Modifier 25 under fire: Are you using it correctly?

by Mark T. Savarise, MD, FACS; Christopher K. Senkowski, MD, FACS; Teri Romano, RN, MBA, CPC, CMDP; and Jan Nagle, MS, RPh

The Centers for Medicare & Medicaid Services (CMS) has again identified the potential overuse and misuse of Current Procedural Terminology (CPT®) code modifier 25. In the recently published proposed rule for the calendar year (CY) 2017 Medicare Physician Fee Schedule, CMS indicates that its CY 2015 Medicare claims review shows that 19 percent of the codes that describe 0-day global services were billed more than 50 percent of the time, with an evaluation and management (E/M) service with modifier 25 appended. CMS maintains that the routine billing of separate E/M services may indicate a possible problem with the valuation of the procedure codes, which are intended to include all of the routine care associated with the procedure. The agency has identified a number of high-volume codes to review for possible duplication of resources and overvaluation.[1]

This issue has been raised on multiple occasions since 2005, when the Office of the Inspector General (OIG) published an analysis showing that 35 percent of Medicare claims for modifier 25 did not meet Medicare program requirements.[2] Since then, CMS and private payors have increased their scrutiny of codes reported with this modifier, sometimes resulting in significant repayment to Medicare. For example, earlier this year, the U.S. Attorney's Office for the Northern District of Georgia reached a settlement with a dermatology practice to pay $1.9 million to settle claims that they violated the False Claims Act by billing Medicare for E/M services that were prohibited under Medicare rules.[3]

To understand why modifier 25 is under this type of scrutiny, surgeons need to understand how its use is defined. Simply put, modifier 25 is appended to an E/M code when a procedure and a separate and significant E/M service is performed by the same physician during the same session or on the same date.[4] For example, an established patient comes to your office with a suspicious lesion and, based on your assessment, you decide to excise it. You wonder if you can report an E/M code with modifier 25 appended, as well as the minor procedure code for excising the lesion. The definition of what is "separate and significant" is at the heart of whether both an E/M

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TABLE 1. PRE-SERVICE TIME FOR SELECTED MINOR SURGICAL PROCEDURES (IN MINUTES)

CPT code	Global period in days	Procedure	Pre-evaluation time	Patient positioning time	Other pre-service time (dress/scrub)	Total pre-service time
10060	10	I&D [incision and drainage] abscess	8	3	5	16
11042	0	Debride subcutaneous tissue	9	1	1	11
32551	0	Tube thoracostomy	30	3	10	43
36561	10	Insert CVA [central venous access] with port	20	5	10	35
45378	0	Colonoscopy, diagnostic	19	3	5	27
49421	0	Insert intraperitoneal catheter, open	33	3	10	46

Source: CY 2016 Medicare Physician Fee Schedule Time/Visit Database

with modifier 25 and a procedure code may be reported together.

Definition of modifier 25

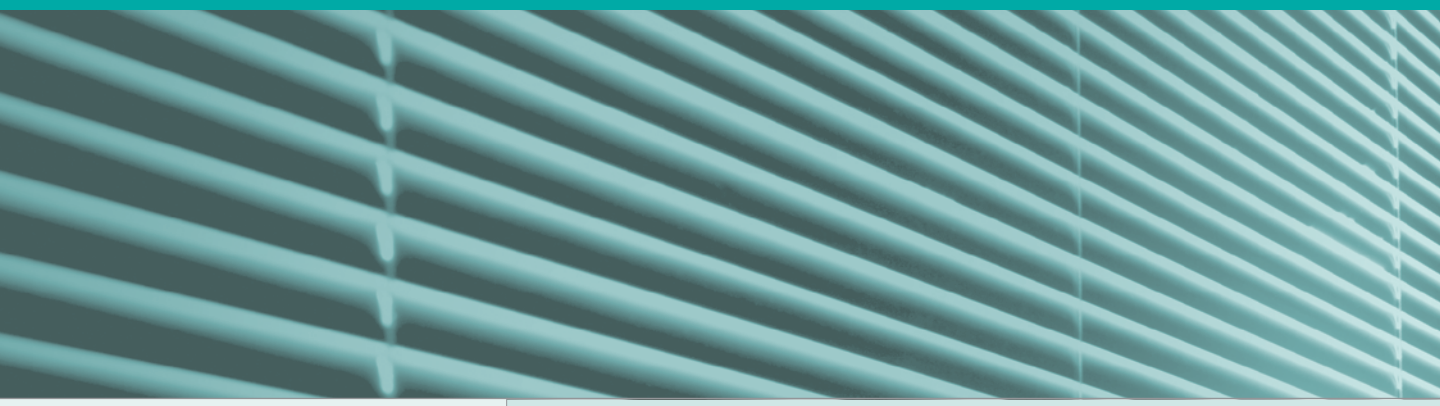
Medicare requires that modifier 25 be used only on claims for E/M services and only when the E/M service is provided by the same physician on the same day as a global procedure or service. In addition, payment is made only if the physician indicates that the service is for a significant, separately identifiable E/M service that is above and beyond the usual preoperative and postoperative work required on the day of the procedure. The physician must appropriately and sufficiently document both the medically necessary E/M service and the procedure in the patient's medical record to support the claim for these services, even though the documentation is not required to submit with the claim.[5]

