of interval changes to the history, examination, or medical decision-making from the previous encounter(s). The only way a payer can determine whether or not an E/M service and its level is appropriate is to request medical records and review them. Denials for lack of medical necessity by a payer without an actual records review should be appealed if you feel your records do support that E/M service. You should force the payer to explain their denial.

It is important to note that the description of the "-25" modifier is part of a standard transaction set (HIPAA). Its application, however, may vary from payer to payer. For example, despite the wave of "-25" modified E/M service denials, Medicare does recognize the modifier. For example, WPS (Wisconsin Physicians Service GHA) publishes a "Modifier 25 Fact Sheet" that notes (excerpts; bold emphasis by author):

Definition: Significant, separately identifiable evaluation and management (E/M) service by the *same physician** on the day of a procedure.

**Same physician*—physicians in the same group practice who are in the same specialty must bill and be paid as though they were a single physician.

All E/M services provided on the same day as a procedure are part of the procedure and Medicare only makes separate payment if an exception applies.

Appropriate Usage

• Modifier -25 indicates that on the day of a procedure, the patient's condition required a significant, separately identifiable E/M service, above and beyond the usual pre- and post-operative care associated with the procedure or service performed.

• Use Modifier -25 with the appropriate level of E/M service.

• The procedure performed has a global period listed on the Medicare Fee Schedule Relative Value File. This global period could be 000, 010, or 090 days.

• An E/M service may occur on the same day as a procedure and within the post-operative period of a previous procedure. Medicare allows payment when the documentation supports the -25 modifier and the -24 modifier (unrelated E/M during a post-operative period.)

• Use Modifier -25 in the rare circumstance of an E/M service the day before a major surgery that is not the decision for surgery and represents a significant, separately identifiable service.

Denials for lack of medical necessity by a payer without an actual records review should be appealed if you feel your records do support that E/M service.

Inappropriate Usage

• Documentation shows the amount of work performed is consistent with that normally performed with the procedure.

Situations occur when it is necessary to report multiple surgery modifiers on the same claim line. The following is an example of appropriate reporting of both modifiers 24 (Unrelated E/M by the same physician during a postoperative period), and 25 (Significant, separately identifiable E/M by the same physician on the same day of the procedure or other service), on the same E/M code.

A physician performs a major surgery and within the global period sees the patient for an unrelated E/M visit. During this unrelated E/M visit, the physician determines the necessity of a minor surgery or other procedure. This minor surgery/other procedure is significant and separately identifiable from the E/M and unrelated to the original major surgery. Both the -24 and -25 modifiers are appropriate to add to the E/M code. The -24 modifier is appropriate because the E/M service is unrelated and during the post-operative period of the major surgery. The -25 modifier is necessary to identify that the minor surgery/procedure performed on the same day is separately identifiable from the E/M service. In addition, the minor surgery procedure code may need a -79 modifier to indicate the procedure is not related to the major surgery.

National Government Services (NGS posts on its website a policy education (which they had not updated since implementation of ICD-10) on modifier "-25" (excerpts; bold emphasis by author):

• Use of modifier 25 indicates a "significant, separately identifiable E&M service by the same physician on the same day of the procedure or other therapeutic service." Both services must be significant, separate and distinct. In general, Medicare considers E&M services provided on the day of a procedure to be part of the work of the procedure, and as such, does not make separate payment. The exception to that rule is when the E&M documentation supports that there has been a significant amount of additional work above and beyond what the physician would normally provide, and when the visit can stand alone as a medically necessary billable service.

• Through the process of medical review, we have found providers frequently fail to produce documentation that is sufficient or convincing enough to support billing for both services. When billing an E&M service along with a procedure, your documentation must clearly demonstrate that:

– The purpose of the evaluation and management service was to evaluate a specific complaint;

– The complaint or problem addressed can stand alone as a billable service;

– You performed extra work that

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went above and beyond the typical work associated with the procedure code;

– The key components of the appropriately selected E&M service were actually performed and address the presenting complaint;

– The purpose of the visit was other than evaluating and/or obtaining information needed to perform the procedure/service; and

– Both the medically necessary E&M service and the procedure are appropriately and sufficiently documented by the physician in the patient's medical record to support the claim for these services.

