Socioeconomic tips

Two pesky CPT modifiers: –25 and –59

by the Division of Advocacy and Health Policy

The Current Procedural Terminology (CPT)* modifiers for a distinct procedural service (modifier –59) and for a significant, separately identifiable evaluation and management (E/M) service (modifier –25) are two troublesome modifiers, known by experts to be subject to misuse. The Office of the Inspector General (OIG) of the U.S. Department of Health and Human Services has recently performed audits of the use of these two modifiers in the Medicare program; the results shed some new light on exactly how these modifiers are misused.

The OIG randomly selected a sample of claims using modifier –59 or modifier –25 from a complete file of all Medicare claims submitted during a 12-month period. The OIG requested, and almost always received, medical records to support the use of the modifier and had certified coders review the records to see whether they met the standards for the use of the modifier. This article reports on the OIG's findings and offers some tips on the use of the modifiers.

Distinct procedural service (modifier –59)

A surgeon may need to indicate that a service was distinct from another service that he or she did on the same date. To quote from the CPT, "This may represent a different session or patient encounter, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries)…." In the case of Medicare, which uses Correct Coding Initiative (CCI) edits, and some other payors, which use similar types of edits, use of a –59 modifier bypasses the edits and both line items on a claim are paid. For the 12-month period ending September 30, 2003, Medicare allowed $245 million for services with a –59 modifier.

The OIG found that in 15 percent of the claims that used modifier –59, the services were not distinct from each other because they were performed at the same session, at the same anatomical site, and/or through the same incision. In another 25 percent of the claims, there were documentation deficiencies. Either one or both services were not documented in the medical record, or the documentation was insufficient to make a determination that the correct code was selected. In a few instances, the documentation showed that a different code should have been used for one or both of the services. Finally, in 11 percent of cases, the modifier was not attached to the code

CPT modifiers –25 and –59

–25, Significant, Separately Identifiable Evaluation and Management Service by the Same Physician on the Same Day of the Procedure or Other Service: 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.

–59, Distinct Procedural Service: Under certain circumstances, the physician may need to indicate that a procedure or service was distinct or independent from other services performed on the same day. Modifier –59 is used to identify procedures/services that are not normally reported together, but are appropriate under the circumstances. *This may represent a different session or patient encounter, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same physician* [emphasis added]. However, when another already established modifier is appropriate it should be used rather than modifier –59. Only if no more descriptive modifier is available, and the use of modifier –59 best explains the circumstances, should modifier –59 be used.

*All specific references to CPT (Current Procedural Terminology) terminology and phraseology are © 2005 American Medical Association. All rights reserved.

in the pair that had the lower price or lower total relative values.

Follow these tips to use modifier –59 correctly:

- Be sure a modifier is needed on the claim by reviewing the list of reasons a modifier –59 can be used. (See CPT definitions in text box, previous page.)
- Be sure a more specific modifier does not exist. The Medicare program recognizes modifiers in the Healthcare Common Procedure Coding System that are anatomically more specific than –59. These are useful when designating the side of the body or the digit that was involved in the operation.
- Check for the presence of an edit if you are billing Medicare. The CCI edits are widely available as part of billing or coding software packages. They also are available on the Web at *http://cms.hhs.gov/NationalCorrectCodInitEd/*.
- If separate diagnosis codes are appropriate, use them and link the diagnosis codes to the appropriate procedure code.
- Attach the –59 to the service with the lower price or lower total relative values.

Significant separately identifiable E/M service (modifier –25)

A physician may be scheduled to perform a surgical procedure but when the patient arrives, he or she says, "I have another problem." The physician then provides an E/M service to address the new problem. Assuming the other problem is unrelated to the surgical procedure, CPT rules allow the surgeon to bill for both the procedure and the E/M service as long as the modifier –25 is appended to the code for the E/M service. In 2002, Medicare reimbursed $1.96 billion for approximately 29 million E/M claims using modifier –25.

The OIG reported that 31 percent of the claims were not properly documented and another 2 percent failed to meet the basic requirement for the modifier—that the visit and procedure were indeed separate. The –25 modifier may be used if the E/M service is separately identifiable or beyond the usual preoperative or postoperative care associated with the procedure.

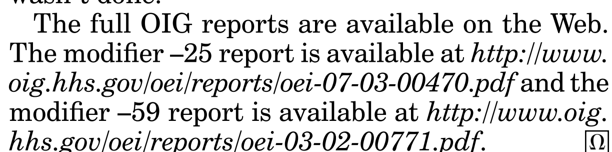
There were also technical problems with the use of the modifier. One was that the modifier was placed on a service but only one service was billed on that day. On claims that did show two services on the claim, 28 percent of the providers using the –25 modifier attached it to the procedure code rather than the E/M code.

Follow these tips to use modifier –25 correctly:

- Be sure both a procedure code and an E/M code are being reported.
- Be certain the ground rules for the –25 modifier are met. (See text box, previous page.)
- Attach the –25 modifier to the E/M code.
- Use appropriate diagnosis code(s) on the claim and link them appropriately to the procedure code and the E/M code. Different diagnosis codes may be appropriate for some situations, but there will be other situations where the same diagnosis code is used for both the procedure and the E/M service.
- Be sure that the surgeon documented *both* the procedure and the E/M service. The documentation for the two should be clearly separated.
- Know whether your payor requires that you submit the documentation with the claim or submit the documentation only if the claim is reviewed. Even in the latter situation, it is important to have good documentation because you never know when you will have to supply it.

Conclusion

Documentation was a big problem with the use of both modifiers, with errors accounting for 25 percent of all claims for modifier –59 and 31 percent of all claims for modifier –25. It is so easy to give short shrift to documentation in a busy surgeon's office, but the importance of good documentation cannot be underestimated. Payors have no choice but to take the attitude that "if it wasn't documented, it wasn't done."



The full OIG reports are available on the Web. The modifier –25 report is available at *http://www.oig.hhs.gov/oei/reports/oei-07-03-00470.pdf* and the modifier –59 report is available at *http://www.oig.hhs.gov/oei/reports/oei-03-02-00771.pdf*. Ω