

Modifier 25 Frequently Asked Questions

1. What is the definition of a “Modifier”?

A modifier is a two-digit numeric or alphanumeric character reported with a HCPCS code, when appropriate. Modifiers are designed to give Medicare and commercial payers additional information needed to process a claim. This includes HCPCS Level I (Physicians’ Current Procedural Terminology [CPT®]) and HCPCS Level II codes.

2. What are the uses of Modifiers?

According to the 2015 CPT© professional Code Book, a modifier provides the means to report or indicate that a service or procedure that has been performed had been altered by some specific circumstances but not changed in its definition or code. Modifiers also enable health care professionals to effectively respond to payment policy requirements established by other entities.

3. What is Modifier 25?

Modifier-25 is used for an unrelated evaluation and management (E/M) by the same provider or other qualified health care professional that is a significant, separately identifiable services performed on the same day as another procedure or service.

The physician must show, by documentation in the medical record, that on the day a procedure was performed, the patient’s condition required a separately identifiable E/M service above and beyond the usual care associated with the procedure that was performed. A significant, separately identifiable E/M service is substantiated by documentation that satisfies the relevant criteria for the respective E/M service to be reported.

4. What are some of the appropriate usages of Modifier 25?

- Use modifier 25 on an E/M service when performed at the same session as a preventive care visit when a significant, separately identifiable E/M service is performed in addition to the preventive care.
- The E/M service must be carried out for a nonpreventive clinical reason, and the ICD-9-CM code(s) for the E/M service should clearly indicate the nonpreventive nature of the E/M service.
- Attach modifier 25 to the E/M code representing a significant, separately identifiable service performed on the same day as routine foot care. The visit must be medically necessary.
- Modifier 25 indicates that on the day of a procedure, the patient's condition required a significant, separately identifiable E/M service, above and beyond the usual pre and post-operative care associated with the procedure or service performed.
- Use Modifier 25 with the appropriate level of E/M service.
- The procedure performed has a global period listed on the Medicare Fee Schedule Relative Value File.
- An E/M service may occur on the same day as a procedure and within the post-operative period of a previous procedure. Medicare allows payment when the documentation supports the 25 modifier and the 24 modifier (unrelated E/M during a post-operative period.)

- Use modifier 25 when the E/M service is separate from that required for the procedure and a clearly documented, distinct and significantly identifiable service was rendered.
- When using 25 on an E/M service on the same day as a procedure, the E/M service must have the key elements (history, examination, and medical decision making) well-documented.

NOTE: However, although CPT does not limit this modifier to use only with a specific type of procedure or service, many third-party payers will not accept modifier 25 on an E/M service when billed with a minor procedure on the same day

5. Can you use Modifier 25 for an unexpected incident or unplanned reason?

If, during the course of the preventive medicine visit, an abnormality or preexisting problem is addressed, physicians may receive payment for that part of the visit; however, the problem should be significant enough to warrant additional work that meets the requirements of at least a problem oriented E&M visit. In this case, that part of the visit may be billed by using the appropriate office/outpatient service code with the modifier 25 (significant, separately identifiable E&M service by the same physician, same day) along with the preventive medicine code.

6. What is the most common use of Modifier 25 for EPSDT (THSteps) checkups?

The most common use of Modifier 25 associated to a THSteps checkup is when an immunization or vaccination is administered. Modifier 25 is used to indicate that the immunization or vaccination is an E/M service that was performed at the same session as a preventive care visit. The use of Modifier 25 appended to the claim form shows (along with documentation in the medical record) that a significant, separately identifiable E/M service was performed in addition to the checkup.

7. What are the requirements for using Modifier 25?

The use of modifier **25** has specific requirements.