CPT, on the other hand, defines modifier 25 as a significant, separately identifiable E/M service that the same physician or other qualified health care professional provides on the same day as the procedure or other service. The CPT codebook also states that a significant, separately identifiable E/M service is substantiated by documentation that satisfies the relevant criteria for the respective E/M service to be reported.[6]

Significant and separately identifiable

What exactly does significant and separately identifiable mean? How do you know when you have performed this service and therefore need to document a significant and separately identifiable E/M service? It is important to note that the relative value unit (RVU) for each minor procedure includes pre-service work that may include pre-evaluation time, patient positioning time, and time to scrub and dress before the procedure (see Table 1, this page, for examples). As shown, the Medicare payment for incising and draining an abscess (10060) in the office includes 16 minutes of pre-service time. Medicare payment for performing a diagnostic colonoscopy (45378) includes 27 minutes of pre-service time. The RVUs for each of these procedures also includes intra-service time (in effect, the time it takes to perform the procedure), as well as post-procedure time. For both services, significant pre-service time is dedicated to evaluation: eight minutes for the abscess and 19 minutes for the colonoscopy.

Reporting an E/M code and a procedure code when your evaluation is limited to assessing the specific problem (for example, an abscess) is essentially double billing for the pre-service evaluation. Your E/M must significantly exceed the pre-service evaluation already paid as part of the procedure for it to qualify as significant and separately identifiable. If it does not, only the procedure should be billed. A different diagnosis code is not needed, and in most cases the diagnosis code for the E/M code and the procedure code will be the same. What must be documented is the history, exam, and decision-making process (all for a new patient and two of three for an established patient) that includes attention to more than the patient's targeted chief



complaint that is the reason for the minor procedure.

Avoiding misuse of modifier 25

To avoid overuse or misuse of modifier 25 and reduce the risk of an audit and repayment demand by payors, the ACS offers the following recommendations:

- Do not automatically report an E/M code every time you perform a minor procedure in an office or facility.
- Append modifier 25 to the E/M code on the claim, not to the procedure code.
- Recognize that every procedure includes pre-service time as part of the fee.
- If you perform an E/M service above and beyond the pre-service time associated with the procedure, make sure that the extended E/M work is medically necessary; don't evaluate other body areas or organ systems unless a good clinical rationale for doing so can be provided.
- Both the medically necessary E/M service and the procedure must be appropriately and sufficiently documented in the patient's medical record to support the need for modifier 25, even though

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EXAMPLES OF PROPER USE OF MODIFIER 25

Example of an encounter resulting in the reporting of both a procedure code and E/M code with modifier 25, with two different diagnoses: A woman arrives at your office with a suspicious lesion on her arm. She also complains that her left leg has been swelling and she has pain deep in her thigh. Before performing the biopsy on her arm, you take a history related to her complaint of leg swelling with pain and examine the patient, including palpating the lower abdomen and assessing the lower extremities for varicosities and phlebitis. You counsel her to wear compression stockings and elevate her legs and schedule a follow-up to determine if conservative therapy is helpful. Report the biopsy procedure code and an appropriate E/M code with modifier 25. Two separate diagnoses should be reported on the claim.

Example of an encounter resulting in the reporting of both a procedure code and E/M code with modifier 25, with one diagnosis: A patient arrives at your office complaining of bright red blood from the rectum. You conduct a detailed history and physical exam including abdominal, rectal, and genitourinary examination. You then perform a diagnostic anoscopy. Your medical decision making is aided by the anoscopy findings but is based on the history and physical exam. Report the anoscopy and an appropriate E/M code with modifier 25. Only one diagnosis should be reported.

Example of an encounter resulting in only reporting a procedure code: A woman arrives at your office for a repeat injection of steroid at the base of her right thumb to relieve arthritis pain and swelling. She mentions that she has recently had the same pain on her left hand. After a focused exam of her left hand, you decide to perform a second injection. Report the injection code with modifier 59 and modifiers to indicate left thumb and right thumb as appropriate. No separate E/M code should be reported.

the documentation is not required to be submitted with the claim.

- Modifier 25 may be used in the rare circumstance of an E/M service the day before a major operation and represents a significant, separately identifiable service; it likely would be associated with a different diagnosis (for example, evaluation of a cough that might affect the operation).

- Different diagnoses are not required to report the E/M service on the same date as the procedure or other service. As an example, a patient who has been treated in the past for gastroesophageal reflux disease (GERD) and is scheduled to have an upper endoscopy now complains of exacerbation of known irritable bowel syndrome (IBS) and asks that you review the medications for this condition. The upper endoscopy is performed for the workup of GERD and the medications for IBS are adjusted. The work associated with the E/M related to IBS would be reported with the E/M code and modifier 25 appended to indicate this is a separate service. ♦

Disclaimer

Accurate coding is the responsibility of the provider. This summary is intended only to serve as a resource to assist in the billing process.

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