

Modifier 25

Current Procedural Terminology (CPT®) is the most widely accepted US medical nomenclature for reporting singular or multiple medical services and procedures under public and private health insurance programs. In addition to being the code set adopted under the Health Insurance Portability & Accountability Act of 1996 (HIPAA) for outpatient services and procedures, CPT codes create a uniform language for reporting medical services and procedures to allow accurate and efficient claims processing and adjudication. In addition to codes, CPT includes two-digit modifiers, which are appended to codes to indicate that a service or procedure has been altered by a specific circumstance but not changed in its definition. The use of modifiers provides supplementary information for payer policy requirements.

CPT modifier 25 is appended to an evaluation and management (E/M) service code on a claim to indicate the code is a significant, separately identifiable E/M service by the same physician or other qualified health care professional on the same day of the procedure or other service. Its use allows two E/M services or a procedure plus an E/M service that are distinctly different but required for the patient's condition to be appropriately reported and, therefore, appropriately paid. CPT states that a significant, separately identifiable E/M service is defined or substantiated by documentation that satisfies the relevant criteria for the respective E/M service to be reported. While CPT does not outline required documentation for modifier 25, its use indicates that documentation is available in the patient's record to support the reported E/M service as distinct and separately identifiable. Further, the E/M service may be prompted by the symptom or condition for which the procedure and/or service was provided. As such, different diagnoses are not required for reporting of the E/M services on the same date.

When is it appropriate to report modifier 25?

There are two scenarios where modifier 25 is typically used:

1) A Preventive Medicine E/M service provided with a problem-oriented Office or Other Outpatient E/M service

This is a common scenario. For example, a 2-year-old is seen for their well child visit and the physician finds otitis media during the physical examination. When a significant problem is encountered while performing a Preventive Medicine E/M service, requiring additional work to perform the key components of the E/M service, the appropriate Office or Other Outpatient E/M code also should be reported for that service with modifier 25 appended. Modifier 25 allows separate payment for these visits without requiring documentation with the claim form.

2) A minor surgical procedure provided with a problem-oriented Office or Other Outpatient E/M service

CPT codes for minor surgical procedures include preoperative evaluation services (i.e., explaining the procedure, risks, and benefits, and obtaining consent). Therefore, the E/M service has to involve work "above and beyond" the preoperative evaluation services. For example, when a patient presents with a head laceration, and the physician also performs a neurological examination before repairing the laceration, the neurological exam would merit a separate E/M service reported with modifier 25.

However, these are not the only scenarios where modifier 25 can be appropriately reported. Since the CPT definition of a significant, separately identifiable service relies on satisfying the relevant criteria for determining the correct level of E/M service to be reported, the following questions can be used to determine whether an E/M service

justifies use of modifier 25 according to CPT guidelines:

- Did the physician perform and document the level of medical decision making or total time necessary to report a problem-oriented Office or Other Outpatient E/M service for the complaint or problem?
- Could the work to address the complaint or problem stand alone as a reportable service?
- Did the physician perform extra work that went above and beyond the typical pre- or postoperative work associated with the procedure code?

If all answers are “yes,” then use of modifier 25 is consistent with CPT guidelines.

Payer interpretation of modifier 25

The **Centers for Medicare & Medicaid Services (CMS)** requires that modifier 25 be used only on claims for E/M services and only when the E/M service is provided by the same physician on the same day as another procedure or service.

Under certain circumstances, Medicare will allow use of modifier 25 when an E/M service is reported with a global procedure. Global procedures include visits and other physician services provided on the same date of service, provision of the service, and visits and other physician services for a specified number of days after the service is provided.

Modifier 25 may be appended to E/M services reported with minor surgical procedures (i.e., 0-day and 10-day global periods) or procedures not covered by a global period (i.e., XXX). Since minor surgical procedures and XXX-global procedures include pre-service, intra-service, and post-service work inherent in the procedure, the physician cannot report an E/M service for this work in most circumstances when the minor surgical procedure or XXX-global is the primary procedure.

Private payers vary in their interpretation of modifier 25 and may enforce policies such as:

- Flagging claims for prepayment claim validation prior to payment.
- Requiring submission of documentation with the claim.
- Automatic reduction in payment for the second code to account for what they perceive to be “overlap” between the two codes (e.g., a Preventive Medicine Service E/M code reported with an Office or Other Outpatient Service E/M code appended with modifier 25 allows payment of the Preventive Medicine Service code at 100 percent and the Office or Other Outpatient code at 50 percent) – or rejecting the claim altogether.
- Applying the deductible for one of the services or requiring the patient to come back on another date to receive the additional service.
- Carving out the payment for the problem-oriented E/M service from the payment for the preventive medicine E/M service (which results in a total charge that does not exceed that of a comprehensive preventive examination alone).

Key to challenging payer denials

- **Educate payers** on appropriate use of modifier 25 by developing a [standard appeal letter](#) referencing relevant CPT guidelines and AMA policy. Concepts included in your letter can be reinforced by **referencing relevant AMA materials**, including a [March 2023 CPT Assistant article](#) on modifier 25. You can also remind payers that determining RVUs through the RUC ensures that **potential overlap is eliminated** from the physician work, practice expense, and professional liability insurance for services that are frequently provided together.

For more information, please see [Council on Medical Service Report 7-A-23, Reporting Multiple Services Performed During a Single Patient Encounter](#).