Following are examples that illustrate the appropriate use of modifier -25:

• A patient is scheduled by the podiatrist to take care of a fibrous hamartoma. During the visit, the patient indicates that he has had numbness and oozing from a lesion on his heel. The podiatrist evaluates the lesion, determines that it is a diabetic ulcer, and treats it appropriately. In this case, the heel lesion is considered a separate and significant service. *[**Author's Note:** This example does not give the location of the fibrous hamartoma; does not state that "numbness and oozing from a lesion" is related, new, or an established finding; thus, this is a poor example]*

• A patient sees a dermatologist for a lesion on his leg. During the exam, the patient mentions a rash on his arm. The symptoms have been worsening so that the patient has been unable to sleep at night due to the itching. The lesion on the leg is removed and the provider writes a prescription for the rash. In this case the rash is considered to be a separate and significant service. *[**Author's Note:** This is an obvious example of two separate complaints, one of which is new]*

• A patient comes to the office with complaints of right knee pain. The physician takes a history and does an exam. An X-ray of the knee is obtained and the physician writes an order for physical therapy. He determines that the patient would benefit from a cortisone injection to the affected knee. In this case, a separate and significant E&M service was prompted by the knee pain for which the cortisone injection was given. *[**Author's Note:** This is a GREAT supportive example to use in an audit defense; it does not note whether this is a new or established patient, but we assume the problem is new…and the doctor after the work-up administers an injection… and NGS states it is appropriate to bill for both the E/M service (with a "-25" modifier) and the procedure (injection) because—and this is NGS noting—the case satisfies "separate and significant E/M service" leading to the injection; this is an "appeals keeper".]*

Documentation for the E&M service must include the key elements (history, examination, and medical decision-making) that are required for the selected code.

We expect that providers will use modifier -25 only when they can clearly substantiate that the visit was medically necessary, significant, and distinctly separate from the procedure or therapeutic service they provided to the same patient on the same date of service.

Medicare limits its use within the context of the National Correct Coding Initiative ("CCI") bundling edits. If there is no E/M to procedure "bundle", then no "-25" modifier would be applied. That does not mean that the E/M billing is not valid; it means you do not append the "-25" modifier to the E/M code. Non-Medicare payers have their own rules for bundling procedures that typically are not available for provider or coder use, so I recommend always appending a "-25" modifier to E/M services when "minor" procedures are performed on the same day as long as the E/M services are medically necessary and significant, separately identifiable.

When considering billing (or appealing a denied claim) for an E/M service performed the same day as a procedure, if the procedure was pre-scheduled and there was no new significant, separately identifiable information (e.g., a new condition) to qualify an independent E/M service, there would be no support for billing an E/M service with the procedure.

When appealing the denial of an E/M service that was well documented and met the "-25" modifier description as well as medical necessity:

1) Really make sure your documentation clearly supports significant, separately identifiable and medical necessity because that is the core to your appeal;

2) If the denial did not result from a review of a requested record, in your appeal you should hammer home the point that it would have been impossible for the payer to make that determination without review of the medical records;

3) If the denial was based on the need for a different diagnosis, in your appeal, copy the description of the "-25" modifier from CPT and highlight the section that says: "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. This circumstance may be reported by adding modifier 25 to the appropriate level of E/M service."

4) If the payer says it does not pay for an E/M service on the same day as the procedure, you should state in your appeal: a) that means they do not recognize the "-25" modifier whose sole purpose is to allow for significant, separately identifiable evaluation and management services; b) you would like a copy of their medical policy stating they do not recognize the "-25" modifier ever; (c) assume that since they do pay for E/M services performed on the same day as a procedure or surgery (i.e., the use of a "-57" decision for

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surgery modifier), if you worked the patient up for a new problem which is clearly "above and beyond" the E/M service built into a procedure allowance and decide to perform surgery—minor or major—that day, should you correct your claim and apply a "-57" modifier?

5) Ask the payer, if the E/M value is included in the minor procedure allowance, how do they reconcile the fact that the allowance for the minor procedure might be as much as half the allowance as the evaluation and management service; how does that work?;

6) And finally, keep in mind that you are appealing a denied E/M claim worth $25-$180 depending on the level and type of E/M you billed; it will cost your office a good chunk of that potential reimbursement to appeal…it also typically costs the payer more to re-review and issue another determination. If you are the type of person who feels that principle is very important regardless of the cost, appeal and appeal and appeal when you are right. If you remember that the definition of insanity is "doing the same thing over and over again, but expecting different results," you might have to throw up your hands and move on. I happen to be the former ("don't roll-over": payers are doing this less for being right than for saving a buck—fight for your financial rights).

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Dr. Goldsmith of Cerritos, CA is editor of Codingline.com and recipient of the Podiatry Management Lifetime Achievement Award.