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Coding

Use 4 documentation points to square away modifier 25 troubles

Your practice can receive separate payment for an E/M visit on the same day as a minor procedure by using modifier **25** (Significant, separately identifiable evaluation and management service by the same physician or other qualified health care professional on the same day of the procedure or other service).

However, the modifier is also the subject of intense scrutiny because it is associated with abusive and fraudulent billing practices. Some private payers have proposed strict policies, such as automatic prepay review, for claims with modifier 25 (*PBN 5/1/23*).

During the webinar "Reduce Physician E/M Denials with Compliant Modifier 25 Reporting," Betty A. Hovey, BSHAM, CCS-P, CDIP, CPC, COC, CPMA, CPCD, CPB, CPC-I, owner, Compliant Health Care Solutions, shared documentation points and scenarios that will help coders use modifier 25 with confidence while avoiding improper payments. Her guidance will also help providers make sure their documentation stands up to a review if a payer requests documentation or denies a claim.

Incorporate 4 documentation points

Hovey shared the following documentation points that will bolster modifier 25.

1. **Highlight the separate E/M visit.** For example, the patient might bring up a new complaint during the visit for a minor procedure, which is known as the "oh by the way" visit, Hovey said. A change in the condition that is being treated could also prompt a separate E/M visit.

For example, the patient has been coming in for steroid injections for joint pain and says it seems to be aggravated or getting worse. As a result, the provider has to reconsider their treatment plan and perhaps consider more diagnostic tests or other additional work. "Now you are showing that there is medical necessity to do a separate E/M service," Hovey explained

2. **Clearly document the clinical rationale for the minor procedure and the E/M visit.** Make sure the documentation for the procedure doesn't overshadow the E/M visit, Hovey warns. The documentation needs to state the reason for the E/M visit, especially when the diagnosis for the minor procedure and the E/M visit are the same. For example, consider a scenario when the patient has actinic keratosis (AK) and the provider is treating some with cryotherapy and some with medication. "Make sure that you're saying, 'Well, I did this minor procedure, but since the patient still had other AKs in other areas of the body and I'm treating those with a medication, not with cryotherapy, so we have this separate E/M here,'" Hovey said.

3. **Spell out the history of present illness (HPI).** You no longer use history to select the level for an E/M visit, but it is still an important part of the documentation, especially if the provider wants reimbursement for an E/M visit on the same day as a minor procedure. "The HPI is something that when I audit I still see that you can't tell from the HPI whether the patient presented for the minor or procedure or evaluation of the condition," Hovey said. If the chief complaint states "patient here for injection" or "patient here for biopsy," without additional information about the E/M visit, the documentation won't support the use of modifier 25. "Because at the beginning of the note you flat out are saying that the patient is presenting for a minor procedure, which means it was pre-planned," Hovey said.

4. **Separate the procedure note and the E/M documentation.** Hovey often sees charts that bury the note for the procedure in the middle of the documentation for the E/M visit. A busy auditor might miss the procedure and deny payment for the service. "What I instruct my clients to do is do your E/M, do your assessment and plan and underneath it have your minor procedure note there, for whatever that minor procedure is, so that it is clearly separated from your E/M service," Hovey advised. Another benefit of a clear division between the procedure and the E/M visit is the documentation will be clear if you need to appeal a denial. "You want to make it very easy for the payer to see that those are separately identifiable services," she said.

Use scenarios to assist coding

Hovey reviewed a few scenarios that illustrate when you should, and should not, separate a minor procedure from an E/M visit with modifier 25. Here are two scenarios she shared.

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Scenario 1. A 19-year-old female is following up for verruca vulgaris on the left elbow. The patient says the verruca is painful and presents for further evaluation and management of the wart and a lesion on her cheek, which is also painful.

The exam revealed an inflamed epidermoid cyst (**L72.0**) on the left medial malar cheek in addition to verrucous papules with thrombosed capillary loops distributed on the left elbow (**B07.8**). The provider recommended excision of the cyst, but the patient declined and will schedule a follow-up visit because she did not have time for the procedure during that visit. The provider also treated the wart with cryotherapy using liquid nitrogen.

"So that had a separate evaluation, it had a separate examination, and it had a separate plan here for a procedure to be performed at the next visit," Hovey explained.

The provider reported **99213**-25 and **17110** (Destruction [eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement] of benign lesions other than skin tags or cutaneous vascular proliferative lesions; up to 14 lesions).

"In this case it is two separate diagnoses, and so it's clearly significant and separately identifiable," Hovey explained.