- The E/M service must be significant. The problem must warrant physician work that is medically necessary. This can be defined as a problem that requires treatment with a prescription or a problem that would require the patient or family to return for another visit to address it. A minor problem or concern would not warrant the billing of an E/M-**25** service.
- The E/M service must be separate. The problem must be distinct from the other E/M service provided (e.g., preventive medicine) or the procedure being completed. Separate documentation for the E/M-**25** problem is helpful in supporting the use of modifier **25** and especially important to support any necessary denial appeal.
- The E/M service must be provided on the same day as the other procedure or E/M service. This may be at the same encounter or a separate encounter on the same day.
- Modifier **25** should always be attached to the E/M code. If provided with a preventive medicine visit, it should be attached to the established office E/M code (**99211–99215**).
- The separately billed E/M service must meet documentation requirements for the code level selected. It will sometimes be based on time spent counseling and coordinating care for chronic problems.
- A comment from the child or parent turns an encounter that was scheduled as a preventive medicine visit into something more. According to CPT, separate, significant physician

evaluation and management (E/M) work that goes above and beyond the physician work normally associated with a preventive medicine service or a minor surgical procedure is additionally billable.

8. What are incorrect uses of Modifier 25?

- Using modifier 25 to report an E/M service that resulted in the decision to perform major surgery (see modifier 57).
- Billing an E/M service with modifier 25 when a physician performs ventilation management in addition to an E/M service.
- Using modifier 25 on an E/M service performed on a different day than the procedure.
- Using modifier 25 on the office visit E/M level of service code when on the same day a minor procedure (e.g., an endometrial biopsy) was performed, when the patient's trip to the office was strictly for the minor procedure (e.g., biopsy).

9. Where should Modifier 25 be placed on the claim form?

Modifier 25 is appended to an Evaluation and Management (E&M) service (never to a procedure code) to indicate a significant, separately identifiable evaluation and management (E/M) service by the same physician on the same day of a procedure or other service was provided.

10. How do I know if the extra work is “significant” and therefore, additionally billable?

Since CPT does not define “significant,” asking yourself the following questions should lead you to the answer:

- Did you perform and document the key components of a problem-oriented E/M service for the complaint or problem?
- Could the complaint or problem stand alone as a billable service?
- Is there a different diagnosis for this portion of the visit?
- If the diagnosis will be the same, did you perform extra physician work that went above and beyond the typical pre- or postoperative work associated with the procedure code?

11. How do I code for a THSteps checkup and a significant and separate service?

Coding for well visits is much trickier. Well visit codes will be shown as **9938x** or **9939x**, where x is again 1-5 but now represents the age of the patient. “Typical” resources needed are fairly consistent from age to age so CPT E/M codes define a “*typical minimum*” that must be done.

There are, however, two general scenarios in which “*additional*” resources are needed and, therefore, coded and billed:

- When there are “*expert recommendations*” that certain procedures are necessary as the “*standard of care.*” There are **MANY** of these, such as immunizations, developmental assessment, hearing and visions screening tests, anemia and cholesterol blood tests, and screening for health and behavior problems. Each of these “recommendations” has their own unique CPT codes as they require a different set and level of resources. These **CAN** be predicted ahead of time.
- When there are “*additional concerns*” during the well visit **NOT** “typically” part of a well visit.
 - The concern may be expressed by the parent/patient or identified during the visit by the provider or by screening tests/questionnaires.

- The concern may be a new problem or follow-up on an existing problem.
- Since the resources required to deal with the concern are similar in nature to those needed for a separate acute, chronic, and follow-up visits, the acute visit codes 9920x and 9921x are used.
- The “-25 *modifier*” is added to the end of the acute code to show that, while at a well visit, a potential concern was identified that required extra resources.
- The appropriate “level” of acute code is chosen that matches the amount of additional “resources” required.
- The modified code is only billed if the concern and the extra work meet certain strict criteria so that this modified code is not misused/overused. Most of the time you **CAN NOT** predict ahead if a “-25 modifier” code will be used.

