MODIFIER 25

The number of office visit denials being performed at the same time as diagnostic tests (EKGs, spirometers, etc) by commercial carriers is getting ridiculous. Technically, per the CCI edits and standard coding rules accepted by the AMA and CMS, there is no reason to need a modifier 25 on an office visit unless a procedure that has a global fee period is performed on the same day. Diagnostic tests like EKGs or Spirometers or ABIs do NOT have a global fee period and should not activate a flag at any insurance carrier.

Unfortunately - many times they are and the obvious answer for why this is happening is pathetic. It is obviously so that the insurance carrier can either delay paying for the service or so the carrier can keep the money. Insurance carriers know that most physician offices appeal less than 40% of improperly denied claims. When the physician's office fails to appeal (through either ignorance or laziness or apathy), the carrier keeps the money and the physician is screwed out of their rightful income. By the way - only about 50% of improperly denied hospital claims are appealed and 75% of those appeals result in the hospital winning.

So, even though the 25 modifier is not technically required on an office visit to show that it is significant and separately identifiable when performed with a simple diagnostic test, many providers have found it to be expedient to use it. Naturally, we only recommend you use the 25 modifier when the visit is truly separate and significant. For instance, if the doctor tells the patient "I want you to come back in tomorrow for an ABI" and the patient returns simply to get the ABI, then there should not be a visit billed with it, using the 25 modifier, because the intent was simply an ABI. I know that some will teach "make sure you get the vitals during the visit so you can bill the visit code" but that is fraudulent billing in our opinion and should NOT be done. On the other hand, if the patient's test results obtained during the ABI warrant the patient sticking around afterwards to discuss the results with the physician, then a 99212 may be medically indicated and it would be billable. Again, the doctor walks in to see the patient afterwards and says "your test results are fine - no changes needed", I cannot even justify (in my own mind) a 99211 for that as that would not be separately billable. I know if I were the patient and a doctor wanted to charge me for that after billing me for a test (which includes the technical and interpretation), I would have questions about continuing to see that doctor in the future! Remember to treat your patients the way you would want to be treated if you were the patient.