Modifier 25

Documentation Requirements
The submission of modifier -25 appended to a procedure code indicates that documentation is available in the patient's records which will support the distinct, significant, separately identifiable nature of the evaluation and management service submitted with modifier -25.

The National Correct Coding Initiative Policy Manual, chapter one, also addresses that minor surgical procedures include the decision for surgery E/M service; E/M of a different problem/issue not addressed or treated by the procedure would be eligible for consideration of modifier 25. These guidelines apply to all procedure codes with a global days indicator of "000" or "010" on the CMS Physician Fee Schedule. This includes services which would otherwise not be considered "surgical procedures," such as:

- Osteopathic manipulative treatment (OMT) (98925-98929)
- Chiropractic manipulative treatment (CMT) (98940-98942)
- Trimming of dystrophic nails, any number (G0127)
- Application of steri-strips or equivalent (G0168)

By assigning a global days indicator of "000" or "010," CMS is indicating that the RVU for the procedure includes reimbursement for the assessment of the problem, determining that the procedure is necessary, evaluating whether the procedure is appropriate and the patient is a good candidate, discussing the risks and benefits, and obtaining informed consent, as well as performing the procedure.

In order to support reporting a separate E/M with modifier 25, the evaluation must extend beyond what will be treated by the procedure. The example given in the CCI Policy Manual is documenting a complete neurological exam for head trauma, which extended beyond evaluating the head laceration which was sutured. (CMS[8]) The same principles apply to non-suture procedures

Multiple E/M Services
Per CPT and CMS guidelines (*AMA*[7], CMS[9, 10]), only one E&M service code per patient, per physician, per day is eligible for reimbursement, with limited exceptions.

- If the patient is seen for a single visit or encounter:
  - ✓ One preventive medicine service (99381 – 99397) may be reported with one problem-oriented E/M Service, if the following criteria is met:

When, in the process of performing a preventative medicine examination, a pre-existing problem is addressed or an abnormality is encountered and the problem/abnormality *is significant enough to require the additional work of the key components of a problem-oriented E&M service*, the problem-oriented outpatient established patient E/M service code (99211 – 99215) with modifier 25 appended is eligible for separate reimbursement in addition to the preventive visit service. Note the documentation requirements previously mentioned above.
(For Medicare members only: G0402, G0438, G0439, or G0468 are also valid preventive medicine service codes.)

When a preventive medicine service is reported in combination with problem-oriented E/M service, the visit documentation must clearly indicate the separate history, exam, and medical decision-making components related to the problem or abnormality being addressed. No portion of the preventive service documentation may be used to support the problem-oriented E/M code selected; the documentation related to the problem must stand on its own to support the level of service and key components of the procedure code.

- If the patient is seen for a problem-oriented visit (for any reason other than a comprehensive preventive medicine visit), then only one E/M service procedure code may be reported. The individual problems may not be coded under separate E/M visit procedure codes using modifier 25. Select an appropriate E/M code and level of service representative of the evaluation and management of all problems and issues addressed during the entire visit. Proper documentation of the exam, history, and medical decision-making for each problem addressed is essential to support the code selection.
- When a patient presents for a single problem-oriented visit with multiple health concerns, depending upon the remaining patients and procedures scheduled for that day, it may be necessary to prioritize the most pressing needs to address during the current visit, and then schedule a second visit to address the less urgent health concerns. This is solely a provider's workflow and time-management decision, not a coding or financial decision.

 Note: If the patient mentions the second problem at the first visit, and the provider asks the patient to return later in the day for the assessment of the second problem, then all evaluation and management services provided that day would be included in the selection of a single E/M service code.

