

Reporting CPT Modifier 25

REPORTING CPT MODIFIER 25

A modifier provides the means to report or to indicate that a performed service or procedure was altered by some specific circumstance 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. These modifiers and their definitions are listed in Appendix A of the Current Procedural Terminology (CPT®) 2023 code set.

Modifier 25, *Significant, Separately Identifiable Evaluation and Management Service by the Same Physician or Other Qualified Health Care Professional on the Same Day of the Procedure or Other Service*, is used when distinct services are performed on the same day. While the modifier has not been revised for the CPT 2023 code set, confusion exists regarding its appropriate use.

This article discusses the appropriate use of this modifier, outlines key considerations, and provides examples of appropriate use.

APPROPRIATE USE

Modifier 25 is used to indicate that a patient's condition required a significant, separately identifiable evaluation and management (E/M) service above and beyond that associated with another procedure or service being reported by the same physician or other qualified health care professional (QHP) on the same date. This service must be above and beyond the other service provided or beyond the usual preoperative and postoperative care associated with the procedure or service that was performed on that same date, and it must be substantiated by documentation in the patient's record that satisfies the relevant criteria for the respective E/M service to be reported.

It is important to note that the definition of modifier 25 stipulates that 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 the E/M services reported on the same date.

Modifier 25's instructions specifically indicate that it is not to be used to report an E/M service that resulted in a decision to perform surgery. In such instances, modifier 57, *Decision for Surgery*, should be appended to the E/M services code. In addition, for distinct, independent non-E/M services, the instructions refer to the use of modifier 59, *Distinct Procedural Service*.

CONSIDERATIONS

Key considerations for correct reporting of modifier 25 include the following:

- **Append only to E/M services.** Modifier 25 should only be appended to E/M services codes. Instructions reinforcing this can be found throughout the CPT code set, including but not limited to, subsections such as Hemodialysis, Allergy and Clinical Immunology, and Drug Infusions.
- **Requires awareness of usual preoperative and postoperative services.** When an E/M service is reported in conjunction with another procedure, the E/M service should include work performed above and beyond the usual preoperative and postoperative services associated with the procedure performed on the same date of service. Physicians and other QHPs should be aware of what services are included in a surgical package, as those would not be reported separately.

As listed and defined in the surgical package definition in the Surgery guidelines of the CPT code set, some of the specific services included in a given CPT surgical code include E/M service(s) subsequent to the decision for surgery on the day before and/or day of surgery (including patient history and physical examination) and immediate postoperative care, including dictating operative notes, talking with the family and other physicians or other QHPs, writing orders, evaluating the patient in the postanesthesia recovery area, and typical postoperative follow-up care.

Pre- and post-operative services typically associated with a procedure 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.

- **Applicable with multiple E/M services.** At times, more than one E/M service may be performed and reported on the same date. In these cases, the appropriate E/M code(s) would be appended with modifier 25. Instructions for appropriate reporting in these circumstances are outlined in the guidelines in the E/M services’ respective subsections, including but not limited to areas such as preventive medicine services and newborn care services.

These instructions should be reviewed in detail to understand the appropriate use of modifier 25. For example, in the case of preventive medicine services, if an abnormality is encountered or a preexisting problem is addressed in the process of performing a preventive medicine E/M service, and if the problem or abnormality is significant enough to require additional work to perform the key components of a problem-oriented E/M service, then the appropriate office or other outpatient visit E/M code (99202–99205, 99212–99215) should also be reported. Modifier 25 should be appended to the office or other outpatient visit code to indicate that a significant, separately identifiable E/M service was provided on the same date as the preventive medicine E/M service, and the appropriate preventive medicine E/M service is additionally reported without a modifier.

In contrast, if an insignificant or trivial problem or abnormality is encountered during a preventive medicine E/M service that does not require significant additional work, then a separate office or other outpatient visit code should not additionally be reported.

- **Significant, separately identifiable E/M services should be documented.** 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.

USE EXAMPLES

Some examples of appropriate use of modifier 25 follow. Note that these situations do not encompass the full range of the appropriate use of modifier 25.

