

compliance

Significant? Separate? Billable?

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Occasions arise when treating a patient where an evaluation and management (E/M) service and a surgical or infusion service or another procedure occur on the same date. In general, the patient visit is included in the significant procedure performed on the same service date, but on some occasions, it may be appropriate to bypass the edit that combines these two services. However, knowing when to bypass this edit can present a challenge for coding and billing personnel.

Professional Charges

According to authoritative coding guidance and Medicare regulations, the global surgical package includes all necessary services normally furnished before (preoperative), during (intraoperative), and after (postoperative) a procedure by the surgeon or by members of the same group within the same specialty.¹ The global surgical package applies to physician or qualified non-physician healthcare professional services in any setting, including inpatient hospitals, outpatient hospitals, ambulatory surgical centers, and physician or freestanding offices.²

Medicare developed the *National Correct Coding Initiative (NCCI) Policy Manual for Medicare Services* to promote consistent and correct coding and reduce inappropriate payments. Chapter 1 of this guide states³

If a procedure has a global period of 000 or 010 days, it is defined as a minor surgical procedure. In general 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 contains many, but not all, possible edits based on these principles.

Procedures with a global surgery indicator of “XXX” are not covered by these rules. Many of these “XXX” procedures are performed by physicians and have inherent pre-procedure, intra-procedure, and post-procedure work usually performed each time the procedure is completed. This work should never be reported as a separate E&M code. Other “XXX” procedures are not usually performed by a physician and have no physician work relative value units associated with them. A physician should never report a separate E&M code with these procedures for the supervision of others performing the procedure or for the interpretation of the procedure. With most “XXX” procedures, the physician may, however, perform a significant and separately identifiable E&M service on the same date of service which may be reported by appending modifier 25 to the E&M code. This E&M service may be related to the same diagnosis

necessitating performance of the “XXX” procedure but cannot include any work inherent in the “XXX” procedure, supervision of others performing the “XXX” procedure, or time for interpreting the result of the “XXX” procedure.

Chapter 9 of this Policy Manual adds:

When physician interaction with a patient is necessary to accomplish a radiographic procedure, typically occurring in invasive or interventional radiology, the interaction generally involves limited pertinent historical inquiry about reasons for the examination, the presence of allergies, acquisition of informed consent, discussion of follow-up, and the review of the medical record. In this setting, a separate evaluation and management service is not reported. As a rule, if the medical decision making that evolves from the procurement of the information from the patient is limited to whether or not the procedure should be performed, whether comorbidity may impact the procedure, or involves discussion and education with the patient, an evaluation/management code is not reported separately. If a significant, separately identifiable service is rendered, involving taking a history, performing an exam, and making medical decisions distinct from the procedure, the appropriate evaluation and management service may be reported.

As indicated, if the purpose of the encounter is simply to explain the procedure, obtain informed consent, and acquire pertinent history and related information, there is no separate visit to charge. Chapter 9 also includes the following specialty specific guideline:

In radiation oncology, evaluation and management CPT® codes are separately reportable for an initial visit at which time a decision is made whether to proceed with the treatment.

Except for an initial visit E&M service at which the decision to perform radiation therapy is made, E&M services are not separately reportable with radiation oncology services with one exception as noted below. Effective January 1, 2010, CMS eliminated payment for consultation E&M CPT codes 99241-99255. The initial E&M visit for radiation oncology services may be reported with office/outpatient E&M CPT codes 99201-99215, initial hospital care E&M CPT codes 99221-99223, subsequent hospital care E&M CPT codes 99231-99233, or observation/inpatient hospital care with same day admission and discharge E&M CPT codes 99234-99236.

The only radiation oncology services that may be reported with E&M services in addition to an initial visit E&M service are CPT codes 77770-77772 (remote afterloading high dose rate radionuclide brachytherapy). E&M services reported with these brachytherapy codes must be significant, separate and distinct from radiation treatment management services.

This Medicare guideline illustrates the need to research individual payer requirements that go beyond the definition of modifier 25. It is important to obtain all payer policy language before deciding the patient visit is significant and separate.

