

E&M with a minor procedure

Does your documentation support the use of modifier -25 when a minor procedure is performed on the same day? Neither Medicare nor the American Medical Association has clearly identified what a “significant, separately identifiable” E&M service looks like. What we do know is this – Medicare says:

“Modifier -25 is used to facilitate billing of evaluation and management services on the day of a procedure for which separate payment may be made. It is used to report a significant, separately identifiable evaluation and management service by same physician on the day of a procedure. The physician may need to indicate that on the day a procedure or service that is identified with a *CPT* code was performed, the patient’s condition required a significant, separately identifiable evaluation and management service **above and beyond the usual preoperative and postoperative care** associated with the procedure or service that was performed. This circumstance may be reported by adding the modifier -25 to the appropriate level of evaluation and management service.”

Medicare Claim Processing Manual Chapter 12 §40.2 H

“Evaluation and management services on the day before major surgery or on the day of major surgery that result in the initial decision to perform the surgery are not included in the global surgery payment for the major surgery and, therefore, may be billed and paid separately.

In addition to the CPT evaluation and management code, modifier -57 (decision for surgery) is used to identify a visit which results in the initial decision to perform surgery.

If evaluation and management services occur on the day of surgery, the physician bills using modifier -57, not -25. The -57 modifier is not used with minor surgeries because the global period for minor surgeries does not include the day prior to the surgery. Moreover, where the decision to perform the minor procedure is typically done immediately before the service, it is considered a routine preoperative service and a visit or consultation is not billed in addition to the procedure.”

Medicare Claim Processing Manual Chapter 12 §40.2 D

“Visits by the same physician on the same day as a minor surgery or endoscopy are included in the payment for the procedure, unless a significant, separately identifiable service is also performed. For example, a visit on the same day could be properly billed in addition to suturing a scalp wound if a full neurological examination is made for a patient with head trauma. Billing for a visit would not be appropriate if the physician only identified the need for sutures and confirmed allergy and immunization status.”

Medicare Claims Processing Manual Chapter 12 §40.1 C.

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“If a procedure has a global period of 000 or 010 days, it is defined as a minor surgical 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 does contain some edits based on these principles, but the Medicare Carriers (A/B MACs processing practitioner service claims) have separate edits. Neither the NCCI nor Carriers (A/B MACs processing practitioner service claims) have all possible edits based on these principles.

Example: If a physician determines that a new patient with head trauma requires sutures, confirms the allergy and immunization status, obtains informed consent, and performs the repair, an E&M service is not separately reportable. However, if the physician also performs a medically reasonable and necessary full neurological examination, an E&M service may be separately reportable."

National Correct Coding Initiative Policy Manual, Chapter 1

Does your documentation clearly identify an E&M service “above and beyond” the typical pre-op and post-op work done with a minor procedure? If the OIG, CERT or RAC auditors looked at the last three months of your claims for minor procedures, were they all billed with an E&M code and modifier -25? If so, that work is typical. Could an auditor find in the documentation where you did something more for this patient over and above what you normally do? If so, you can feel confident billing the E&M with modifier -25 in addition to the procedure. If not, think twice before billing the E&M.