

# One Diagnosis and Modifier -25: Appropriate or Audit Target?

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## PRACTICE POINTS

- Modifier -25 use is appropriate and critical for high-quality, efficient dermatology care.
- Correct use and documentation can help avoid loss of audits associated with modifier -25.

An established patient comes into your office with a painful new lesion on the hand. He thinks it may be a wart. You take a focused history of the lesion, do a physical examination, and confirm the diagnosis of verruca vulgaris. You discuss treatment options, risks, and the benefits of treatment, as well as the pathophysiology of warts. The decision is made to proceed that same day with cryosurgical destruction, which is performed. You feel that billing both an office visit with an appended modifier -25 and the benign destruction code 17110 is warranted, but your biller says only the procedure should be reported. Who is correct?

Modifier -25 use has come under increased scrutiny by insurers and regulators. There is a perception that this modifier is frequently used inappropriately or unnecessarily. In fact, the Office of Inspector General reported that 35% of claims using modifier -25 that Medicare allowed did not meet the requirements. The Office of Inspector General has recommended that the “[Centers for Medicare & Medicaid Services] should work with carriers to reduce the number of claims submitted using modifier -25” and “include modifier -25 reviews in their medical review strategies.”<sup>1</sup> Translation: More chart reviews and audits! In my discussions with insurer medical directors, they point to the single diagnosis modifier -25 as likely abused and feel that its use in this context is almost never

appropriate. Their audits have been focused on this aspect of dermatologists’ coding. In addition, some private insurers have started to discount reimbursement for office visits billed with modifier -25 by 50% to account for the level of perceived overuse.<sup>2</sup>

The *Current Procedural Terminology* description of modifier -25 is relatively clear: Modifier -25 is used to facilitate billing of evaluation and management (E/M) services on the day of a procedure for which separate payment may be made.<sup>3</sup> This modifier indicates that a significant, separately identifiable E/M service was performed by the same physician on the day of a procedure. To appropriately bill both the E/M service and the procedure, the physician must indicate that the patient’s condition required an E/M service “above and beyond the usual pre- and post-operative work of a procedure.”<sup>4</sup> However, it is largely left up to the physician to decide what constitutes the significant, separately identifiable E/M service.

As dermatologists, we all report modifier -25 appropriately as part of our daily practice. Performance of a medically necessary procedure on the same day as an E/M service generally is done to facilitate a prompt diagnosis or streamline treatment of a complex condition. Providing distinct medically necessary services on the same date allows physicians to provide effective and efficient high-quality care, in many cases saving patients a return visit. The most common scenario for using modifier -25 involves multiple concerns and multiple diagnoses, some of which are not associated with a procedure(s) that is performed on the same date of service. With multiple diagnoses, it is straightforward

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to demonstrate the separate E/M service associated with the nonprocedure-related diagnosis code(s); however, with one diagnosis for both the office visit and the procedure, clear documentation of the separate and identifiable E/M service is critical and is dependent on understanding what is included in the global surgical package.

Insurer payment for procedures includes local or topical anesthesia, the surgical service/procedure itself, immediate postoperative care including dictating the operative note, meeting/discussing the patient's procedure with family and other physicians, evaluating the patient in postanesthesia/recovery area, and writing orders for the patient. This group of services is called the global surgical package. For minor procedures (ie, those with either 0- or 10-day global periods), the surgical package also includes same-day E/M associated with the decision to perform surgery. An appropriate history and physical examination, as well as the discussion of differential diagnosis, treatment options, and risk and benefits of treatments, are all included in the payment of a minor procedure itself. Therefore, if an E/M service is performed on the same day as a minor procedure to decide whether to proceed with the minor surgical procedure, this E/M service cannot be separately reported. Moreover, the fact that the patient is new to the physician is not sufficient to allow reporting of an E/M service with such a minor procedure. For major procedures (ie, those with 90-day postoperative periods), the decision for surgery is excluded from the global surgical package.

Therefore, it is clear that the clinical scenario for verruca vulgaris treatment as described at the start of this article does not meet criteria for an office visit billed in addition to the destruction. The E/M services performed prior to the patient's verruca vulgaris treatment are integral to and necessary for the decision to perform the procedure. Making and confirming the diagnosis of a condition or lesion prior to a procedure either by physical evaluation or by interpretation of a pathology report is part of the evaluation required to make the decision to proceed with a particular procedure.

There are clinical scenarios in which a physician can support additional E/M services beyond that of the procedure with just one diagnosis. If a patient presents with warts on the hand and face with resultant cryosurgical destruction done on the hand and a prescription for imiquimod to be used on the face to induce immunologic clearance of viral infection and decrease the risk of scarring, it is clear that a significant and separately identifiable E/M service exists. The evaluation of the facial warts and the prescription of medication and discussion of

the risks, benefits, and therapeutic effects of that prescription is definitely distinct from the procedure. Similarly, if an evaluation of a patient with a rash results in only a diagnostic biopsy with no separate cognitive services other than the decision to perform the biopsy, an office visit charge in addition to the biopsy charge would not be warranted. However, if in addition to the biopsy the rash also is treated with topical or systemic steroids because of pruritus or a more extensive evaluation for systemic complications is required, an office visit charge is appropriate.

The frequent use of modifier -25 is a critical part of a high-quality and cost-effective dermatology practice. Same-day performance of E/M services and minor procedures allows for more rapid and efficient diagnosis and treatment of various conditions as well as minimizing unnecessary office visits. However, modifier -25 use, particularly in the context of the same diagnosis for the office visit and the procedure, is under intense insurer scrutiny. Careful and complete documentation of the additional E/M service provided, including the additional history, physical examination results, and treatment considerations above and beyond those typically required by the minor procedure, will reduce the likelihood of re-terminations from reviews and audits. Understanding Medicare guidelines and National Correct Coding Initiative recommendations will help keep the dermatologist out of hot water.<sup>5</sup>

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