Coding Conundrum: E/M with a Procedure

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The urgent care practitioner may not live by coding alone, but proper reimbursement depends on it. To that end, Dr. David Stern, a certified coder who is in great demand as a speaker and consultant on coding in urgent care, will offer answers to commonly asked questions in every issue of *JUCM*.

In this issue: proper coding for evaluation and management (E/M) in addition to other procedures.

Q. We always get denials for the E/M code in addition to a procedure. Are we doing something wrong?

A. Denials for payment for an E/M in addition to a procedure may stem from several sources:

- *Missing modifier*
  If you perform a procedure with a 0- or 10-day global period and you perform and document a separate E/M on the same day, always attach modifier -25 to the E/M to reduce denials and costs of rebilling. Use modifier -57 for an E/M performed on the same day as a procedure with a 90-day global period.
- *Payor policy*
  Some payors routinely deny payment for an E/M in addition to certain (rarely all) procedures.
- *Bundling issues*
  Generally, procedure codes include a basic level of evaluation of management within the procedure code. In the urgent care setting, however, bundling the E/M into the procedure code is frequently not appropriate.
- *Lack of supporting documentation*
  Some payors automatically deny an E/M in addition to a procedure, or at least in addition to a certain procedure. For example, some payors deny payment for an E/M when billed in a claim along with a code for ear wax removal. Even in these cases, however, payment might be obtained by submitting proper documentation.

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Q. What urgent care procedures require modifier -25?

A. In general, all procedures with a 10-day global period (and many others with a 0-day global period) should have modifier -25 attached to the E/M code.

Q. When is modifier -25 used?

A. Per the AMA definition, modifier -25 should be used when a "significant, separately identifiable E/M service above and beyond the other service provided or beyond the usual preoperative and postoperative care associated with the procedure that was performed" is required. The interpretation of this rule is sometimes difficult and there are a few gray areas where not all coders or payors agree. For example:

Patients who are new to a practice The initial E/M (99201-99205) for a new patient who also has a minor procedure (0- to 10-day global period) performed on the same day should not require the -25 modifier on the E/M code. This makes sense, as the patient is not known to the provider and all of the baseline history, medications and basic health status must be determined prior to doing the "usual preoperative care."

New problems that require significant evaluation beyond the procedure For example, a patient may present with knee pain. After evaluation of the knee, the physician determines that the problem may be gout or infectious arthritis, and that it is necessary to aspirate the joint and send the fluid to the lab for analysis to help confirm the diagnosis. Code with the E/M with modifier (for example, 99213-25) and 20610 for the knee joint aspiration. Thus, a new problem that requires more than a cursory review also, generally, qualifies for an E/M with modifier -25.

"Established patients" with additional medical problems

Patients undergoing a procedure that is made more complicated because of an underlying medical problem should have that problem evaluated and managed appropriately. Take, for example, a patient who presents with an abscess and who also suffers from AIDS, diabetes, valvular heart disease, or elevated blood pressure. In this case, the physician should document evaluation and management of both the problem that is addressed by the procedure and the E/M of the complicating problem. An E/M with modifier -25 is always appropriate in addition to the code for the procedure.

"Established patients" with a second medical problem that requires attention An E/M is always appropriate for patients receiving evaluation and management services for diagnoses in addition to the problem necessitating the procedure. For example, a patient may present with a laceration, but in the course of evaluation and management the physician determines that the patient has also been suffering from chronic diarrhea. The physician begins the work-up by ordering collection of a stool specimen for culture and microscopic examination for ova and parasites. The laceration code and the E/M code with modifier -25 should be used.

"Established patients" seen in the urgent care setting A typical urgent care center is quite different from a typical physician office. In the urgent care center, very few patients are truly established with the provider who is providing the services. Essentially, these are new patients who truly need a thorough history and physical prior to the initiation of the usual preoperative care. Thus, in the urgent care center a full history and physical are almost always required to evaluate the past medical history, medications, and current symptoms prior to initiating the usual preoperative care that would be provided to a patient who was truly established and, thus, well known to the provider.

It is one thing for Dr. Welby to walk in the room and say, "Oh, Johnny, so you cut your finger again. You need to be more careful with your whittling knife. Don't worry, we'll sew that up in a jiffy. Since you don't have any other problems except for that heart murmur, you should do great."

It is another matter entirely for Dr. Urgentowitz to see the same patient, and inquire about diabetes, history of infections, the relevance of the heart murmur, and the patient's experience with previous injuries. Then the urgent care doctor examines the patient's skin, eyes, heart, lungs, and peripheral vasculature to evaluate the status of any known conditions and to see if there are any additional underlying or complicating medical conditions.

Generally, a separate E/M is appropriate for patients seen in the urgent care center. Of course, if the urgent care physician also functions as the primary care provider for the patient, the patient is truly *established* with the practice and an additional E/M is often not appropriate.

Q. Must I have a separate diagnosis to code modifier -25?

A. One myth that seems to have a life of its own is that the patient must have a "significant separately identifiable" problem that is managed on this visit. But the AMA definition of modifier -25 clearly states:

"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 services on the same date."

The problem and confusion arises, however, when overzealous payors (in direct contradiction of AMA guidelines) require physicians to treat a second condition before they will consider payment for an E/M with modifier -25. It is the E/M note, not a second presenting problem, which must be "significant and separately identifiable." Nonetheless, several large payors continue to apply the tightfisted requirement that the physician must supply both documentation of a second diagnosis and medical records supporting separate E/M services for that second diagnosis.

Q. Will attaching modifier -25 to an E/M where the modifier was not required trigger a denial?

A. No, payors almost never deny payment for attaching modifier -25 to an E/M code where the modifier was not required. Be careful to use modifier -25 only when a procedure is performed, as overuse of the modifier may trigger a payor audit.

Q. I was audited and the carrier denied payment because of inadequate documentation. Do I simply need a longer visit note?

A. It is not the length, but the content of the visit record that is important. In order to support both an E/M code and a procedure code, the patient record must contain documentation of the level of *evaluation and management AND a significant, separately identifiable procedure note*. It is best to not include the procedure note within the evaluation and management note, as some auditors will deny the code because the procedure note was not "separately identifiable" from the evaluation and management documented in the patient record. Some coders go so far as to recommend a separate page, template, or dictation for each E/M and each procedure note.■