12. What are some scenarios and examples of coding per the previous question?

Scenario

During a checkup mom states that Jacob has had an itchy red rash on his face, elbows, and knees for a couple weeks. Mom expresses no other concerns. Physical exam reveals mild inflammatory eczema affecting the above areas and is otherwise normal. Jacob is diagnosed with mild eczema. The provider discusses basic skin care with mom and recommends the use of over the counter moisturizing cream and hydrocortisone cream.

Billing codes

99391 Established patient, well visit 0-11 months old

99212-25 Acute visit – new problem, OTC medications, follow-up as needed

Scenario

During a scheduled checkup if the pediatrician spends significant extra time evaluating a language problem, then an E/M service office/outpatient code from the 99201-99215 series may be reported using a modifier 25, linked to the appropriate ICD-9-CM code(s) as appropriate (e.g., 315.31, Expressive language disorder; 315.32, Mixed receptive-expressive language disorder; 315.39, Other developmental speech or language disorder).

Scenario

When a child is seen for a complete well child EPSDT exam visit and has a presenting problem of moderate to high severity and a, reimbursement can be claimed for both services. The documentation must support both the EPSDT exam and the presenting problem or other diagnoses. An EPSDT code with V20.2 as the primary diagnosis, with an Evaluation and Management (E&M) code and Modifier 25 to denote additional services were provided on the same day by the same provider will allow additional reimbursement when documentation supports the provision of the separate and significant E&M codes as outlined in Table IV below.

TABLE IV. Coding for a Problem Focused Visit Within an EPSDT Visit.

| EPSDT codes | PLUS Evaluation and Management (E&M) codes | PLUS Modifier 25* | PLUS ICD-9 Diagnosis codes |
|---|--|--|---|
| 99381–99385 or 99391-99395 The components of the EPSDT visit must be provided and documented. | 99203–99215 The presenting problem must be of moderate to high severity. | Documentation must support the use of modifier 25. | V20.2 or V70.0 must be the primary diagnosis code for the visit. Add the diagnosis codes for the presenting problem focused evaluation. |

**If a patient is evaluated and treated for a problem during the same visit as an EPSDT exam, the problem-oriented exam can be billed along with the EPSDT visit when accompanied by the 25 modifier. Modifier 25 means that a significant, separately identifiable evaluation and management service was provided by the same physician on the same day of the procedure or other service which was provided. In other words, two services were provided on the same day by the same provider, which could have been billed separately if the patient had been seen on two separate dates.*

The information above as well as additional information and resources for Modifier 25 can be found at the following web sites:

<http://www.aap.org/en-us/professional-resources/practice-support/Coding-at-the-AAP/Pages/Modifier-25-Primer-Use-It-Dont-Abuse-It.aspx#sthash.ojD0i0Zp.dpuf>

<http://www.aap.org/en-us/professional-resources/practice-support/Coding-at-the-AAP/Pages/Modifier-25-Primer-Use-It-Dont-Abuse-It.aspx>

<https://questions.cms.gov/faq.php?id=5005&faqId=2029>

<http://www.aap.org/en-us/professional-resources/practice-support/Coding-at-the-AAP/Pages/Modifier-25-Primer-Use-It-Dont-Abuse-It.aspx>

<http://www.aafp.org/fpm/2004/1000/p21.html>

<http://www.aap.org/en-us/professional-resources/practice-support/Coding-at-the-AAP/Pages/Modifier-25-Primer-Use-It-Dont-Abuse-It.aspx#sthash.ZBzAnkip.dpuf>

<http://www.kidz1st.com/Portals/0/10%20-%20Understanding%20the%20-25%20Well%20Visit%20Acute%20Problem%20Modifier.pdf>

<http://www.cdc.gov/ncbddd/childdevelopment/documents/aapcodingfactsheetforprimarycare.pdf>

<http://www.mdwise.org/MediaLibraries/MDwise/Files/For%20Providers/Quality/HEDIS/epsdt-codingbooklet.pdf>

http://www.aaputah.org/Spring_2013_Supplement_CPT_Codes.pdf