

ALERT! MODIFIER 25 IN DERMCODER

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New Rules for the bundling of E/M visits with Minor Procedures (codes with 0 or 10 postop days)

In January 2013, CMS released **updated** instructions to the National Correct Coding Initiative. In the Integumentary Section of these instructions, new guidelines and rules were provided on billing E/M visits (for both new and established patients) with minor procedures. A minor procedure is a code with 0 or 10 postop days.

You may download a copy of the updated Integumentary Section Instructions from Ellzey Coding Solutions (ECS). Changes are in red throughout the document.

http://www.ellzeycodingsolutions.com/content/CHAP3-CPTcodes10000-19999_final103115.pdf

On page 3, you will find the following instruction/rule change. The change is in **bold** below.

*If a procedure has a global period of 000 or 010 days, it is defined as a minor surgical procedure. **E&M services on the same date of service as the minor surgical procedure are included in the payment for the procedure.** The decision to perform a minor surgical procedure is included in the payment for the minor surgical procedure and should not be reported separately as an E&M service. However, a significant and separately identifiable E&M service unrelated to the decision to perform the minor surgical procedure is separately reportable with modifier 25.*

The E&M service and minor surgical procedure do not require different diagnoses. If a minor surgical procedure is performed on a new patient, the same rules for reporting E&M services apply. The fact that the patient is "new" to the provider is not sufficient alone to justify reporting an E&M service on the same date of service as a minor surgical procedure. NCCI does contain some edits based on these principles, but the Medicare Carriers have separate edits. Neither the NCCI nor Carriers have all possible edits based on these principles.

What this is saying is that the Evaluation and Management required to address the patient's specific chief complaint(s) is included in the reimbursement for the billable minor procedure. This would include determining the chief complaint(s), taking or updating history, review of systems, examining the patient, past family/social history, diagnosing the problem, making the decision on how to treat the problem, informing the patient, obtaining consent, and providing postop instructions. In summary, none of the aforementioned tasks/processes can be billed for separately if they are related to a billable minor procedure.

The **exception**, is when there is a "separately identifiable" E/M service performed during that visit that goes "above and beyond" the E/M necessary for the billable minor procedure.

Note: This rule only pertains to procedures with 0 and 10 postop days (i.e., minor procedures. This rule applies whether there are one or more minor procedures billed during the visit.

Q: What does "separately identifiable" mean in regards to adding modifier 25 (or 57) to an E/M visit?

A: A "separately identifiable" E/M visit is one that goes above and beyond the normal evaluation and management required to perform a procedure.

For example, a patient has several large cysts on his neck and schedules an appointment with the dermatologist. The dermatologist examines the lesions, asks some relevant HPI and PFSH questions, performs a brief exam, and makes the decision to inject the lesions with Kenalog. The E/M performed in this situation is required to perform the procedure and is not separate and identifiable. In this example, reimbursement for the E/M service is **included** in the procedure and cannot be billed separately.

Here is a SIMPLE way to look at it...

Take the chart note for the date of service in question, take a highlighter, and highlight all the documentation related to performing the procedure **including** the documentation required for evaluating, diagnosing, examining the patient,

making the decision to perform the procedure in question, performing the procedure, and providing postoperative instructions and any prescriptions. Now, if the remaining documentation from that date of service can stand alone as a billable E/M visit (with all the appropriate elements required), then there is a high probability that this will stand as a “separate and identifiable” E/M visit.

Note: The rules about “separate and identifiable” E/M visits apply to BOTH new patient and established patient E/M visits.

Per the NCCI General Instructions published January 1, 2013 (see page 18)...

“If a minor surgical procedure is performed on a new patient, the same rules for reporting E/M services apply. The fact that the patient is “new” to the provider is not sufficient alone to justify reporting an E/M service on the same date of service as a minor surgical procedure.”

Source: 2016 NCCI Policies

Great article!

Here is a **brand new article** published by the *American Academy of Dermatology* which addresses separate and identifiable E/M visits, with examples. <http://www.aad.org/dw/cracking-the-code/2013/july#allpages>

Helpful Documentation Tips

Documentation in the patient’s medical record must support the use of this modifier. The CPT 2015 description for this modifier specifies that a significant, separately identifiable E/M service is defined or substantiated by documentation that satisfies the relevant criteria for the respective E/M services to be reported.

