Crossroads Health Resources
Coding • Credentialing • Compliance

Modifier 25

The description for modifier 25 is a 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.

What does this mean?

Codify

When using modifier 25, you should remember this maxim: If you don't have a HEM (history, exam, and medical decision–making), you can't bill an E/M. All procedures include some service related to patient evaluation and management, but a separate E/M should include its own HEM. In other words, *the physician needs to determine whether the problem is significant enough to require additional work to perform the key components of the problem–oriented E/M service.*

Modifier 25 submissions require a minimum of two codes. Without an accompanying initial service or procedure, you can't have a significant, separately identifiable service. This statement in Codify does not follow CMS guidance; however, it is a good rule of thumb to follow.

Modifier 25 should not be used on the same day as a procedure that has no global days. The CMS definition, which is spelled out in MLN Matters article MM502, is still commonly misunderstood by many practices. Because many commonly billed procedures, such as EKGs, don't have a global period, modifier 25 should not be necessary for many claims. However, some payers do require the modifier even in these circumstances, so you should check with your payer to see whether you should include modifier 25.

CMS MLN Article MM502

Different diagnoses are not required for reporting the E/M service on the same date as the procedure or other service. *Both the medically necessary E/M service and the procedure must be appropriately and sufficiently documented* by the physician or qualified non-physician practitioner in the patient's medical record to support the claim for these services, even though the documentation is not required to be submitted with the claim. For more information, refer to the Medicare Claims Processing Manual, Chapter 12, Sections 30.6.6.

CMS Claims Processing Manual, Chapter 12, 30.6.6

30.6.6 - Payment for Evaluation and Management Services Provided During Global Period of Surgery (Rev. 954, Issued: 05-19-06, Effective: 06-01-06, Implementation: 08-20-06)

B. CPT Modifier "-25" - Significant Evaluation and Management Service by Same Physician on Date of Global Procedure

Medicare requires that Current Procedural Terminology (CPT) modifier -25 should only be used on claims for evaluation and management (E/M) services, and only when these services are provided by the same physician (or same qualified nonphysician practitioner) to the same patient on the same day as another procedure or other service. A/B MACs (B) pay for an E/M service provided on the day of a procedure with a global fee period if the physician indicates that the service is for a significant, separately identifiable E/M service that is *above and beyond the usual pre- and post-operative work of the procedure*. Different diagnoses are not required for reporting the E/M

service on the same date as the procedure or other service. 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 nonphysician practitioner in the patient's medical record to support the claim for these services, even though the documentation is not required to be submitted with the claim. If the physician bills the service with the CPT modifier "-25," A/B MACs (B) pay for the service in addition to the global fee without any other requirement for documentation unless one of the following conditions is met:

• When inpatient dialysis services are billed (CPT codes 90935, 90945, 90947, and 93937), the physician must document that the service was unrelated to the dialysis and could not be performed during the dialysis procedure;

• When preoperative critical care codes are being billed on the date of the procedure, the diagnosis must support that the service is unrelated to the performance of the procedure; or

• When an A/B MAC (B) has conducted a specific medical review process and determined, after reviewing the data, that an individual or a group has high use of modifier "-25" compared to other physicians, has done a case-by-case review of the records to verify that the use of modifier was inappropriate, and has educated the individual or group, the A/B MAC (B) may impose prepayment screens or documentation requirements for that provider or group. When a A/B MAC (B) has completed a review and determined that a high usage rate of modifier "-57," the A/B MAC (B) must complete a case-by-case review of the records. Based upon this review, the A/B MAC (B) will educate providers regarding the appropriate use of modifier "-57." If high usage rates continue, the A/B MAC (B) may impose prepayment screens or documentation requirements for that provider or group. A/B MACs (B) may not permit the use of CPT modifier "-25" to generate payment for multiple evaluation and management services on the same day by the same physician, notwithstanding the CPT definition of the modifier.

Caveats

- When in doubt, highlight anything that is not related to the procedure being performed. Is there enough medically necessary documentation to support a separate E/M?
- Compare modifier 25 to a trip to the hair salon. You go for a haircut and to have your eyebrows groomed. Will the provider charge you for the eyebrow grooming?
    - If one hair is plucked from your eyebrows, there will probably not be a separate charge.
        - If the stylist completely grooms your eyebrows, you will likely be charged for the additional service.

  When you look at this comparison, it becomes clearer when a separate E/M might be billed. If the provider is doing something that is related to the procedure (haircut) it is included in the haircut price. The E/M (eyebrows) identifies something separate that occurred.