Modifier 25 Primer: Use It, Don't Abuse It

Modifier **25** (significant, separately identifiable evaluation and management [E/M] service by the same physician on the same day of the procedure or other service) is the most important modifier for pediatricians in *Current Procedural Terminology (CPT®).* It creates the opportunity to capture physician work done when separate E/M services are provided at the time of another E/M visit or procedural service. This allows for more efficient use of your time and may save the patient another visit. However, use of this modifier has been associated with frustration because many payers, including Medicaid, do not recognize it. The landscape is now changing, with many major payers facing the pressure of successful class-action lawsuits requiring them to recognize and follow *CPT* guidelines, including modifier **25.**

The use of modifier **25** has specific requirements.

1. The E/M service must be significant. The problem must warrant physician work that is medically necessary. This can be defined as a problem that requires treatment with a prescription or a problem that would require the patient or family to return for another visit to address it. A minor problem or concern would not warrant the billing of an E/M-**25** service.
2. The E/M service must be separate. The problem must be distinct from the other E/M service provided (eg, preventive medicine) or the procedure being completed. Separate documentation for the E/M-**25** problem is

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MLN Matters Number: MM5025 | Related Change Request (CR) #: 5025

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Related CR Transmittal #: R954CP | Implementation Date: August 20, 2006

Note: This article was updated on November 1, 2012, to reflect current Web addresses. All other information remains unchanged.

Payment for Evaluation and Management Services Provided During Global Period of Surgery

Provider Types Affected

Physicians and qualified nonphysician practitioners (NPP) who bill Medicare Carriers for their services

Key Points

- The Centers for Medicare & Medicaid Services (CMS) has clarified the documentation requirements and policy requirements for the use of CPT modifier -25 used with E/M services. Please refer to the manual attachment to CR5025, *The Medicare Claims Processing Manual*, Publication 100-04, Chapter 12, Section 30.6.6, for revisions regarding the use of CPT modifier -25.
- Physicians and qualified nonphysician practitioners (NPP) should use CPT modifier -25 to designate a significant, separately identifiable E/M service provided by the same physician/qualified NPP to the same patient on the same day as another procedure or other service with a global fee period.
- Common Procedural Terminology (CPT) modifier -25 identifies a significant, separately identifiable evaluation and management (E/M) service. It should be used when the E/M service is above and beyond the usual pre- and post-

operative work of a procedure with a global fee period performed on the same day as the E/M service.

- Different diagnoses are not required for reporting the E/M service on the same date as the procedure or other service with a global fee period. Modifier -25 is added to the E/M code on the claim.
- Both the medically necessary E/M service and the procedure must be appropriately and sufficiently documented by the physician or qualified NPP in the patient's medical record to support the need for Modifier -25 on the claim for these services, even though the documentation is not required to be submitted with the claim.
- Your carrier will not retract payment for claims already paid or retroactively pay claims processed prior to the implementation of CR5025. But, they will adjust claims brought to their attention.
- Carriers will not pay for an E/M service reported with a procedure having a global fee period unless CPT modifier -25 is appended to the E/M service to designate it as a significant and separately identifiable E/M service from the procedure. Such payment will be denied with the following messages:

Claim Adjustment Reason Code

- 97 - Payment is included in the allowance for another service/procedure.

Remittance Advice Remark Code

- M144 - Pre-/post-operative care payment is included in the allowance for the surgery/procedure.

Additional Information

CR1250, Transmittal A-00-40, July 20, 2000, *Further Information on the Use of Modifier -25 in Reporting Hospital Outpatient Services,* can be found at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/A0040.PDF on the CMS website. This article provides information that is especially helpful for emergency department use of modifier -25.

CR1725, Transmittal A-01-80, June 29, 2001, *Use of Modifier -25 and Modifier -27 in the Hospital Outpatient Prospective Payment System (OPPS)*, can be found at *http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/A0180.pdf* on the CMS website.

CR5025 is the official instruction issued to your carrier regarding changes mentioned in this article, MM5025. CR 5025 may be found by going to

helpful in supporting the use of modifier **25** and especially important to support any necessary denial appeal.
3. The E/M service must be provided on the same day as the other procedure or E/M service. This may be at the same encounter or a separate encounter on the same day.
4. Modifier **25** should always be attached to the E/M code. If provided with a preventive medicine visit, it should be attached to the established office E/M code **(99211–99215).**
5. The separately billed E/M service must meet documentation requirements for the code level selected. It will sometimes be based on time spent counseling and coordinating care for chronic problems.

Other issues include the importance of linking each *CPT* service provided to a distinct *International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM)* diagnostic code. This clearly supports the medical necessity of furnishing the E/M-**25** service separate from another procedure or E/M service. However, while a separate *ICD-9-CM* code may help to support medical necessity for the 2 distinct services, *CPT* points out that it is not always required. Under the guidelines for the Hydration, Therapeutic, Prophylactic, and Diagnostic Injections and Infusions section **(90760–90779),** it states that *different diagnosis is not required* to use modifier **25.**

Some insurance companies may require separate co-payments on both services. Although one of the co-payments may be dropped if the patient appeals, this unfortunate requirement is subject to the family's plan benefit design and is not controlled by you, the provider. You are contractually obligated to comply with the plan's requirements. It should be pointed out to the family that there would be another co-payment if the patient returned for another encounter to address the problem. This would require a significant additional investment of time and would be inconvenient.

Example 1

A 5-year-old boy is seen for his preventive medicine visit. All necessary components of a preventive medicine E/M visit are provided including hearing and vision screening, appropriate laboratory tests, and immunizations. He has diagnosed attention-deficit/hyperactivity disorder (ADHD) and is on a stimulant medication. The patient is evaluated for his ADHD, and multiple parent concerns are discussed. A medication increase is made and follow-up arranged in 1 month. Fifteen minutes of face-to-face physician time is spent in counseling for this problem, addressing parent concerns and behavior management.
Complete documentation of the preventive medicine visit is made on an age-appropriate preventive medicine template. The ADHD is addressed with separate documentation on the back of the template form with careful notation of the 15 minutes devoted to counseling for this diagnosis.

Coding	
CPT	***ICD-9-CM***
99393	V20.2
Preventive medicine	**Well-child visit (5–11 y)**
99213-25	314.01
(15 minutes)	**ADD with hyperactivity**

Example 2

A 15-month-old girl presents with a fever (103°F) and mom states the girl has been tugging at her right ear for 2 days. A detailed history is obtained and a problem-focused examination is completed. When the doctor examines the ears he notices that the middle ear is very inflamed (pus is present) and the child is extremely uncomfortable. The doctor decides to administer ceftriaxone sodium to the child. The final diagnosis is acute suppurative otitis media without rupture of eardrum.

Coding	
CPT	*ICD-9CM*
99213-25	**382.00**
90777	**382.00**
J0696	**382.00**

Some carriers, such as Ohio Medicaid, continue to fail to recognize modifier **25** and its appropriate use. Therefore, to get paid for seeing Medicaid patients with significant concerns, another visit on another day will be required for these patients' Early Periodic Screening, Diagnosis, and Treatment visits or their medical concerns. It should be pointed out that some Medicaid managed care companies may allow and pay for these services