Appropriate Use of Modifier 25

#	Appropriate Use of Modifier 25 Example Scenario	Correct Code(s)	Coding Rationale
1	An established patient is seen for periodic follow-up for hypertension and diabetes. During the visit, the patient asked the physician to address right knee pain which developed after recent yard work. The physician performed a problem-focused history and exam of the patient's hypertension and diabetes, and adjusted medications. Then the physician evaluated the knee and performs an arthrocentesis.	99212-25 20610	The evaluation of the knee problem is included in the arthrocentesis reimbursement. The presenting problem for the visit was other than the knee problem. A separate evaluation of the hypertension and diabetes was performed (*Grider*[4]) (and would have been performed if the knee problem did not exist), making the use of modifier 25 appropriate.

#	Appropriate Use of Modifier 25 Example Scenario	Correct Code(s)	Coding Rationale
2	An established patient is seen for a 2.0 finger laceration, which is closed with a simple repair. The patient also asks the physician to evaluate sinus problems, which is addressed with an expanded problem-focused history and exam and low medical decision making.	12001 99213-25	The patient presented to the provider with two problems. A surgical procedure was performed, and a separate E/M service was performed to address the second problem. The visit notes clearly document the assessment and treatment of the two problems separately. (*Grider*[4])
3	A new patient presents with head trauma, loss of consciousness at the scene, and a 4.2 cm scalp laceration. The physician determines the laceration requires sutures, confirms the allergy and immunization status, obtains informed consent, and performs a simple repair. Due to the loss of consciousness, the physician also performs a full neurological examination with an expanded problem-focused history, expanded problem-focused examination, and medical decision making of low complexity.	12002 99202-25	The possible neurological damage from the head trauma extended beyond the laceration which was repaired. The full neuro exam, history, and medical decision making outside of the laceration issues are separate and distinct, significantly separate, and well documented to support the use of modifier 25. (CMS[8])

Improper Use of Modifier 25

#	Improper Use of Modifier 25 Example Scenario	Correct Code(s)	Coding Rationale
4	An established patient returns to the orthopedic physician with escalating right knee pain 6 months post a series of Hyaluronan injections. After evaluating the knee and the patient's medical suitability for the procedure (meds, vitals, etc.), the physician determines a second series of hyaluronan injections is needed and performs the first of three intra-articular injections.	20610	It would not be appropriate to bill the E/M visit with modifier 25, because the focus of the visit is related to the knee pain, which precipitated the injection procedure. The evaluation of the knee problem and the patient's medical suitability for the procedure is included in the injection procedure reimbursement/RVU, per CMS NCCI Policy Manual. (CMS[8])

#	Improper Use of Modifier 25 Example Scenario	Correct Code(s)	Coding Rationale
5	A 63-year-old woman presents with complaint of multiple skin lesions on her arms. The physician determines these are actinic keratosis and recommends removal. Informed consent was obtained. A total of 12 lesions were removed with cryosurgery.	17110	The office visit is considered part of the surgery service and therefore not separately reimbursable. The use of modifier 25 is not appropriate because the E/M service did not go above and beyond the usual preoperative service. (*Grider*[4]) Also, since 17110 has a global period of 010 days, the decision for surgery E/M services on the same date of service as the minor surgical procedure are not eligible to be reported with modifier 57 either, but are included in the payment for the surgery procedure. (*CMS*[2])
6	A new patient was hit by a falling icicle and presents with a 2.2 cm laceration of the forehead. The physician determines the laceration requires sutures, confirms the allergy and immunization status, obtains informed consent, and performs a layered, intermediate repair. No loss of consciousness was reported by those at the scene and the patient reports no dizziness or blurred vision, so the physician does not perform a full neurological examination.	12051	The physician is not concerned about possible neurological damage based on the information supplied, so no full neurological exam was performed. The additional exam questions to determine this are not significant and separately identifiable as key components of an E/M service extending beyond the laceration which was repaired. The documentation does not support the use of modifier 25 with an E/M code. (CMS[8])
7	The patient returns to the office to review the results of the MRI of the left elbow. The results of the MRI were reviewed and treatment options were discussed. PARQ was then held regarding further diagnostic as well as potentially therapeutic options including corticosteroid injection. The patient elected to proceed with the injection which was then performed.	20605	It would not be appropriate to bill the E/M visit with modifier 25, because the focus of the visit is related to the elbow pain, which precipitated the injection procedure. The evaluation of the elbow MRI results and the patient's medical suitability for the injection procedure, discussion of treatment options, risks, benefits, PARQ is ALL included in the injection procedure reimbursement/RVU, per CMS NCCI Policy Manual. (CMS[8])

Codes and Definitions

E/M Evaluation and Management

E&M Evaluation and Management

E & M Evaluation and Management

(Abbreviated as “E/M” in CPT book guidelines, sometimes also abbreviated as “E&M” or “E & M” in some CPT Assistant articles and by other sources.)

