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	
APPROVED BY: Coding Policy Review Committee	NUMBER: **MC 31.0**	PAGE: **1 of 3**

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 MC 18.0.)

PROCEDURE:
Use modifier 25 when the E&M service is separate from the evaluation required to perform the procedure and a clearly documented, distinct and significantly identifiable service was rendered. The E&M service must have the key elements (history, examination, and medical decision making) required to support the level of service chosen, and these must be separate from the usual preoperative and postoperative care included in 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. This includes CPT codes 99202-99499 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 a confusing and undiagnosed rash. He/she evaluates the patient and documents an extensive history trying to determine the etiology of the rash. He also performs a thorough exam and documents medical decision making, in addition to performing a punch skin biopsy to help make the diagnosis. To receive reimbursement for

the evaluation portion of the service, the physician needs to add modifier 25 to the E&M code. (Note: A problem-focused exam related only to the rash is included in payment for the procedure and should not be reported separately.)

2. A patient with vague pelvic and bladder complaints is referred to a gynecologist for a consultation. The gynecologist performs a lengthy evaluation and includes a bladder catheterization. To receive reimbursement for the evaluation portion of the service, the physician needs to add modifier 25 to the E&M code.

3. Patient presents for scheduled procedure but requires evaluation of an unrelated condition. It would be appropriate to bill the E&M visit with modifier 25, and there would likely be a different diagnosis for the E&M.

4. 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. It would be 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 would be inappropriate.

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 used, as they include limited evaluation. An E&M code with modifier 25 would be inappropriate.

3. 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 and 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:
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