Scenario 2. The patient is a 74-year-old man who presents today for evaluation of his right index and long finger metacarpophalangeal (MCP) joints. The treating provider has performed cortisone injections for the patient's condition for a few years. During the visit the provider decides to perform injections for each finger.

The physician performed joint injections on two fingers and reported 99213-25, and the injections with **20600** (Arthrocentesis, aspiration and/or injection, small joint or bursa [eg, fingers, toes]; without ultrasound guidance) with modifiers **F6** (Right hand, second digit) and **F7** (Right hand, third digit), and the appropriate code for the drug.

However, the documentation for the encounter does not support a separate E/M visit, Hovey warned. According to National Correct Coding Initiative (NCCI) guidelines, the decision to perform the minor procedure is still bundled into doing the procedure. "Even though the patient didn't present for the injection, the evaluation was of those two fingers, it wasn't of anything else. So in this case it does not support the E/M being separately reported," she explained.

Share the full descriptor

A final tip that can prevent modifier 25 confusion is to make sure staff are familiar with the full descriptor because it summarizes the requirements for the code: "Significant, separately identifiable evaluation and management service by the same physician or other qualified health care professional on the same day of the procedure or other service: It may be necessary to indicate that on the day a procedure or service identified by a CPT code was performed, the patient's condition required a significant, separately identifiable E/M service above and beyond the other service provided or be beyond the usual preoperative and postoperative care associated with the procedure that was performed. A significant, separately identifiable E/M service is defined or substantiated by documentation that satisfies the relevant criteria for the respective E/M service to be reported (see Evaluation and Management Services Guidelines for instructions on determining level of E/M service). 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. This circumstance may be reported by adding modifier 25 to the appropriate level of E/M service. Note: This modifier is not used to report an E/M service that resulted in a decision to perform major surgery. See modifier **57.** For significant, separately identifiable non-E/M services, see modifier **59.**" — *Julia Kyles, CPC* (julia.kyles@decisionhealth.com) ■

Compliance

Will Fla. ruling mean the end of *qui tam*? Not right away

A federal judge has declared the *qui tam* (whistleblower) provisions of the False Claims Act (FCA) unconstitutional. This ruling has the potential to end the incentives that drive most FCA prosecutions, including those in health care. Experts have mixed opinions as to how this ruling will play out in higher courts, but even before it's retried it may affect how such cases are brought and defended.

In the United States District Court for the Middle District of Florida, Judge Kathryn Kimball Mizelle issued a ruling on Sept. 30, 2024, that not only threw out the whistleblower case United States of America ex rel. Clarissa Zafirov v. Florida Medical Associates LLC but also created implications for all other such cases.

Zafirov, a former employee of Florida Medical Associates, had brought a case against her old company as a whistleblower, claiming misrepresentations of patients' medical conditions to Medicare she had allegedly witnessed. The Department of Justice considered but decided against intervening in her suit; Zafirov kept up the action as a relator on behalf of the government, also rolling up other defendants, as the FCA allows.

Mizelle, a Trump appointee and member of the conservative Federalist Society, noted in her ruling that Zafirov has alleged no injury to herself, and "instead, like a United States Attorney, Zafirov proceeds on behalf of the 'real party of interest in this case,' the 'United States of America.'" The problem, Mizelle says, is that Zafirov is not an officer of the United States, but a private citizen; in Mizelle's reading of the Appointments Clause of the U.S. Constitution, only officers of the United States may pursue actions on its behalf.

"Because Zafirov is not constitutionally appointed," Mizelle rules, "dismissal is the only permissible remedy."

How the ruling affects future cases

While this ruling by itself does not invalidate the FCA or its related amendments, it is now relevant precedent within its own circuit, in the case of the Middle District of Florida, the Eleventh Circuit. Experts say this invites defendants in other cases to cite the ruling, or at least try the argument, which may eventually lead to contrary rulings and a "circuit split," and invite appeals and petitions for the intervention of the U.S. Supreme Court.

Khaled J. Klele, a health care attorney and partner with McCarter & English in Newark, N.J., notes that two other Circuit Courts, the Fifth and Tenth Circuits, previously addressed this issue "and both Circuits came to the opposition conclusion to the District Court's decision; if the Eleventh Circuit affirms the Middle District of Florida's decision, then that will create a split with the Fifth and Tenth Circuits."