Hospital Charges

When a patient visit is performed in the hospital outpatient department, the

physician or non-physician practitioner bills and receives reimbursement for the professional E/M service only. The hospital then charges the payer for the practice expense technical component for the patient visit service; this is commonly referred to as the hospital clinic visit. Each technical patient encounter is reimbursed to the hospital with a Medicare Ambulatory Payment Classification (APC) allowance in the same manner as other outpatient procedures. Effective Jan. 1, 2014, CMS collapsed these technical visits into a single HCPCS Level II code: G0463 for “hospital outpatient clinic visit for assessment and management of a patient.”

Payers other than Medicare should be contacted to obtain their coding guidelines since many non-governmental insurers continue to accept the new patient (codes **99201-99205**) and established patient (codes **99211-99215**) E/M codes for hospital clinic visits. The Medicare Benefit Policy Manual, Chapter 6, defines a hospital technical visit:⁴

A hospital outpatient “encounter” is a direct personal contact between a patient and a physician, or other person who is authorized by State licensure law and, if applicable, by hospital or CAH staff bylaws, to order or furnish hospital services for diagnosis or treatment of the patient.

As defined, the hospital technical service is not intended to be a “nurse visit” in the absence of a professional visit charge. CMS provides the following information regarding hospital charges for a procedure and patient encounter occurring during the same treatment session:⁵

Billing a visit code in addition to another service merely because the patient interacted with hospital staff or spent time in a room for that service is inappropriate.

There are also Medicare instructions specific to reporting a visit in addition to a drug administration service:⁶

Hospitals are reminded to bill a separate Evaluation and Management code (with modifier 25) only if a significant, separately identifiable E/M service is performed in the same encounter with OPPI drug administration services.

Documentation must be clear that the patient visit service provided was ordered and performed by the physician or qualified non-physician practitioner and was separate and distinct from the procedure performed. This means that the criteria for both a professional and technical patient visit charge with modifier 25 are essentially the same.

Modifier 25

CPT Assistant, March 2012, provides details of services included in the surgical or significant medical procedure, such as dictating procedure notes, talking with the family or other physicians, writing orders, evaluating the patient prior to or immediately after the procedure, and typical follow-up care. This document also provides the following instructions for reporting a significant, separate encounter with **modifier 25**:

- Was the physician’s evaluation and management of the problem significant and beyond the normal preoperative and postoperative work? If yes, then an E/M service may be reported with modifier 25 appended. If not, it is not appropriate to

report an E/M service with modifier 25 appended, as the service is included as part of the surgical package.

- Was the procedure or service scheduled before the patient encounter? If yes, then it would not be medically necessary to report an E/M service unless the patient had other concerns or problems that were addressed during the same encounter.

When all criteria are met for separate payment of the patient visit and procedure or surgery, it may be necessary to append a modifier to the evaluation and management (E/M) code. The *CPT Manual* defines **modifier 25** as follows:

Significant, separately identifiable evaluation and management services by the same physician or other qualified healthcare professional on the same day of other 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 or 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. 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 service on the same date. This circumstance may be reported by adding modifier 25 to the appropriate level of E/M service.

For coding purposes, the primary concern surrounds identifying when the patient evaluation represents a “significant, separately identifiable service.” In essence, medical record documentation should clearly support substantial patient evaluation work not usually performed when deciding whether or not to perform the surgical or other procedure. For example, when a patient presents for the initial simulation, the physician may want to remind the patient of the services included in the course of therapy, perform an interval examination, and update patient history, but this would not be separately charged as a patient visit in addition to the simulation procedure.

According to *CPT Assistant*, November 2004, separate documentation of each service (the patient visit and procedure) is necessary so that each can be easily identified. While separate pages for each service is not required, there must at least be a separate paragraph for the surgical service or other procedure.

E/M Same Day as Drug Administration

It is good practice for physicians to provide frequent face-to-face services with their drug administration patients. However, patient visits can be separately billed in addition to an infusion or injection service only when they are significant and separate from the drug administration service. Noridian Medicare provides the following examples:⁷

Example: The patient arrives for chemotherapy treatment. The nurse completes an assessment including vital signs, confirms there are no new or interval issues; starts the treatment and continues to periodically monitor the patient during the treatment. A separately identifiable E/M service has not been provided and should not be billed with modifier 25.

