

## PREVENTIVE VS. SICK VISIT: HOW AND WHEN TO USE MODIFIER 25!

One of the most requested topics during our recent coding seminar series, was the proper use of modifier 25 when a patient presents for both a well (or Preventive) visit and has other medical problems addressed at that same visit. This is one of the most common problem areas for coders in specialties such as, OB/Gyn, Internal Medicine, Family Practice and Pediatrics.

From a pure coding perspective, the guidelines for billing an E/M service in addition to a preventive service are spelled out under the Preventive Medicine Services section in the **CPT 2007** book. The guidelines state; **“If an abnormality/ies is encountered or a preexisting problem is addressed in the process of performing this preventive medicine evaluation and management service, and if the problem/abnormality is significant enough to require additional work to perform the key components of a problem-oriented E/M service, then the appropriate Office/Outpatient code 99201-99215 should also be reported. Modifier 25 should be added to the Office/Outpatient code to indicate that a significant, separately identifiable Evaluation and Management service was provided by the same physician on the same day as the preventive medicine service.”** The key to adding an E/M service to a preventive service is the significance of the problem, the amount of work required at that visit to deal with the problem, and how clearly this is documented in the patient chart.

Let us look for a moment at the key components for a problem-oriented E/M service; **History, Examination, and Medical decision-making.**

1. **History** can be Problem focused, Expanded problem focused, Detailed or Comprehensive. A paragraph in the **CPT 2007** book under the heading Determine the Extent of History Obtained states **“*The comprehensive history obtained as part of the preventive medicine E/M service is not problem-oriented and does not involve a chief complaint or present illness. It does, however, include a comprehensive system review and comprehensive or interval past, family, and social history as well as a comprehensive assessment/history of pertinent risk factors.*”** This is an important factor to keep in mind when looking at the level of history when choosing an additional E/M service code.
2. **Examination** can, again, be Problem focused, Expanded problem focused, Detailed or Comprehensive. Under the heading Determine the Extent of Examination Performed a note follows the description for a comprehensive exam that states, **“*The comprehensive examination performed as part of the preventive medicine E/M service is multisystem, but its extent is based on age and risk factors identified.*”** This is, again, important information to keep in mind when choosing that additional E/M service code.

3. **Medical decision-making** has four recognized types; straightforward, low complexity, moderate complexity, and high complexity. These levels of decision making are measured by a number of factors including; the number of possible diagnoses or management options, the volume of medical records or diagnostic tests that must be obtained and reviewed, along with the risk of significant complications associated with the patient's presenting problem, diagnostic procedures or management options. There is a table in the CPT book to use as a guide for choosing the level of medical decision-making.

For new patients, **all three of the key components** must meet or exceed the stated requirements at each level to qualify for a particular level of service. Established patient codes must meet or exceed **two of the three key components**. This means for E/M visits that are reported in addition to a preventive medicine visit that the documentation must reflect a completely separate exam.

**Documentation** is the key to whether or not the additional work during the preventive visit qualifies for an additional E/M visit code. Keep in mind another paragraph in the guidelines under the Preventive Medicine Services section in **CPT 2007** which states, *“An insignificant or trivial problem/abnormality that is encountered in the process of performing the preventive medicine evaluation and management service and which does not require additional work and the performance of the key components of a problem-oriented E/M service should not be reported”*. This applies specifically to stable, chronic conditions that do not require further evaluation or to minor problems that do not require a full work-up.

Remember that these guidelines are from a pure coding perspective, which in a perfect world would be observed as they were written by all agencies involved. Unfortunately, insurance payers often set their own guidelines and do not strictly follow the established CPT guidelines. It is prudent to be aware of each payer's specific guidelines for billing an E/M visit in addition to a preventive visit. If your documentation supports the use of the additional visit with a modifier 25, do not automatically accept a denial from an insurance payer. Appealing denials is one way of getting payers to take a look, over time, at changing their guidelines. This happened most recently with AETNA, who after years of denying additional visits with a modifier 25, changed their guidelines and now allows this code combination, when appropriate. Other payers are reviewing their policies on this issue.

But you must be ready to prove that the documentation in the chart supports the submitted codes. One way many offices report successful documentation is with the establishment of two separate chart notes, one for the preventive exam and a separate sheet for the evaluation of the additional problem. In this way, the additional work is **clearly**

documented. It can be difficult to prove additional work was performed when all the information for the exam is contained within the preventive visit note.

Also remember, insignificant or minor problems that do not require additional work-up **should not** be reported separately. For example; during a well-child exam on an infant the physician notes diaper rash and writes a prescription, or during a well-child exam on a teenager the physician notes acne and writes a prescription, or during a well-woman exam the physician notes a yeast infection and writes a prescription, or during a routine physical for a man the doctor notes that his chronic hypertension is under control and refills a prescription. These situations would not necessarily qualify for an additional E/M visit.

If the physician encounters a significant new problem or a preexisting problem that requires a significant work-up including, the ordering of additional tests, consultation with other specialists, and/or further follow up care, then the appropriate level of E/M for the additional work should be coded. For example; during a well-child exam on an infant the physician notes unexplained rash (or other symptom) and after further work-up orders additional tests (not normally ordered during routine well child exam) and schedules a follow up visit to discuss the test results, or during a well-woman exam the physician notes a breast lump and after further work-up orders diagnostic tests and schedules a follow up visit to discuss results and/or treatment options, or during a routine physical on a man the physician discovers previously controlled hypertension is no longer controlled and so orders further diagnostic tests writes a new prescription and schedules a follow up visit. These situations could qualify for an addition E/M code, if the chart is adequately documented to prove the additional work.

Communication between physicians and coders is essential in order to ensure that claims are coded correctly and documentation in the chart clearly supports the codes submitted to insurances, as we continue to strive for our common goals of quality patient care and accurate reimbursement for services provided.

Written by: Arlene J. Smith, CPC  
WSMA, Health Care Economics, Coding Specialist