



## UEI Coding Alert # 38

### October 11, 2006

### Understanding Coding for Office Visits and Minor Procedures Performed on the Same Day

When performing a minor procedure on the same day as an office visit, the doctor may be able to bill both the E/M code (99201-99215, 92002-92014) or consultations (99241-99245) in addition to the procedure code. When billing both codes, the doctor must append Modifier - 25 (*significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service*) to the E/M code, making sure to link the appropriate ICD-9 and CPT codes.

"Minor Procedures" are those in which a zero or 10-day postoperative period applies and they **do not** include significant, separately identifiable services performed on the day of the procedure. A service that is significant and separately identifiable from the procedure is therefore a billable service. On the other hand, the "Usual Preoperative Care" as performed immediately prior to a procedure is not a billable service. "Usual Preoperative Care" includes assessment of symptoms, condition, and treatment site. It also includes obtaining informed consent.

It is relatively easy to establish that a service is significant and separately identifiable from the procedure when the patient presents with separate problems. In the not so obvious cases, some guidelines will help

#### Separate the Office Visit From the Procedure

While the expanded definition of modifier - 25 states that the diagnosis can be the same for the office visit and the procedure, two separate diagnoses may help clarify for the payer that the office visit is separate from the procedure. If the symptom that brought the patient in for the office visit is linked to the final diagnosis of the procedure, you often find there are two separate diagnoses.

An established patient presents with pain in one eye. An intermediate ocular exam is performed evaluating **both** eyes. The office notes for the visit clearly document that a significant evaluation is performed incorporating consideration of the differential diagnosis of monocular pain. The only identifiable cause for the ocular pain is a corneal foreign body, which is removed with a slit lamp. The appropriate codes are CPT 92012 - 25 (or appropriate evaluation and management code with modifier 25) and CPT 65222 (*removal of foreign body; external eye; corneal, with slit lamp*). The appropriate diagnosis for both services will be 930.0 (*corneal foreign body*).

Another example would be a patient who **reports dry, itchy or uncomfortable eyes**. The doctor performs a complete eye examination to exclude several differential diagnoses, but ultimately determines that the patient has dry eyes. The doctor initiates treatment with artificial tears and asks the patient to return in two weeks for follow-up. If the plan was to return in two weeks to **evaluate** the effectiveness of the prescribed treatment and after examination it is determined that insertion of punctal plugs is medically necessary. The doctor then places collagen punctal plugs in the two lower punctal to see if this resolves the problem. Bill 68761 (*closure of the lacrimal punctum; by plug, each*) on two lines with -E2 (*lower left, eyelid*) and -E4 (*lower right, eyelid*) appended to denote the lids. Link 375.15 (*disorders of lacrimal gland; tear film insufficiency*,) to the punctal plug closure codes. Also bill an E/M service with modifier 25 and 379.91(*pain in and around the eye*).

### **When To Bill for Procedures Only**

This example could still involve the dry eye patient. In this scenario, the doctor initiates treatment with artificial tears and asks the patient to return in two weeks for insertion of punctal plugs. On the return visit, the decision for punctal plugs has already been made and no office visit should be charged.