"Even the fact that this ruling is out there, that this discussion has been reinvigorated and people are actually giving it serious thought suggests it's something that could run all the way up the ladder," says Paul Werner of the Buttaci, Leardi and Werner law firm in Princeton, N.J. "The more this issue gets raised, the more likely it is that we're going to see a circuit split and the Supreme Court can be swayed to intervene."

Werner notes that Mizelle cited a dissent by SCOTUS Justice Clarence Thomas in the 2023 *qui tam* case Polansky, another relator-only case (*PBN 6/26/23*). Thomas said then that "the *qui tam* device is inconsistent with Article II and … private relators may not represent the interests of the United States in litigation." Two other Justices, Amy Coney Barrett and Brett Kavanaugh, expressed sympathy with Thomas' opinion.

"That means we only need one more justice on the Supreme Court to subscribe to that position to grant certiorari if someone were to raise the issue," Werner says.

What if SCOTUS agrees?

Qui tam is the engine of an overwhelming number of FCA prosecutions. Mizelle cites a source that says "DOJ [the U.S. Department of Justice] used to receive about six *qui tam* cases a year" before the 1986 amendments to FCA that expanded the use of relators, leading to the hundreds of such cases now seen every year, including relator-only cases like Zafirov.

Thomas Barnard, a former Assistant United States Attorney (AUSA) and now a shareholder with Baker Donelson in Baltimore, reflects: "I don't know if, when they drafted this statute, [Congress] ever envisioned it would become as common as it is for the relator to kind of go it alone and essentially turn it into a plaintiff's case."

If SCOTUS gets the case, based on previous decisions, Jason N. Silberberg, a partner in Frier Levitt's health care litigation section and co-chair of the firm's value-based care litigation group, thinks Mizelle's interpretation has a fair chance of success. He cites Loper Bright, the decision that killed Chevron deference, and Jarkesy, which put limits on the Securities and Exchange Commission's own whistleblower program, as examples of SCOTUS decisions that "arguably were

(continued on p. 6)

Benchmark of the week

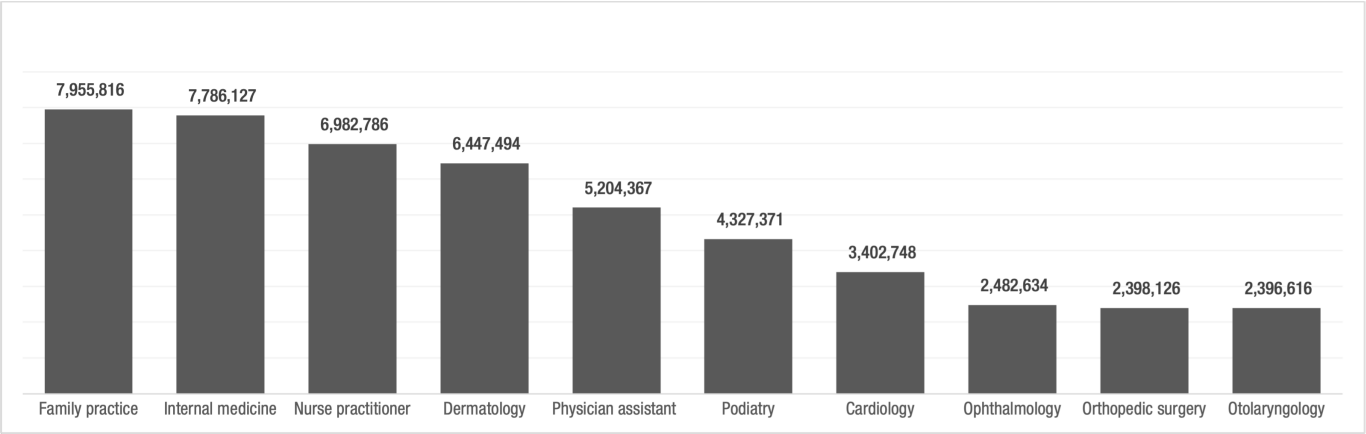
Modifier 25, highly used, tops $4B in associated payments

Modifier **25** (Significant, separately identifiable evaluation and management service by the same physician or other qualified health care professional on the same day of the procedure or other service) continues to see high utilization. Providers reported it on more than 65 million claims in 2023.