Example: The patient arrives for chemotherapy treatment, newly refusing to continue home medication regimen due to side-effects. The physician/NPP evaluates the patient complaint and makes a determination on potential changes in the treatment plan. The patient also receives chemotherapy. In addition to the administration of the chemotherapy, the modifier 25 may be appended to the physician/NPP submitted E/M service.

In general, a visit to clear the patient for drug administration is not a separately billable service; this would be part of the injection or infusion service performed. In addition, when a subcutaneous injection (procedure code **96372**) is performed on the same service date as a patient visit, the payer will typically allow only the patient visit and the drug charge; the injection code may be included in the patient visit on the same date.

Audits & Investigations

There have been governmental investigative reports into, as well as fines levied against, individual providers relating to incorrect application of **modifier 25**. The Office of

Inspector General (OIG) published a report titled “Use of Modifier 25” in November 2005, which reviewed provider application of modifier 25. This report includes:⁸

Thirty-five percent of claims using modifier 25 that Medicare allowed in 2002 did not meet program requirements, resulting in \$538 million in improper payments. Medicare should not have allowed payment for these claims because the E/M services were not significant, separately identifiable and above and beyond the usual preoperative and postoperative care associated with the procedure; or because the claims failed to meet basic Medicare documentation requirements.

This was followed in May 2012 by the OIG report titled “Coding Trends of Medicare Evaluation and Management Services,” which includes:⁹

CMS should encourage its contractors to review physicians' billing for E/M services and produce comparative billing reports. Such reports provide a documented analysis of a physician's billing pattern compared to those of his or her peers. These reports provide helpful insights into physicians' billing patterns to avoid improper Medicare payments.

In addition, both physician practices and hospitals have made refunds for incorrect use of **modifier 25**, including but not limited to the following:

- Easton Hospital agreed to pay the government \$454,866 to resolve allegations of improper Medicare claims.¹⁰ According to the settlement: *In this matter the government determined that Easton Hospital incorrectly attached modifier 25 to Medicare claims that led Medicare to pay the hospital for evaluation and management services that were not significant and separately identifiable from the underlying procedure for which Medicare also paid the hospital.*
- St. Luke's University Health Network agreed to pay the government \$1,029,791 to resolve alleged improper Medicare claims.¹¹ According to the Department of Justice release: *Medicare does not normally allow additional payments for such services performed by a provider on the same day as a procedure unless the service is significant, separately identifiable and above and beyond the usual preoperative and postoperative care associated with the procedure.*

- Oncology practice to pay \$4.1 million to settle false claims act investigation.¹² This settlement includes:
The civil settlement resolves the United States’ investigation into Georgia Cancer Specialists’ practices relating to billing for evaluation and management (E&M) services on the same day as a related procedure.
- Dermatology Physicians and Practice to pay \$1.9 million to settle false claims act investigation into overbilling Medicare for evaluation and management services.¹³ The Department of Justice release includes:
Providers are not permitted to bill both E&M services and a procedure on the same day under the Medicare program’s regulations unless a significant, separately identifiable service has been performed. HHS-OIG has identified the inappropriate billing of E&M services as a national issue costing taxpayers billions of dollars.

Closing Considerations

If there is a significant, separately identifiable visit performed on the same date as a procedure, **modifier 25** may be appended to report this circumstance in all practice settings. In general, the payment for evaluating the condition and deciding to perform a procedure is considered part of the payment for the procedure. For example, an evaluation to clear the patient for scheduled chemotherapy may not qualify as a separately payable patient visit service.


