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Eli's Rehab Report

Understanding Starred and Minor Procedures Will Optimize Pay Up

When is a small procedure, such as a biopsy or an injection, considered minor, and when is it considered starred? Understanding the difference between these terms can help practices determine whether they can perform evaluation and management (E/M) visits with starred procedures, or whether they can perform a starred procedure and another procedure on the same date of service.

Starred procedures are relatively simple surgical procedures that rarely are associated with complications. These procedures include trigger point injections (20550), bursa injections (20600-20610), or muscle biopsies using percutaneous needles (20206). They are designated in CPT by an asterisk following the numerical code.

CPT offers specific coding rules and states that the fee includes the starred procedure only, and therefore, pre- and postoperative periods are not associated with these codes. If the starred procedure is carried out at the time of an initial or established patient visit involving significant identifiable services, the appropriate visit can be listed with modifier -25 (significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service).

For example, an established patient who has been experiencing generalized muscle weakness and muscle inflammation (**ICD-9 728.9** , unspecified disorder of muscle, ligament, and fascia) comes to the office for a muscle biopsy (20206, biopsy, muscle, percutaneous needle). Before the biopsy, the patient informs the physiatrist that she has been experiencing occasional tic-like movements in her face (**ICD-9 307.20** , tic disorder, unspecified). The physiatrist examines the patient but does not find any evidence of a tic. The physiatrist completes the E/M for the tic complaint, then performs the muscle biopsy. The practice can bill for the E/M visit to evaluate the tic (99212-99215, office or outpatient visit for the evaluation and management of a new patient) with the 728.9 diagnosis and modifier -25, plus the biopsy using 20206 with diagnosis 728.9.

Use of modifier -25 can be carrier-specific, says **Catherine Giblin,** president of Medical Consultants of America, a healthcare practice management and billing firm in Haddonfield, N.J. Giblin advises that practices ask their insurers if they recognize modifier -25 when billed for E/M services with starred procedures.

Dealing With Code 99025

Billing for starred procedures that comprise most of the doctors visit with a new patient can be different. CPT 2000 states, When the starred procedure is carried out at the time of an initial new patient visit and this procedure constitutes the major service at the visit, 99025 (initial visit when the starred surgical procedure constitutes major service at that visit) is listed in lieu of the usual initial visit as an additional service.

For example, if a patients care has been transferred to the physiatrist from a primary care physician (PCP) within the same practice, the physiatrist might perform a very short evaluation because the PCP has provided significant information about the patients condition. If the physiatrist already is aware that the patient needs trigger point injections (20550, injection, tendon sheath, ligament, trigger points or ganglion cyst) to treat fibromyalgia (729.1, myalgia and myositis, unspecified), he or she might forego an E/M but probably would perform the injection, which would constitute the major service at that initial patient visit. The practice could bill 20550 with 99025 for the visit, but experts warn that Medicare or some private insurers do not cover 99025.

Thomas Kent, CMM, president of Kent Medical Management, a physician practice management and billing firm in Dunkirk, Md., recommends not using code 99025 unless a carrier asks for it. It boils down to what you are doing for the patient, he says. If you are looking to use 99025 merely for setting up a record for a new patient who is just having a

procedure, then it doesnt apply. If you have legitimate work that you are doing for that patient in addition to that procedure, use a new patient E/M code with a -25 modifier.

Multiple Starred Procedures and Modifier -59

Suppose the patient presents with bursitis of the ankle (726.79) and bursitis of the shoulder (726.10), requiring bursa injections to both sites? Giblin says that practices can bill both the 20605 for the ankle injection and the 20610 for the shoulder injection during the same visit, despite the fact that both procedures are starred, because the bursitis diagnoses in different sites should prove medical necessity for both procedures.

If the two starred procedures youre performing are bundled together as part of the Correct Coding Initiative, says Giblin, you would have to add modifier -59 (distinct procedural service) to indicate that youre performing the two starred procedures on different sites or during different sessions, Giblin advises. Whether or not you also append modifier -51 (multiple procedures) following the modifier -59, the insurer will add modifier -51 to your claim and will pay the second procedure at a lower rate. Giblin advises practices to add modifier -51 to the cheaper procedure, in this case the ankle injection, so that the more expensive procedure is paid at 100 percent.

Some insurers dont recognize modifier -59, says Giblin, so adding it to your claim is no guarantee that youll get paid for both procedures. But if you can prove medical necessity for both procedures, you have a better chance of receiving the maximum level of reimbursement.