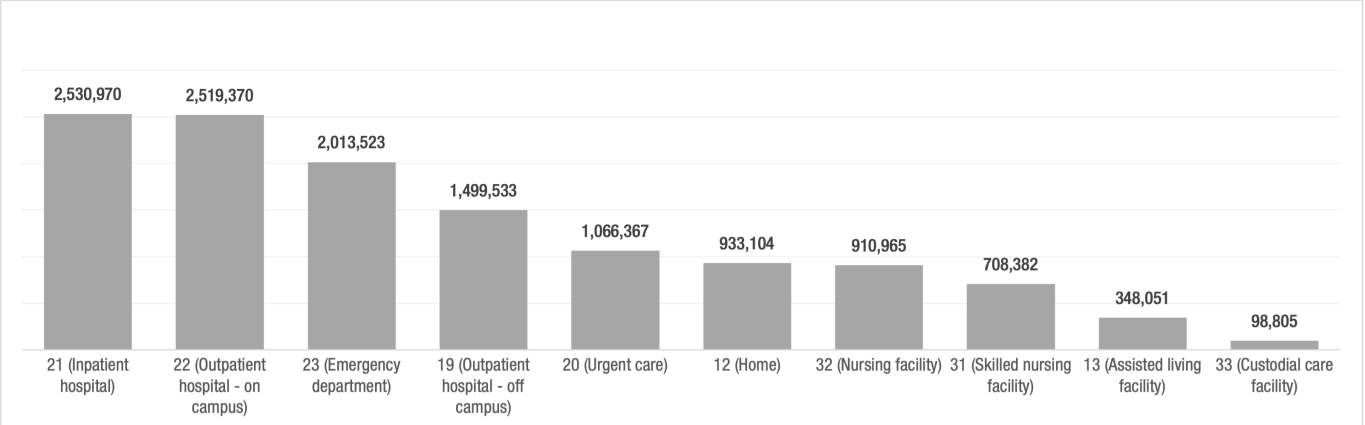
That high rate of utilization made it the third most reported CPT modifier in 2023, according to the latest available Medicare Part B claims data. It was also associated with more than $4 billion in reimbursement, which made it the top the CPT modifier for payments. A closer look at the data shows a wide range of providers working in a variety of settings contributed to these numbers.

The first chart below shows the top 10 provider specialties based on the number of claims with modifier 25. The next chart shows the top 10 settings where the separately identifiable E/M visits were performed, excluding place of service 11 (Office), which was the site of nearly 50 million claims in 2023. — *Julia Kyles, CPC* (julia.kyles@decisionhealth.com)

Modifier 25 – top 10 specialties, 2023



Modifier 25 – top 10 settings, excluding office, 2023



Source: Part B News *analysis of 2023 Medicare claims data and Physician/Supplier Procedure Summary: https://data.cms.gov/summary-statistics-on-use-and-payments/physiciansupplier-procedure-summary/data*

(continued from p. 4)

designed to protect the independence of Article III Courts from administrative [or] legislative overreach" (*PBN 8/5/24*).

"If we follow the clear trend hewn by the Court in its last session through the matters," Silberberg says, "it is not a leap to think SCOTUS may take similar steps to protect the independence of the executive. And, indeed, this was at least one of the reasons SCOTUS ruled as it did last term in the U.S. v. Trump matter — protection of Article II independence and the separation of powers more broadly."

If this ruling is upheld by SCOTUS, should you expect the FCA numbers to go back to single digits?

Silberberg thinks the result would likely be "the FCA becoming like any other civil or criminal statutory tool the government could leverage to go after fraud waste, and abuse claims involving federal dollars. As the Zafirov opinion itself implied, without the veritable army of private relators ready and willing to file suits on the government's behalf, the number of FCA suits filed per year would plummet precipitously — as would all of the government revenue these relator-initiated suits bring with it."

But Barnard says the fact that Zafirov is based on a relator-only case should reduce the fallout of such a decision.

"I think as long as the whistleblower is acting as a whistleblower, bringing the information to the government, and the government remains in charge, constitutionally they're safe," Barnard says. "The moment they're actually acting as the government, especially protecting the government's interest in court, [that changes]. There's a reason why the government doesn't farm out legal work — you act as an officer of the United States. And that's why I think the relator-only cases are the ones that present the challenge."

It's possible that DOJ would redirect some of its energies to other fraud programs, such as the current pilot program that seeks leads on frauds that may be prosecuted on non-FCA grounds (PBN 8/26/24).

What to watch in the short run

But for now, Zafirov is mostly an ominous shadow. "I believe the DOJ will continue business as usual and will closely watch this case," Klele says. "The FCA has been an effective tool for them and, so, I do not think it will change its behavior in light of one ruling."

