Focused Physician Coding Audits: Using Modifier 25

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by Mary H. Stanfill, RHIA, CCS, CCS-P

The physician section of the 2004 OIG work plan includes a focus on appropriate use of modifiers used to bypass National Correct Coding Initiative edits and modifier 25 (Significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service).[1] This focus on modifier 25 is not new (it was in the OIG work plan in 1998), but it has resurfaced after several years, no doubt due to the volume of reporting.

According to the OIG, $1.7 billion of the $23 billion billed for evaluation and management (E/M) services in 2001 was under modifier 25.[2] Modifiers may also be a focus because there is much confusion on their appropriate use. According to the American Medical Association, at one time one of the most commonly asked questions about CPT coding involved the use of modifier 25.[3] Whatever the reasons, expect that auditors will be reviewing documentation in 2004 to determine whether physicians are inappropriately using modifiers to increase reimbursement. This article will discuss the appropriate use of modifier 25 and how to focus coding audits in this area.

Appropriate Use of Modifier 25

Modifier 25 is particularly confusing for physician reporting. This modifier is appended to an E/M service when it is reported by the same physician on the same day the physician reports a procedure or other service. Difficulties arise in determining which E/M services are included in the procedure and which warrant separate reporting. Often physicians expect that the E/M service is the "base service," and anything else done during a clinic visit may be reported separately. However, even minor procedures include pre-service, intra-service, and post-service work.

Exactly what is "pre-service" work is a gray area. The Medicare Claims Processing Manual states that the initial evaluation is always included in the allowance for a minor surgical procedure.[4] This makes sense in light of the fact that CPT codes for procedures include the evaluation services necessary prior to the performance of the procedure.

Examples of included "necessary evaluation services" from *CPT Assistant* are: assessing the site/condition of the problem area, explaining the procedure, and obtaining informed consent.[5] When additional E/M services are performed beyond those typically required to perform the procedure, a separate E/M code may be reported with modifier 25 appended. CPT Assistant indicates that "separate" E/M services would include E/M key components or counseling services that are not included in the descriptor for the procedure.[6]

Whether both a procedure and an E/M service should be coded and reported depends on what service is provided and documented. For example, an E/M visit on the same day could be properly assigned in addition to the CPT code for suturing a scalp wound if a full neurological examination is done for head trauma. In this case, documentation of the neurological exam must be present to support the additional E/M service. However, coding a separate E/M service would not be appropriate if the physician only identified the need for sutures and confirmed allergy and immunization status. See "Applying Modifier 25" for examples of appropriate and inappropriate uses of modifier 25. Keep in mind that facility reporting of modifier 25 varies significantly from the physician reporting discussed here. See "Hospital Outpatient Reporting of Modifier 25."

Focused Coding Audits

Coding audits to assess appropriate use of modifier 25 could focus on records representing the procedures that are most commonly reported with E/M services on the same date. Identify the practice's top 10 procedures performed in the clinic and determine how often these procedures are submitted with E/M services on the same date. Focus auditing efforts on the type of cases where this is done most frequently. Audits can also be focused based on results of internal risk assessments or where use of modifiers varies significantly from benchmark data.

The objective of the coding audit is to determine if codes and modifiers are assigned correctly and to verify that the physician performed and documented the procedure and the key components of separate and distinct E/M services reported on the same date. The auditor will look not only for correct code assignment, but also for adequate documentation to support the codes assigned.

Here are some examples of what to look for in health record documentation to support the use of modifier 25:

- Documentation that the patient's condition supports a separately identifiable service above and beyond that typically provided to perform the procedure
- Documentation of care outside the usual preoperative and postoperative care associated with the procedure
- Documentation of the key components of an E/M service (history, exam, medical decision making)
- Documentation that supports the extra physician work deserving the additional payment

Coding audits should be carefully planned and conducted in a manner that is consistent with the practice's compliance plan. Details such as sample size and sample selection should be determined to maximize statistical validity.[7] Policies and procedures for reconciling audits should be established before the audit is performed.

What Comes Next?