When a claim is submitted to the insurer that includes **modifier 25** on the patient visit, this is an instruction for the payer to allow both the E/M visit and the procedure performed on the same date. The American Academy of Family Physicians (AAFP) recommends the following check list before appending modifier 25:¹⁴

The key is recognizing when your extra work is “significant” and, therefore, additionally billable. CPT does not define “significant,” but asking yourself the following questions should lead you to the answer:

- *Did you perform and document the key components of a problem-oriented E/M service for the complaint or problem?*
- *Could the complaint or problem stand alone as a billable service?*
- *Is there a different diagnosis for this portion of the visit?*

- *If the diagnosis will be the same, did you perform extra physician work that went above and beyond the typical pre- or postoperative work associated with the procedure code?*

In addition, it is good practice to run frequent utilization reports and perform internal audits on modifier 25 usage.

Remember that local Medicare contractor or other payer guidelines take precedence over general coding information and should be carefully reviewed. Complete documentation of all services performed and appropriate use of **modifier 25** can ensure that patient encounters and procedures performed on the same day are correctly reimbursed. Considering the many auditing entities watching for mistakes in this area, it is worth the extra effort to make certain that all compliance guidelines are being followed. 

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References

1. AMA. CPT® Assistant. March 2012.
2. CMS. Global Surgery Booklet. August 2017. Available online at: cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/GlobalSurgery-ICN907166.pdf. Last accessed October 10, 2017.
3. CMS. National Correct Coding Initiative Policy Manual for Medicare Services. Available online at: cms.gov/Medicare/Coding/NationalCorrectCodInitEd/NCCI-Manual-Archive.html. Last accessed October 10, 2017.
4. CMS. Medicare Benefit Policy Manual: Chapter 6 – Hospital Services Covered Under Part B. Available online at: cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c06.pdf. Last accessed October 10, 2017.
5. CMS. OPPTS Visit Codes Frequently Asked Questions. Available online at: cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Downloads/OPPS_QandA.pdf. Last accessed October 10, 2017.
6. CMS. Medicare Claims Processing Manual: Chapter 4 – Part B Hospital (Including Inpatient Hospital Part B and OPPTS). Available online at: cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c04.pdf. Last accessed October 10, 2017.
7. Noridian Healthcare Solutions. E/M Services and Drug Administration Billing. Available online at: med.noridianmedicare.com/web/jfa/policies/coverage-articles/em-services-and-drug-

[administration-billing](#). Last accessed October 10, 2017.

8. OIG. Use of Modifier 25. Available online at: oig.hhs.gov/oei/reports/oei-07-03-00470.pdf. Last accessed October 10, 2017.

9. OIG. Coding Trends of Medicare Evaluation and Management Services. Available online at: oig.hhs.gov/oei/reports/oei-04-10-00180.pdf. Last accessed October 10, 2017.

10. DOJ. Easton Hospital Agrees to Pay Government \$454,866 to Resolve Allegation of Improper Medicare Claims. April 3, 2013. Available online at: justice.gov/usao-mdpa/pr/easton-hospital-agrees-pay-government-454866. Last accessed October 10, 2017.

11. DOJ. St. Luke’s University Health Network Agrees to Pay Government \$1,029,791 to Resolve Alleged Improper Medicare Claims. April 3, 2013. Available online at: justice.gov/usao-mdpa/pr/st-luke-s-university-health-network-agrees. Last accessed October 10, 2017.

12. FBI. Leading Oncology Practice to Pay \$4.1 Million to Settle False Claims Act Investigation. September 19, 2012. Available online at: archives.fbi.gov/archives/atlanta/press-releases/2012/leading-oncology-practice-to-pay-4.1-million-to-settle-false-claims-act-investigation. Last accessed October 10, 2017.

13. DOJ. Dermatology Physicians and Practice to Pay \$1.9 Million to Settle False Claims Act Investigation into Overbilling Medicare for Evaluation and Management Services. April 18, 2016. Available online at: justice.gov/usao-ndga/pr/dermatology-physicians-and-practice-pay-19-million-settle-false-claims-act. Last accessed October 10, 2017.

14. Felger TA, Felger M. Understanding when to use Modifier -25. *Fam Pract Manag.* 2004 Oct;11(9):21-22. Available online at: aafp.org/fpm/2004/1000/p21.html. Last accessed October 10, 2017.