Reduction in Reimbursements for Modifier -25

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Q. Last fall, Anthem Blue Cross Blue Shield sent a notice to physicians in several states regarding their intent to reduce reimbursement rates on any evaluation and management (E/M) services billed with modifier -25, "significant, separately identifiable E/M," by 50% effective January 1, 2018. What are the implications for urgent care?

A. This announcement initially spurred action from the California Medical Association (CMA) to coordinate with the American Medical Association (AMA), as well as other state medical and dermatology societies, to squelch the effort. Based on that feedback, Anthem then stated in early January 2018 that they would reduce the reimbursement by only 25% effective March 1, 2018. However, after more pushback from the CMA, AMA, and numerous other physician groups, Anthem rescinded its decision entirely and will not cut the reimbursement rate at this time.

Anthem Blue Cross Blue Shield previously sent letters to California providers warning them that they were closely monitoring these types of claims for possible overpayments. According to the March 9, 2018, issue of *Part B News,* Anthem says they are still "confident that duplication of payment for fixed/indirect practice expenses exists when physicians bill an E/M service appended with modifier -25 along with a minor surgical procedure performed the same day," so look for future efforts from the payer on this front. With reimbursement rates topping $2.5 billion in 2015 according to a *Part B News* analysis of Medicare claims data, it's no surprise that these types of claims are a target for rate adjustment.

In order to protect your reimbursement for services performed and billed with an E/M code with modifier -25, you need to make sure you are documenting E/M services separately from the services included with the procedure. This could be a separate page, template, or dictation for each E/M and each procedure note.

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These are some situations in which modifier -25 would be appropriately billed with the E/M service:

- When an E/M and a procedure are billed together and the diagnoses for each is the same.
  - Example: A patient comes into the urgent care center with an injured right hand, including an open wound. The provider is not familiar with the patient's history, so they perform a full history. This should include potential issues that may indicate the risk of complications such as a history of diabetes, heart valve issues, medications such as immunosuppressant and/or anticoagulant medications, history of frequent infections, etc. The provider also may perform a full physical exam to evaluate for any indications of chronic conditions that could be unknown to the patient, the status of any of these conditions, and the ability of the patient to comply with instructions. Before repairing the laceration, the provider examines the hand, checks its mobility, and determines whether the wound has impacted any deeper structures such as tendons, joint capsules, or blood vessels, discusses the repair and potential complications with the patient, and then repairs the wound with sutures.

    For this example, the provider billed a level 3 E/M service, or 99213, with a diagnosis of S61.411A, "Laceration without foreign body of right hand, initial en-

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counter." The repair to the hand was 3.0 cm, so the provider also billed Current Procedural Terminology (CPT) code 12002, "Simple repair of superficial wounds of scalp, neck, external genitalia, trunk and/or extremities (including hands and feet); 2.6 cm to 7.5 cm" with the same diagnosis code. Because the provider did significant work before he started the actual procedure, an office visit may be billed along with the procedure. Modifier -25 would be appended to the E/M service code 99213.

- E/M and a procedure billed together with a different diagnosis for each:
  - Example: A patient is scheduled to see the provider in the urgent care center for a follow-up on a single laceration repair. The repair was simple, so there was no global period. The visit is documented and billed with the appropriate level of service for the E/M with modifier -25 appended and linked to the diagnosis code for the laceration. While the patient is talking with the provider, he complains of severe wax build-up in his ears. A separate assessment confirms there is impacted wax in the right ear, so the provider would document the findings and service on a separate page or template and bill CPT code 69210, "Removal impacted cerumen requiring instrumentation, unilateral" with modifier –RT to indicate the service was performed on the right ear and use diagnosis code H61.21,"Impacted cerumen of right ear." ■

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