Common Errors for Modifiers 25

- Duplicate claim submission
- Timely filing limit
- Patient not eligible for Medicare Part B
- Records show Medicare beneficiary is under Hospice or HMO coverage
- Medicare Secondary Payer
- Inappropriately appended to procedure codes that are not E&M (25)
- Surgical, clinical laboratory, physical therapy

For detailed documentation and coding information on “Office or other outpatient visit for the evaluation and management of an established patient” (Mod 25) refer to the following references:

American Medical Association Current Procedural Terminology (CPT ®) Standard Edition

Medicare Claims Processing Manual, Chapter 12, Section 30.6.12

1995/1997 Documentation Guidelines for Evaluation and Management Services

Q: What if I perform multiple procedures because the patient has multiple problems/complaints? During that visit, I have to examine multiple areas of the body. Is that enough to justify billing a new or established office visit?

A: Technically, no. Even, if you perform multiple procedures on the same visit and have to examine multiple areas of the body, than each procedure will have a certain inherent amount of E/M service included with each procedure, including the exam.

Again, follow the test above. Take the chart note, and highlight all the documentation that has to do with each of the procedures, including any examination required to address the chief complaint(s). Look at what’s remaining in the chart note. Is there enough documentation, and are there enough elements left to stand on their own as a complete E/M visit? If the answer is yes, then you should feel reasonably comfortable to justify billing a separate E/M service for that visit.

Q: What if I perform a procedure, such as an excision or a biopsy, on a new or established patient, and I also address a second complaint that doesn’t require a billable procedure, but results in some *other* type of

medical decision making, such as writing a prescription. Would that qualify for billing a separate E/M visit?

A: If the chart documentation supports it, then most likely, you could bill a separate E/M. For example, if you examine the patient for an issue, like acne, that is unrelated to one or more procedures also performed that day, then you would need to document some additional E/M elements like history of present illness, social history, and any examination of the affected lesions. If you decide to place the patient on prescription such as Doxycycline along with an OTC like 10% benzoyl peroxide lotion then you would **not** have any billable procedure to place on a claim for the acne complaint. In this example, the E/M related to addressing the patient's acne complaint would be separate and identifiable from unrelated procedure(s) also billed on that day. As long as the documentation is in place, then this would support billing a separate new or established E/M visit.

Q: Is a separate diagnosis code required for a "separate and identifiable" E/M visit?

A: According to CMS and the CCI, the answer is no.

Per the NCCI General Instructions published January 1, 2013 (see page 18 of the link above)...

"However, a significant and separately identifiable E/M service unrelated to the decision to perform the minor surgical procedure is separately reportable with modifier 25. The E/M service and minor surgical procedure do not require different diagnoses."

On the Palmetto website link (above), it states...

"A different ICD-9-CM code from the one submitted with the minor surgery is not required with the E/M code. The diagnosis for the E/M service and the other procedure may be the same or different."

On the NHIC website link (above), on page 23, it states...

"A significant, separately identifiable E/M service is defined or substantiated by the documentation that satisfies the relevant criteria for the respective service to be reported. 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. Documentation in the patient's medical record must support the use of this modifier."

Lastly, CPT specifically states in Appendix A, under Modifier 25...

"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."

HOWEVER, some recent RAC audits have been reported with carriers denying E/M visits (with modifier 25) if a separate diagnosis code isn't listed. So the policy regarding separate diagnoses is confusing and inconsistent, to say the least.

How to handle denials of E/M visit with procedures.

If you receive a claim denial for an E/M visit with a procedure, you have several courses of action.

1. If it's a new patient, call the carrier and ask if they require modifier 25 (or 57) to designate separate and identifiable new patient E/M visits. If so, add the required modifier and resubmit the claim.
2. Many carriers are requiring supporting documentation (i.e., copy of the chart notes) in order to authorize payment for E/M visits with procedures. Be sure that your chart note justifies a separate and identifiable E/M visit and submit your claim as an appeal.
3. According to the above sources, you should not require separate diagnoses. If your denial was based on only having one diagnosis code on the claim, you may want to copy Appendix A of the 2013 CPT manual where it discusses modifier 25 to show that *different diagnoses are not required for reporting of the E/M services on the same date*. Include this reference to CPT in the cover letter with your appeal.

