Modifier 25: What You Need to Know

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Modifier 25 is used to indicate that a significant, separately identifiable evaluation and management (E/M) service was required on the day of a minor surgical procedure. The procedure performed must have a global period of 0 or 10 days. An example of this is a laceration repair.

Modifier 25 is overused in the industry and has been under scrutiny from payers for decades. Now private payers are implementing policies to monitor the use of modifier 25, or in some instances, reduce payment when it is used.

Starting in 2023, Horizon is paying for problem E/M services (ie, 99202-99215) with a 25 modifier at 50% of their allowable if a minor surgical procedure is reported on the same date. UnitedHealthcare is also considering this approach.

Cigna attempted to implement a policy which would require medical records to be required at the time of claim submission when practices bill a minor surgical procedure with an established E/M code (99212-99215). Fortunately, Cigna has since delayed implementation due to industry backlash over the administrative burden this would cause.

So, what is an appropriate use of modifier 25? To understand that, you first need to understand why modifier 25 is needed.

Every procedure has a degree of evaluation built into its allowable. Pricing includes preoperative, intraoperative, and postoperative work. Billing an E/M separately from the procedure would mean that a practice is getting paid for the same service twice, also known as "double dipping."

There are times, however, when the medical decision-making to diagnose a patient and then order a procedure is beyond the routine level of evaluation included in the pre- and postoperative work. In these instances, the E/M is identified as a separate payable service by appending modifier 25.

Per the American Medical Association, pre- and postoperative services typically associated with a procedure

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include the following and cannot be reported with a separate E/M services code:

- Review of patient's relevant past medical history
- Assessment of the problem area to be treated by surgical or other service
- Formulation and explanation of the clinical diagnosis
- Review and explanation of the procedure to the patient, family, or caregiver
- Discussion of alternative treatments or diagnostic options
- Obtaining informed consent
- Providing postoperative care instructions
- Discussion of any further treatment and follow-up after the procedure

Documentation to use modifier 25 should show the amount of work performed is more than the level of effort normally performed with the procedure.

Examples:

- *Appropriate use:* A patient presents with severe pain in the right knee. The evaluation determines the patient has arthritis and the decision is made to perform a large joint injection. This procedure has a 0-day global period, which means any E/M performed on that same date is

included in the injection procedure. Modifier 25 should be appended to the E/M since the procedure was unplanned. The medical decision-making involved with diagnosing the patient and selecting the management option of a large joint injection is "significant and separate" from the preoperative work for the procedure.

- *Inappropriate use:* The same patient cannot get the injection on that date. They plan to come back the next day for a planned injection. There is no change in their condition. The decision to perform an injection was already made the day before. A separate E/M on the date of the injection, and thus modifier 25, should not be reported with this planned procedure.
- *Appropriate use:* The same patient returns for a second planned injection. However, their condition has worsened, and this requires additional evaluation to determine if an injection should be done. The patient's treatment plan is altered by adding a prescription. Modifier 25 should be appended to the E/M because the circumstances of their treatment has changed.

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There are a number of myths surrounding the use of the 25 modifier. The most common are:

- *My diagnosis for the E/M cannot be the same as the procedure.* Incorrect. Different diagnoses are not required to report a separate E/M with modifier 25.
- *Modifier 25 is needed whenever there is more than one code on the claim.* Incorrect. As discussed previously, only minor surgical procedures include payment for pre- and postoperative work. Diagnostic testing should be paid separately from the E/M services. Per correct coding, modifier 25 is not required.

For more information, the AMA has published a handout, Reporting CPT Modifier 25; it's accessible at https://www.ama-assn.org/system/files/reporting-CPT-modifier-25.pdf ■