Silberberg thinks, however, that if DOJ sees "a clear and present danger to the FCA's *qui tam* provisions as a result, they may try and file and prosecute as many cases as possible between now and whenever Zafirov or a case like it gets to SCOTUS — under the theory that even if those provisions are stricken, the Court would not nullify already-filed cases, due to a presumption against retroactive effect of judicial decisions."

Barnard thinks the government is going to be "sensitive" to the threat, and perhaps make small adjustments in how they handle these cases.

"There are some things you can do in the government to not drop all the way out of the case," Barnard says. "In other words, we might see more non-intervention notices, for example, so they're not formally out of the case. And they may put more effort into negotiating with the relator if they're thinking of declining a case."

In the last ditch, Barnard says, "if there are a more rulings like this in other districts, there's a good chance that someone will take this to the Senate to fix it — because it involves protecting government money." — *Roy Edroso (roy.edroso@decisionhealth.com)* ■

Ask Part B News

Home BP readings for 'white coat hypertension'? OK, but probably not RPM.

Question: *I have a patient who claims "white coat hypertension" — that is, he says his home blood pressure readings are significantly lower than the ones we get in the office. He has a home BP device, a Pressure X Pro, that connects to the internet. Can I take a reading via this device? And, in addition to adding it compliantly to encounter notes, can I claim* ***99091*** *(Collection and interpretation of physiologic data [eg, ECG, blood pressure, glucose monitoring])?*

Answer: Providers frequently note home blood pressure readings that the patient self-reports, though they are labeled as such and the provider may also take a reading of their own, white coat hypertension (HTN) or no.

It's also true that CMS has been pushing the use of remote physiologic monitoring codes such as 99091, as well as **99453** (Remote monitoring of physiologic parameter[s] … initial; set-up and patient education on use of equipment) and **99454** (Remote monitoring of physiologic parameter[s] … initial; device[s] supply with daily recording[s] or programmed alert[s] transmission, each 30 days), which specifically mention blood pressure. And essential hypertension is the overwhelming diagnosis cited for it (*PBN 10/7/24*).

But Rajeev Mudumba, CEO of Cooey Health, an AI-enabled care management platform company in Sunnyvale, Calif., notes that while "under normal circumstances, vitals like blood pressure can qualify for RPM if they meet the specific billing requirements … there are nuances that could pose denial risks."

White coat HTN is an observed phenomenon and has actually been cited in some national coverage determinations (NCD), such as the one for ambulatory blood pressure monitoring. In that case, the measurement is required to be done on a 24-hour basis (*PBN 7/27/10*). Mudumba says suspected white coat HTN "could support RPM if it's clinically warranted for diagnosing or managing the condition."

But, Mudumba adds, "if the only justification is patient preference — i.e., avoiding in-office readings due to anxiety, rather than a need for clinical management — it could be seen as lacking medical necessity, which poses a denial risk when billing RPM codes. Medicare and insurers typically require RPM to be medically necessary for the management of chronic conditions or ongoing care, not solely for convenience or preference."

For this reason, the provider notes should cover the medical necessity for the remote monitoring. "If the data collected doesn't influence treatment decisions or isn't necessary for ongoing clinical management," Mudumba says, "the claim could be denied."

Have a question? Ask PBN

Do you have a conundrum, a challenge or a question you can't find a clear-cut answer for? Send your query to the *Part B News* editorial team, and we'll get to work for you. Email *askpbn@decisionhealth.com* with your coding, compliance, billing, legal or other hard-to-crack questions and we'll provide an answer. Plus, your Q&A may appear in the pages of the publication.

Also, billing 99091 requires the device be FDA-approved, and that the provider spend at least 30 minutes within the month reviewing and interpreting the collected data. Most significantly, the RPM codes are generally intended for chronic or long-term conditions. If there's no evidence for that, you claim could be kicked out. — *Roy Edroso* (*roy.edroso@decisionhealth.com*) ■

RESOURCE

- CMS, national coverage analysis and determination, ambulatory blood pressure monitoring ABPM), July 2, 2019: *www.cms.gov/medicare-coverage-database/view/ncacal-decision-memo.aspx?proposed=N&NCAId=294*

Ask Part B News

When coding eating disorders, start with initial visit, include all services

Editor's note: *This question was answered by Shelley C. Safian, PhD, MAOM, RHIA, CCS-P, CPC-I, an AHIMA-approved ICD-10-CM/PCS trainer and president of Safian Communications Services Inc., during the JustCoding webinar, 2025 ICD-10-CM Coding for Eating Disorders.*

Question: *What codes should a coder consider for a patient diagnosed with an eating disorder (e.g., anorexia nervosa, bulimia nervosa, and avoidant/restrictive food intake disorder)?*

Answer: Logically, due to the fact that all of these diagnoses are identified as psychiatric diagnoses, the first thing to look at is referring this patient to a psychiatrist. And the type of therapy is cognitive behavioral therapy, which is not just talk therapy but connecting thoughts to behaviors.

