# Coding Policy

# Modifier -25: Evaluation and Management Same Day as Procedure or Other Service

**CODING POLICY NUMBER:** 31

**Effective Date:** 6/1/2025

**Last Review Date:** 5/2025

**Next Annual Review:** 2026



**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"). **The full Company portfolio of current coding policies is available online and can be accessed here.**

## POLICY APPLICATION

☒ Providence Health Plan Participating Providers ☒ Non-Participating Practitioners

☒ Commercial ☒ Medicaid/Oregon Health Plan ☒ Medicare

## POLICY STATEMENT

I. 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."

II. Minor procedures include an Evaluation and Management (E/M) service on the date of the procedure. When the patient's condition requires a significant E/M service on the same day as a procedure, and that E/M service is separately identifiable from the usual pre-procedure and post-procedure care associated with the procedure, modifier 25 may be added to the E/M code.

III. This policy applies to procedures with global surgery indicators of 0, 10, and XXX. See also Coding Policy 12.0 (Global Surgical Package: Pre- and Post-Operative Care).

IV. No modifier is required on an E/M code when performing an E/M service on the same day as venipuncture (CPT code 36415). See also Coding Policy 18.0 (Venipuncture).

## *PROCEDURE*

**GENERAL**

The E/M service must have documentation showing either medical decision-making (MDM) or total time spent on the date of service as required to support the level of service chosen. Documentation must also show that the E/M service was significant enough to require a separate service above and beyond the usual pre- and post-procedure evaluation included with the procedure.

When a procedure is performed as a follow-up service or is scheduled as the primary reason for a patient encounter, reporting an E/M service is only warranted if a significant, separately identifiable condition arises or a new problem is identified.

If the level of service for the E/M code is chosen based on time rather than MDM, time must be documented for the procedure(s) performed as well. <u>The time documented for the procedure must be entirely separate from the time documented for the E/M service, without overlap in minutes.</u>

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**

**Appropriate use of modifier 25**

1. <u>Extensive evaluation</u>: when the E/M service is more extensive than the usual pre- and post-procedure evaluation included with the procedure, a separate E/M may be billed with modifier 25.

   - A dermatologist sees a new patient for an undiagnosed rash. The physician evaluates the patient and documents an extensive history to determine etiology of the rash. The physician 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.

2. Separate conditions: when the E/M service is unrelated to or significantly and separately identifiable from the procedure, a separate E/M may be billed with modifier 25.

- A patient presents to an otolaryngologist for a scheduled keloid removal but also requires evaluation for new hearing loss. The provider may bill the E/M visit with modifier 25, reporting different diagnoses for the E/M service and the procedure.

- A patient with vague pelvic and bladder complaints is referred to a gynecologist for a consultation. The physician performs a lengthy evaluation and bladder catheterization. The physician documents separate time spent on the E/M visit and time spent on the procedure.

3. Managing treatment plans: when further discussion of treatment options is necessary because a patient has not shown improvement under the current plan, a separate E/M may be billed with modifier 25.

- A patient returns to their PCP for a corticosteroid injection for chronic low back pain complaining that the last injection made their pain worse. The physician evaluates the patient and discusses the available treatment options including continuing treatment and observing for improvement, stopping or changing treatment, referring the patient for a consultation, etc., and the patient decides to try another injection. Time is documented separately for the procedure and the E/M service without overlap.

**Inappropriate use of modifier 25**

1. Limited evaluation: because a limited history and exam are included in payment for the procedure, a separate E/M code should not be billed.

- A new patient presents to a dermatologist for a suspicious skin lesion. A brief history is taken, a problem-focused exam is performed, and the lesion is removed.

- 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.

- A new patient is seen by an orthopedist for knee pain and medication is prescribed for joint effusion. Two weeks later, the patient returns with continuing effusion, at which time the joint is injected with cortisone.

2. Evaluation of procedure: the physician's work in reviewing the response to treatment – examining the patient to determine if the selected treatment is effective, assessing if changes in therapy are needed, etc. – is included in the procedure's global payment and does not support reporting an additional E/M code.

- A patient tolerates a scheduled procedure without significant or unexpected adverse effects or complications.

**EXCEPTIONS**

**Multiple E/M Services**

- See Coding Policy 52.0 (Medical Visits).

**E/M and Closed Fracture Treatment Without Manipulation**

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 bypass this edit.

## *REFERENCES*


1. Current Procedural Terminology (CPT)
2. Providence Health Plan Clinical Coding Edits
3. National Correct Coding Initiative (NCCI) Policy Manual (cms.gov)


## *POLICY REVISION HISTORY*

| Date | Revision Summary |
| --- | --- |
| **3/2001** | **Original policy effective date.** |
| 1/2023 | Annual review. Converted to new template 5/2023. |
| 1/2024 | Annual review. No changes to policy. |
| 1/2025 | Annual review. No changes to policy. |
| 5/2025 | Annual review. Restructured examples and reduced policy redundancies. |