The –25 Modifier: When and Why?

BY GEORGE A. WILLIAMS, MD

The advent of retinal drug therapy has redefined retinal practice. In 2000, approximately 3000 intravitreal injections were performed in the Medicare population. In 2010, nearly 1.3 million injections were performed, an increase unprecedented in the history of the Centers for Medicare and Medicaid Services (CMS). Today, there are 5 US Food and Drug Administration-approved drugs for intravitreal injection, not including bevacizumab (Avastin, Genentech). Additional drugs are in development and new indications are likely to be approved in the near future, suggesting the inevitability of further growth in intravitreal injections.

This explosion in intravitreal injections has attracted the attention of payers. In 2009, the CMS required that code 67028, intravitreal injection of a pharmacologic agent (separate procedure), be reviewed by the Relative Value Scale Update Committee (RUC). CMS is always concerned when a procedure shows unusual growth. The American Academy of Ophthalmology (AAO) explained that the growth was related to the advent of new and effective drugs for neovascular age-related macular degeneration (AMD). The RUC accepted this explanation but recommended a significant decrease in payment, which was implemented by CMS in 2011. As most retina specialists have already noted, the 2012 payment is approximately 10% less than 2011. This is the result of a transition to lower practice expense payments, and there will be a further cut in 2013. The final piece of "good news" is that CMS has again requested that the RUC review 67028 for physician work value in 2012.

The increase in intravitreal injections creates significant practice logistic issues requiring that retina specialists become more efficient in delivering care. Depending on a variety of factors, the typical patient is seen every 4 to 8 weeks and receives 7 to 8 injections during the first year of therapy as seen in the as-need (prn) arms of the CATT. The CATT clearly demonstrated the value of monthly evaluation with treatment based on clinical examination and ocular imaging. The CATT provides strong level 1 evidence that regular ocular examination and ocular imaging are necessary to maximize clinical outcomes and minimize costs.

CAUSE OF CONFUSION

The need for an ocular examination to establish the indication for intravitreal injection has raised questions about correct coding. The Health Policy Committee of the AAO has published recommendations on proper coding of evaluation and management (E/M) services on the same day of an intravitreal injection using the –25 modifier.[1] The –25 modifier is perhaps the most complicated and potentially confusing of all the modifiers and is defined as follows:

> Significant, separately identifiable E/M service by the same physician on the same day of the procedure or other service.

The Current Procedural Technology (CPT) definition includes the following discussion:

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 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. 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 service on the same date. This circumstance may be reported by adding modifier 25 to the appropriate level of E/M service.[2]

The definition and discussion of the –25 modifier clearly indicates that for many patients receiving an intravitreal injection, the use of the –25 modifier with an appropriate E/M service is correct. In fact, a major factor in the decrease in payment for 67028 was the determination by the RUC that an E/M service, which removes 11 minutes of pre-service time, is billed for the typical patient. Importantly, the RUC rationale and description of the procedure clearly recognizes that the work of the procedure begins after the decision to perform the procedure is made. This is the raison d'être for the –25 modifier.

With the above in mind, when is it appropriate for the retina specialist to bill an E/M service with the –25 modifier on the same day as an intravitreal injection? The following are common examples:

1. Whenever the retina specialist performs an E/M service to establish the need for an injection. This may include imaging as indicated.
2. If the patient has symptoms related to the fellow eye and the fellow eye is examined.
3. If the retina specialist manages an ocular problem unrelated to the intravitreal injection.

If the need for the injection has already been established on another day, however, and the patient is in the office solely to be injected, an E/M service should not be billed. The preinjection examination and any review of imaging are included in the injection payment. These services constitute the usual preoperative care associated with the injection.

THE DREADED AUDIT

One concern about the –25 modifier is that it is on the US Department of Health and Human Services Office of Inspector General Work Plan and retina specialists use the –25 modifier excessively, they may be subject to audit. Although this may be true, audits are intrinsic to the practice of medicine. In fact, as taxpayers, we should all recognize the value of audits in identifying fraud. A retina specialist who understands the indications for the –25 modifier and appropriately documents the E/M service and the rationale for treatment has nothing to fear. ■

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1. Vicchrilli S, Williams GA. Modifier -25 revisited. *Eyenet.* 2010; 14(9):67.
2. American Medical Association. *CPT 2012 Professional Edition.* Chicago: American Medical Association; 2012.

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