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: 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 (see Evaluation and Management Services Guidelines for instructions on determining the level of E/M service.) The E/M service may be prompted by the symptoms 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 day. The circumstances 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 surgery. See modifier 57. For significant, separately identifiable non-E/M services, see modifier 59.

Coding Guidelines

“Modifier 25 may be appended to E&M services reported with minor surgical procedures (global period of 000 or 010 days) or procedures not covered by global surgery rules (global indicator of XXX). Since minor surgical procedures and XXX procedures include pre-procedure, intra-procedure, and post-procedure work inherent in the procedure, the provider should not report an E&M service for this work. Furthermore, Medicare Global Surgery rules prevent the reporting of a separate E&M service for the work associated with the decision to perform a minor surgical procedure whether the patient is a new or established patient.” (*CMS*[2])

“The CPT codes for procedures do include the evaluation services necessary prior to the performance of the procedure (eg, assessing the site/condition of the problem area, explaining the procedure, obtaining informed consent), however, when significant and identifiable (ie, key components/counseling) E/M services are performed, these services are not included in the descriptor for the procedure or service performed. It is important to note that the diagnosis

reported with both the procedure/service and E/M service need not be different, if the same diagnosis accurately describes the reasons for the encounter and the procedure." (*AMA*[3])
"Osteopathic manipulative treatment (OMT) is a form of manual treatment applied by a physician or other qualified health care professional to eliminate or alleviate somatic dysfunction and related disorders. This treatment may be accomplished by a variety of techniques. Evaluation and management services including new or established patient office or other outpatient services (99201- 99215)… **may be reported separately using modifier 25 if the patient's condition requires a significant, separately identifiable E/M service above and beyond the usual preservice and postservice work associated with the procedure.**" (*AMA*[6])

"When the patient is admitted to the hospital as an inpatient in the course of an encounter in another site of service (eg, hospital emergency department, observation status in the hospital, office, nursing facility) all evaluation and management services provided by that physician in conjunction with that admission are considered part of the initial hospital care when performed on the same date as the admission. The inpatient care level of service reported by the admitting physician should include the services related to the admission he/she provided in the other sites of service as well as in the inpatient setting.

Evaluation and management services including new or established patient office or other outpatient services (99201-99215), emergency department services (99281-99285), nursing facility services (99304-99318), domiciliary, rest home, or custodial care services (99324-99337), home services (99341-99350), and preventive medicine services (99381-99397) on the same date related to the admission to "observation status" should **not** be reported separately." (*AMA*[7])
"If more than one evaluation and management (face-to-face) service is provided on the same day to the same patient by the same physician or more than one physician in the same specialty in the same group, only one evaluation and management service may be reported unless the evaluation and management services are for unrelated problems. **Instead of billing separately, the physicians should select a level of service representative of the combined visits and submit the appropriate code for that level." (CMS9)**

When Not to Use the Modifier 25

1.Do not use a 25 modifier when billing for services performed during a postoperative period if related to the previous surgery.

2.Do not append modifier 25 if there is only an E/M service performed during the office visit (no procedure done).

3.Do not use a modifier 25 on any E/M on the day a "Major" (90 day global) procedure is being performed.

4.Do not append modifier 25 to an E/M service when a minimal procedure is performed on the same day unless the level of service can be supported as significant, separately identifiable. All procedures have "inherent" E/M service included.

5.Patient came in for a scheduled procedure only