Codify
BY AAPC

Eli's Rehab Report

Modifier -25: Its Not an E/M Cure-All, but Its Close

Although most coders believe that hospital admissions always include all of the E/M services that the physiatrist performs on that day, you may be able to report both the hospital admission and an unrelated outpatient E/M visit. Modifier -25 (Significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service) is the key to reimbursement.

Patients often present to PM&R practices with symptoms that necessitate an immediate hospital admission. For instance, suppose you evaluate an amputation patient in your office and discover a severe infection at the stump site (997.62).

You admit the patient directly to the hospital, but because CPT states, "When the patient is admitted to the hospital as an inpatient in the course of an encounter in another site of service ... all evaluation and management services provided by that physician in conjunction with that admission are considered part of the initial hospital care when performed on the same date as the admission," you cannot report both the office visit (**CPT 99201** - **99215**) and the hospital admission (99221-99223).

You can consider your outpatient evaluation "bullets," however, when determining the hospital admission code level, says **Patrick Cafferty, PA-C, MPAS**, president/CEO of Neurosurgical Associates of Western Kentucky. You should add your documentation from the outpatient visit to your inpatient admission documentation, because you can use both visits to support a higher level of care. "If you provided the initial treatment in the office and concluded treatment later in the hospital, you would use the sum total of the services you provided to the patient that day" to determine the appropriate E/M code, Cafferty says.

Separate Conditions Warrant -25

But what if you perform an outpatient E/M visit in the morning for a patient's arthritic knee, and an inpatient admission in the afternoon for a herniated disc?

If you see the patient early in the day at your office for one diagnosis, and then you perform the inpatient admission later in the day for another condition, you **can** report two separate E/M codes. You should append modifier -25 to the outpatient CPT code and link the separate ICD-9 codes to the claims so your insurer will know that the services were unrelated.

Remember that no modifier is a cure-all. Although using modifier -25 usually allows your insurer to process your claims on first submission, modifier -25 will not guarantee payment without an appeal. As with all modifiers, carriers sometimes request documentation to support modifier -25's use, even if you've submitted your claim correctly.

Modifier -25 Allows E/M With Procedure

Physiatrists should also append modifier -25 to report E/M services with other procedures. Suppose you perform an expanded history and physical requiring straightforward medical decision-making for a new patient (99202).

If you determine that the patient requires a nerve block, you should report 62311 (Injection, single [not via indwelling catheter], not including neurolytic substances, with or without contrast [for either localization or epidurography], of diagnostic or therapeutic substance[s] [including anesthetic, antispasmodic, opioid, steroid, other solution], epidural or subarachnoid; lumbar, sacral [caudal]) and 99202-25 to show your carrier that the nerve block was a separate service.

But not all pain management injections warrant a full E/M service. If you see a patient for her scheduled nerve block and

administer it without evaluating the patient, you should report only the injection code, says **Heidi Stout, CPC, CCS-P,** coding and reimbursement manager at University Orthopaedic Associates in New Brunswick, N.J.

"Ask yourself, 'What did I do differently for this patient that I don't do for every other patient receiving this type of injection?'" Stout says. "If the answer is 'a significant level of service,'then you can append modifier -25."

For instance, suppose you see a patient for her scheduled trigger point injection (TPI, 20552-20553) and she tells you she is suffering from a sudden-onset severe headache that causes temporary blindness in her left eye. You perform an expanded problem-focused examination, and after discussing the patient's history of present illness, you determine that the headache may be stress-induced. You advise the patient to return to your office should the headache return.

You should report the appropriate TPI code, linked to the ICD-9 code for the condition that warranted the injection (such as myalgia, 729.1), along with 99213-25 linked to the headache diagnosis (307.81, Tension headache).

Different Diagnoses Aren't Required

CPT notes, "Different diagnoses are not required for reporting the procedure and an E/M service on the same day," as long as you perform a separately identifiable E/M service "above and beyond other services provided or beyond the usual preservice and postservice care associated with the procedure that was performed." Therefore, if a headache patient presents for an epidural injection but complains that her headaches have worsened significantly despite the pain management injections, you might perform an E/M service to investigate the source of the chronic pain. In this case, you should append modifier -25 to the E/M visit, and send the carrier a note explaining why you performed an additional E/M service for the same condition.