Example 1: E/M Service Reported with Preventive Medicine Service Performed On the Same Date (Pediatrics)

A female brings her 3-year-old son, an established patient, to the physician's office for health supervision and evaluation. She states that although the appointment was scheduled for health maintenance, her son had irritability and ear pulling for the past 2 days, which she requests the physician to evaluate at the same appointment. A comprehensive system review and past and family/social medical history is obtained, along with a comprehensive assessment of patient history of pertinent risk factors. A comprehensive multisystem examination is performed based on the patient's age and the risk factors identified, and interventions are discussed. Growth and blood pressure are checked, and development, speech, and behavior are also assessed. Immunizations are reviewed. Anticipatory guidance is given to the mother regarding prevention of injuries in this age group, good parenting practices, nutrition, discipline, and dental care. Medically appropriate laboratory tests are ordered.

Scenario

During this preventive medicine encounter, the physician asks for additional history of the acute concern, and the mother reports a low-grade fever, rhinorrhea, and difficulty sleeping. On examination, the physician notes inflammation of the boy's right tympanic membrane. Additional relevant examination findings, beyond those typically performed in a routine health maintenance visit, are documented, including nose, throat, chest, and hydration status. The physician diagnoses acute right otitis media. As part of the medical decision making (MDM) process, there was discussion regarding appropriate use of antibiotics, why laboratory evaluation was not indicated at this time, and indications for contacting the office or seeking care in the emergency room.

In summary, the physician performed the key components of a problem-oriented E/M service, which included a medically appropriate history and examination relative to the problem identified, and MDM level that was significant beyond the services of the preventive medicine visit.

How to Report

Code 99392, *Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient; early childhood (age 1 through 4 years)*, would be reported for the preventive medicine visit. In addition, the appropriate level of E/M service for an office or other outpatient visit for an established patient (99212–99215) would be reported. Modifier 25 would be appended to the office or other outpatient visit code to indicate that a significant, separately identifiable E/M service was provided.

Example 2: E/M Service Reported with a non-E/M Service Performed On the Same Date (OB/Gyn)

Scenario

A postmenopausal female with diabetes, who is struggling with recurrent urinary tract infections and frequency/urgency of urination, presents for an office visit. There have been no prior evaluations. She is not using any topical therapy to assist with the menopausal issues that are possibly causing the symptoms. There is no information regarding diabetes control.

The decision was made to perform a simple in/out catheter for post-void residual urine to evaluate urinary retention or incomplete emptying/voiding dysfunction. MDM necessitates a procedure to be performed to evaluate a post-void residual urine. A separate procedure note is completed in addition to the E/M documentation supporting the level of service.

How to Report

Code 51701, *Insertion of non-indwelling bladder catheter (eg, straight catheterization for residual urine)*, would be reported with the appropriate level of E/M service for an office or other outpatient visit for a new or established patient, as appropriate. Modifier 25 would be appended to the E/M visit code.

Example 3: E/M Service Reported with a non-E/M Service Performed On the Same Date (Emergency Department [ED])

Scenario

An 87-year-old male presents to the ED after a fall while walking near his home. He injured his arms and head and sustained a 1-inch laceration to his scalp. He has been on Plavix since his cardiac stent. His evaluation includes a medically appropriate history and physical examination, EKG, X-ray studies, laboratory studies, and a computed tomographic (CT) scan of the head. His workup is negative, his wound is closed in the usual manner, and he is discharged home.

How to Report

Codes 12001, *Simple repair of superficial wounds to the scalp, neck, axillae, external genitalia, trunk and/or extremities (including the hands and feet); 2.5 cm or less*, and 99285, *Emergency department visit for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and high level of medical decision making*, with modifier 25 appended, would be reported. Modifier 25 is appended to indicate that a significant, separately identifiable E/M service was performed by the same physician or other QHP on the same date.

Example 4: E/M Service Reported with Fine-Needle Aspiration (FNA) Biopsy Performed On the Same Date

Scenario	A 25-year-old female (new patient) with a soft tissue breast lesion is referred to the surgeon by her primary care physician. The surgeon evaluates the patient and performs a medically appropriate history and physical examination of her neck, breasts, and lymph nodes. Based on the patient’s history and the examination findings, the surgeon recommends an FNA biopsy using ultrasound, and the patient consents after education about the procedure.
How to Report	Code 10005, <i>Fine needle aspiration biopsy, including ultrasound guidance; first lesion</i> , would be reported for the FNA biopsy. In addition, the appropriate level of E/M service for an office or other outpatient visit for a new patient (99202–99205) would also be reported with modifier 25 appended to indicate that a significant, separately identifiable E/M service was provided.