Audits must result in action to address any problems identified. A provider has a legal obligation to refund any overpayments. Isolated coding errors may result in submission of corrected claims. Repetitive coding errors or trends must also be addressed. Depending on what is encountered, it may be necessary to seek legal counsel before disseminating results or taking action. Above all, follow the policies outlined in the compliance plan and make sure the compliance officer or committee is informed.

Audit results should be analyzed to identify education or training needs. For example, physicians may need education on what services justify reporting both a procedure and an E/M visit or on what to record so that both services are reflected in the documentation for the encounter. Coding staff may need education on guidelines for reporting modifiers. Coding education is most effective when relevant case examples are used to illustrate appropriate and inappropriate code assignment or documentation principles. It is advisable to perform a follow-up audit a few weeks after providing education to determine if educational efforts were successful.

Inappropriate or over use of modifiers may result in "overpayments." For this reason many physician practices have included the use of modifiers in their compliance efforts. In light of the OIG focus on modifiers in the 2004 work plan, it is now imperative for physician practices to include modifier usage in their compliance efforts.

Modifier 25 Dos and Don'ts

Dos	Don'ts
• Append only to E/M CPT codes • Use to report a distinct service above and beyond that typically provided to perform the procedure • Investigate payer specific requirements for reporting, including contractual obligations with private payers	• Append to any CPT code outside the E/M section • Use to un-bundle care that is typically required to perform the procedure • Use when the E/M service resulted in the decision for surgery (modifier 57 is used in this instance)

Applying Modifier 25

Case examples correctly applying Modifier 25:
A cardiologist sees an established patient with new onset of chest pain, performs a comprehensive

history and exam (CPT 99215), and then performs a cardiac catheterization. Code both the applicable cardiac catheterization codes and 99215-25.

A patient with vague pelvic and bladder complaints is referred to a gynecologist for a consultation. The gynecologist performs a lengthy evaluation (CPT 99245) and includes a bladder catheterization (CPT 51701). Code both 51701 and 99245-25.

Case examples where Modifier 25 is not appropriate:
A new patient is seen by an orthopedist because of effusion in the knee joint. Medication was prescribed. Two weeks later, the patient returns to the orthopedist with continuing effusion. At this visit the joint is injected with cortisone. On the second visit, only the joint injection and the specific medication administered should be reported.

An established patient with a history of biopsy and removal of a basal cell lesion returns to the dermatologist with a similar lesion in a different location. A limited evaluation is done and a punch biopsy (CPT 11100) is performed. Code only 11100. The key is that only a limited evaluation was done, so a distinct and separate E/M service was not performed.

Hospital Outpatient Reporting of Modifier 25

Modifier 25 is approved for ambulatory surgery center and hospital outpatient use. Note that requirements for facility reporting of modifier 25 under the Outpatient PPS vary significantly from the requirements for physician reporting included in this article. For information on facility reporting of modifier 25, go to the CMS Web site at http://cms.hhs.gov/providers/hopps/.

The following transmittals are specifically related to modifier 25:
Transmittal No. A-01-80, June 29, 2001 http://cms.hhs.gov/manuals/pm_trans/A0180.pdf
Transmittal No. A-00-40, July 20, 2000 http://cms.hhs.gov/manuals/pm_trans/A0040.pdf

Notes

1. Office of Inspector General. “2004 Work Plan.” Available at http://oig.hhs.gov/publications/ workplan.html#1
2. *Ibid.*
3. American Medical Association. *CPT Assistant* 8, no. 9 (1998): 4.
4. CMS. *Medicare Online Claims Processing Manual* pub 100-4, Chapter 12, section 40.1, “Definition of a Global Surgical Package.” Available online at www.cms.hhs.gov/manuals/ cmsindex.asp.
5. American Medical Association. *CPT Assistant* 8, no. 9 (1998): 5.
6. *Ibid.*
7. For more information on planning and conducting audits, refer to the AHIMA publication *Health Information Management Compliance—A Model Program for Healthcare Organizations* by Sue Prophet, RHIA, CCS, available at http://imis.ahima.org/orders.

***Mary Stanfill** (mary.stanfill@ahima.org) is a coding practice manager at AHIMA.*

Article citation:
Stanfill, Mary H. "Focused Physician Coding Audits: Using Modifier 25." *Journal of AHIMA* 75, no.2 (February 2004): 62-64.