Coding Policy **Policy and Procedure**		
SUBJECT: Coding Policy 31.0 Modifier 25 Evaluation and Management Same Day as Procedure or Other Service	DEPARTMENT: **Coding Compliance**	
ORIGINAL EFFECTIVE DATE: 03/01	DATE(S) REVIEWED/REVISED: 03/02-01/09, 01/10, 01/11, 03/11, 01/12, 01/13, 01/14, 01/15, 01/16, 01/17, 01/18, 1/19, 6/19, 01/20, 01/21, 04/21	
APPROVED BY: Coding Policy Review Committee	NUMBER: **MC 31.0**	PAGE: **1 of 4**

SCOPE:
Providence Health Plan, Providence Health Assurance, Providence Plan Partners, and Ayin Health Solutions as applicable (referred to individually as "Company" and collectively as "Companies").

APPLIES TO:
Health Plan Providers
All Lines of Business

POLICY:
Modifier 25 is used to report: "Significant, Separately Identifiable Evaluation and Management Service by the Same Physician on the Same Day of the Procedure or Other Service"

Modifier 25 is used when the provider performs a procedure and needs to indicate that the patient's condition required a significant, separately identifiable Evaluation and Management (E/M) service above and beyond the usual pre-procedure and post-procedure care associated with the procedure that was performed. This policy applies to procedures with global surgery indicators of 0, 10, and XXX, with the exception of venipuncture (CPT code 36415). No modifier is required on an E/M code when performing an E/M service on the same day as venipuncture. (See also Coding Policy 18.0.)

PROCEDURE:
When selecting an ***office visit E/M code***, the clinician may use either the new medical decision making definitions or total time spent on that date of service. **Time spent by the practitioner must be documented in the chart, including start and end times, with a description of how the time was spent. Documentation must support all acute and/or chronic conditions addressed.** (See also Coding Policy 58.0)

Use modifier 25 when the E/M service is separate from the evaluation required to perform the procedure and a clearly documented, distinct, separately identifiable service was rendered. The E/M service must have documentation showing either medical decision making or total time spent on that date of service as required to support the level of service chosen, and these must be separate from the usual preoperative and postoperative care included in the procedure.

For services on or after 01/01/21, time must be documented for procedures performed on the same day as an E/M service if the level of service for the E/M code is chosen based on time rather than medical decision making. The time documented for the procedure must be entirely separate from the time documented for the E/M service. The documentation for the E/M visit must show a service that is separate from the usual pre- and post-procedure evaluation included with the procedure.

Application of modifier 25 is not restricted to any particular level or type of E/M service. **It is not appropriate to use modifier 25 on any code other than an E/M code. E/M codes include CPT codes 99201-99499 or any HCPCS code that is used to identify an E/M service, including, but not limited to, G0378, G0379, G0438, G0439, or G0463.**

Examples of appropriate use of modifier 25:

1. A dermatologist sees a new patient for an undiagnosed rash. He/she evaluates the patient and documents an extensive history to determine etiology of the rash. He/she performs a thorough exam and documents medical decision making to support the level of E/M service. A punch skin biopsy is performed to help make the diagnosis. Because the E/M service is more extensive than the usual pre- and post-procedure evaluation included with the biopsy, and because the provider did not use time alone to support the level of E/M service billed, it is not necessary for the provider to document time spent performing the procedure. The provider may add modifier 25 to the E/M code to receive reimbursement for both the procedure and the E/M service.

2. A patient with vague pelvic and bladder complaints is referred to a gynecologist for a consultation. The gynecologist performs a lengthy evaluation and performs bladder catheterization. The physician documents time spent for the E/M visit and time spent for the procedure. Because the time spent performing the procedure is separate from the time for the E/M service, and the E/M service is separately identifiable from the usual pre- and post-procedure evaluation included in the procedure, the provider may bill an E/M code with modifier 25.

3. A patient presents for scheduled procedure but requires evaluation of an unrelated condition. Time spent performing the procedure and time spent performing the E/M service are documented and are separate. The provider may bill the E/M visit with modifier 25, showing different diagnoses for the E/M service and the procedure.

4. A patient presents for scheduled procedure but has not shown improvement on the current regimen or has shown deterioration, and the physician discusses treatment options, including, but not limited to, stopping or changing the treatment regimen, referring patient for consultation, etc. The treatment regimen may or may not be changed in this situation, depending upon the outcome of the discussion between patient and doctor. As long as time is documented for both the procedure and the E/M service, and there is no overlap in time, it is appropriate to bill the E/M visit with modifier 25.

Examples of inappropriate use of modifier 25:

1. An established patient with a history of biopsy and removal of a basal cell lesion returns to the dermatologist with a similar lesion in a different location. A punch biopsy is performed. In this situation, the limited evaluation is included in the procedure code and billing for a separate E/M service with modifier 25 is not appropriate.

2. A new patient is seen by an orthopedist because of an effusion in the knee joint. Medication is prescribed. Two weeks later, the patient returns with continuing effusion, at which time the joint is injected with cortisone. At this second visit, only the injection and medication codes should be reported, as the procedure includes a limited evaluation. Reporting an E/M code with modifier 25 is not appropriate.

3. A patient presents for scheduled procedure without significant or unexpected adverse effects or complications. The physician's work in reviewing the response to the treatment regimen, assessing if changes in therapy need to occur, examining the patient to determine if this treatment is effective, etc., is included and does not warrant additional payment. Some E/M payment is already factored into the procedure global payment and additional payment, and use of E/M code with modifier 25 is not appropriate.

4. A new patient presents to a dermatologist for a suspicious skin lesion. Brief history is taken, a problem-focused exam is performed, and the lesion is removed. Because a limited history and exam are included in payment for the procedure, a separate E/M code should not be billed.

Examples of exceptions to modifier 25 (See also Coding Policy 52.0):
When a problem-focused E/M service and a preventive service are billed on the same date of service, only the preventive service is eligible for reimbursement. The addition of modifier 25 will not affect the edit.

When a health behavior assessment and a preventive service or problem-focused E/M service are billed together on the same date of service, only the health behavior assessment will be allowed. The addition of modifier 25 will not affect this edit.

When an Ophthalmology new patient or established patient service is billed together with a preventive service or problem-focused E/M service, only the Ophthalmology visit will be allowed. The addition of modifier 25 will not affect this edit.

When an E/M service and closed fracture treatment without manipulation are billed on the same date of service, only the fracture care code is eligible for reimbursement. The addition of modifier 25 will not affect this edit.

REFERENCE:

Current Procedural Terminology (CPT)
Providence Health Plan Clinical Coding Edits
National Correct Coding Initiative Policy Manual