Q: Why is DermCoder no longer adding modifier 25 to NEW patient visits billed with procedures? Has something changed?

A: This is a complicated topic. First, CMS (Medicare) rules state that separate and identifiable new patient E/M visits do not require modifier 25 when billed with minor procedures (i.e., procedures with 0 or 10 postop days). They also state that modifier 57 is used in place of modifier 25 when an E/M service is billed with procedures that have 90 postop days.

Most of the Medicare contractors have also published such policies regarding the new patient codes. Here are some examples...

1. Palmetto GBA, states...

"This modifier should not be submitted with E/M codes that are explicitly for new patients only: CPT codes 92002, 92004, 99201-99205, 99281, 99285, 99321-99323, and 99341-99345. These codes are 'new patient' codes and are automatically excluded from the global surgery package, meaning that they are reimbursed separately from surgical procedures. No modifier is required in order for these codes to be separately reimbursed."

Source: <http://www.palmettogba.com/palmetto/webTool.nsf/vTool/mod25>

2. Here is a great article from the *American Academy of Dermatology* that discusses this issue.

Article: To 25 or not? Part One <http://www.aad.org/dw/monthly/2013/june/to-25-or-not-part-one#allpages>

Article: To 25 or not? Part Two <https://www.aad.org/dw/monthly/2013/july/to-25-or-not-part-two#allpages>

Modifier 25 and the CCI

Next, as of July 1st 2013,, the National Correct Coding Initiative (NCCI), as published by CMS, added over 18,800 new bundles, which specifically addresses the bundling of E/M visits with procedures. These new bundles specifically EXCLUDE new patient visits (in other words, the new patient visits were not included in the list of new bundle edits). This further reinforces the above concept that new patient visits are not bundled with procedures.

DermCoder uses the National CCI tables for the some of the QuickCheck logic which is why you are not seeing modifier 25 added to the new patient E/M codes. (i.e., the CCI tables do not bundle most procedures with new patient E/M visits. There are a few exceptions like patch testing, and injections where specific edits **do** exist.

DISCLAIMER

Even though there are written policy examples (as in above) stating the modifier 25 is **not** required with New Patient E/M visits billed with procedures, most carriers will probably still accept claims with modifier 25 included. It will be interesting to see that now that the 18,800 new CCI edits came out, whether they will continue to ignore modifier 25 on new patient visits (as they have done previously) or whether they will start to enforce (i.e., deny) new patient E/Ms billed with modifier 25. Yes, it is confusing.

Local Medicare contractors and other commercial carriers may have their own rules, variations, and special policies. If your commercial carriers or your local Medicare contractor requires modifier 25/57 on all E/M visits (including new patient visit) when billed with procedures, then you will need to add it to your claims for processing.

Additional Articles of Interest

OIG Position Statement on Modifier 25 (from 2005)

<https://oig.hhs.gov/oei/reports/oei-07-03-00470.pdf>

Articles from the AAD

Article: To 25 or not? Part One <http://www.aad.org/dw/monthly/2013/june/to-25-or-not-part-one#allpages>

Article: To 25 or not? Part Two <https://www.aad.org/dw/monthly/2013/july/to-25-or-not-part-two#allpages>

OIG Cracking Down on Modifier 25 Use

<http://medicaleconomics.modernmedicine.com/medical-economics/news/tags/cms/oig-still-cracking-down-use-modifier-25>

CMS Global Surgical Package Fact Sheet

<http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/GlobalSurgery-ICN907166.pdf>

WPS Medicare Modifier 25 Fact Sheet

<http://www.wpsmedicare.com/j5macpartb/resources/modifiers/modifier-25.shtml>

E/M Update: DOJ Targets Improper Use of Modifier 25

http://www.martindale.com/health-care-law/article_Marshall-Dennehey-Warner-Coleman-Goggin_1786564.htm

Coding edit change for modifier 25

http://www.bluecrossmn.com/internet_core/en_US/ccurl/246/220/QP19R1-1_%20Final_with_header.pdf

Latest CCI edits make it tougher to report E/M service with minor procedures

http://blogs.aafp.org/fpm/gettingpaid/entry/latest_cci_edits_make_it

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