CPT code **90792** could be used to document that first visit psychiatric diagnostic evaluation with medical services. You should include the medical services as this patient may be in a clinic, for example. Remember, patients with an eating disorder may have medical issues, such as heart rhythm problems, dehydration, electrolyte imbalances and malnutrition. Eating is a way to nourish, to give the body energy. When that is askew, it is very logical that physical and physiological systems are going to be negatively impacted. So those need to be addressed simultaneously with psychiatric support.

Then there's psychotherapy CPT code **90834** (Psychotherapy, 45 minutes with patient). A 45-minute session is the standard length for a cognitive behavioral therapy session. Of course, you can't just report this; the doctor has to document it. We need to understand by looking at the documentation why this patient is having this psychiatric diagnostic evaluation with medical services so we can identify the correct ICD-10-CM codes so that it all connects.

The number one purpose of physician documentation is continuity of care. But reimbursement is also important as you want to show a tracking of this patient's health. Especially in 2024 moving forward, we now have electronic health records which enable us to start creating longitudinal patient records, which means you start when the patient is born, and you have one patient record that goes with them throughout their life. The amount of information that's included in that is beyond beneficial to the patient. That's a very important underlying reason why it is so important that that we as medical coding professionals make certain that the codes we report are accurate to what is actually going on with this patient.

Then there's nutrition therapy: CPT code **97802** (Medical nutrition therapy; initial assessment and intervention, individual, face-to-face with the patient, each 15 minutes) and CPT code **97803** (Medical nutrition therapy; re-assessment and intervention, individual, face-to-face with the patient, each 15 minutes).

I also want to point out, in my experience, a third-party payer will balk at paying for nutrition therapy unless it is documented with a national provider identifier (NPI) of a certified nutritional therapist. It cannot just be the physician, the psychiatrist, or whomever is talking to the patient about what they're eating. For these two codes, this must be a certified nutritionist. — *Son Hoang* (*pbnfeedback@decisionhealth.com*) ■

Brief

HHS issues RFI for Part D '$2 drugs' on some widely-used prescriptions

Adding to its other pioneering prescription drug programs under Medicare, the Biden administration announced Oct. 9 that it would issue a request for information (RFI) on a potential "Medicare $2 Drug List Model" that would make some much-used drugs for hypertension, high cholesterol and other common conditions available to Part D beneficiaries for a couple of bucks.

The model would be administered by the Center for Medicare and Medicaid Innovation (CMMI) and would "standardize cost sharing for low-cost generics through a new, easy-to-understand option for people with Medicare Part D enrolled in a participating plan and their health care providers," CMMI says.

The 270 potential drugs (including various doses and formulations) listed by CMMI include anti-depressants escitalopram and bupropion; the antipsychotic lithium; blood pressure medications metoprolol, hydrochlorothiazide and amlodipine; antibiotics penicillin and amoxicillin; statins atorvastatin and simvastatin; the antifungal fluconazole; and the blood-thinner warfarin.

CMS and CMMI cite a mandate from President Biden's Oct. 14, 2022, Executive Order on prescription drug prices, which does not specify a $2.00 initiative, and HHS Secretary Xavier Becerra's Feb. 14, 2023, report, which calls for a "Medicare High-Value Drug List" pilot "allowing Part D Sponsors to offer a Medicare-defined standard set of approximately 150 high-value generic drugs with a maximum co-payment of $2 for a month's supply, applying across all phases of Part D coverage up to the out-of-pocket limit."

The program would be voluntary for Part D sponsors, CMS says, and "pending further development, could start as early as January 2027."

The RFI lists "primary areas of interest" that include: "Drug List Development Process" and "Maximizing Plan Participation," among others. Responses are due by Dec. 9, 2024. — *Roy Edroso* (*roy.edroso@decisionhealth.com*) ■

RESOURCES

- Press release: *www.cms.gov/newsroom/press-releases/biden-harris-administration-takes-next-step-proposed-model-lower-prescription-drug-costs-people*
- Request for information: *https://surveys.cms.gov/jfe/form/SV_40iDHQWMNuVfyGq*