Example 5: E/M Service Reported with Thoracostomy

Scenario	While providing 45 minutes of critical care for a trauma patient who was recently admitted to the intensive care unit, the intensivist places a chest tube.
How to Report	Code 32551, <i>Tube thoracostomy, includes connection to drainage system (eg, water seal), when performed, open (separate procedure)</i> , would be reported for the chest tube placement. In addition, code 99291, <i>Critical care, evaluation and management of the critically ill or critically injured patient; first 30–74 minutes</i> , would also be reported with modifier 25 appended to indicate that a significant, separately identifiable E/M service was provided.

Example 6: E/M Service Reported with Laryngoscopy

Scenario

A 36-year-old female presents with persistent hoarseness following an upper respiratory infection 6 weeks ago. She is a recreational singer and occasional smoker, without antecedent hoarseness prior to this present episode. A comprehensive history of present illness, system review, and past, family and social history is taken, a comprehensive head and neck examination is performed, and vital signs are taken. Her gag reflex prevents adequate examination of the larynx with a mirror. A flexible laryngoscopy is recommended and discussed with the patient, and all questions answered. Informed consent is obtained. Her nasal cavity is topically anesthetized and decongested. After allowing the topical medicine to take effect, a flexible laryngoscopy is performed, examining the nasopharynx, oropharynx, hypopharynx, and larynx. A left vocal polyp is noted. The differential diagnosis and treatment plan is discussed with the patient, and she is referred to a speech-language pathologist for medical management and voice therapy. A return appointment in 1 month is also scheduled.

How to Report

Code 31575, *Laryngoscopy, flexible; diagnostic*, would be reported for the laryngoscopy. In addition, the appropriate level of E/M service for an office or other outpatient visit for a new or established patient (99202–99205, 99212–99215) would be reported with modifier 25 appended to indicate that a significant, separately identifiable E/M service was provided.

Example 7: E/M Service Reported with Tangential Skin Biopsy (Dermatology)

Scenario

An established patient presents with a growing lesion on the nose. In addition, the patient reports multiple enlarging growths on the back and dense scaly lesions on a bald scalp. A suspected basal cell carcinoma on the nose is tangentially biopsied using the tangential/shave technique. In addition, the patient is reassured that the lesions on the back are seborrheic keratoses that do not require treatment; however, the patient was diagnosed with diffuse scalp actinic keratoses for which topical 5-fluorouracil cream treatment is prescribed and the treatment plan is discussed.

How to Report

Code 11102, *Tangential biopsy of skin (eg, shave, scoop, saucerize, curette); single lesion*, would be reported for the biopsy. Code 99213, *Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and low level of medical decision making*, would be reported with modifier 25 appended to indicate that a significant, separately identifiable E/M service was provided.

While the evaluation and management associated with the suspected basal cell carcinoma is included in the global package for the skin biopsy code, the management of multiple enlarging growths on the back and the scaly lesion on the scalp may be reported as a separate E/M service.

Example 8: Reporting Modifiers 25 and 51

Scenario

A 60-year-old female presents to the ED after a slip and fall on ice. She struck her head on the ground with a brief loss of consciousness and sustained an injury to her arm and hand. A medically appropriate history and physical examination are performed, identifying a scalp laceration and deformed finger. Medically appropriate tests are ordered. As the patient is not on anti-coagulation and is neurologically intact, the Canadian CT Head Injury/Trauma Rule is used in a discussion of shared MDM, in which it is agreed to defer radiology imaging. Head injury and concussion precautions are discussed, and a 2.0-cm scalp laceration is surgically repaired. Examination of the hand reveals a deformed fourth digit. X-ray findings confirm a dislocation of the distal interphalangeal joint without fracture. The dislocation is treated with a digital block followed by successful reduction and splinting.

How to Report

Code 26770, *Closed treatment of interphalangeal joint dislocation, single, with manipulation; without anesthesia*, would be reported for treatment of the finger dislocation. If the physician who provided the initial treatment does not provide the subsequent treatment, modifier 54 should be appended to the code.

CPT code 12001, *Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet); 2.5 cm or less*, may be reported with modifier 51 appended to indicate that multiple procedures were performed by the same individual physician during the same patient encounter for repair of the scalp laceration.

In addition, the appropriate level of E/M service for an ED visit (99282–99285) may be reported with modifier 25 appended to indicate that a significant, separately identifiable E/M service was provided on the same date.

SUMMARY

The key points for reporting modifier 25 are summarized as follows.

Key Points for Reporting Modifier 25

- Modifier 25 should only be used with E/M codes.
- Modifier 25 is not restricted to a specific level of E/M service.
- The E/M service provided must meet the criteria applicable to that service (ie, medically appropriate history and/or examination, and MDM or total time on the date of the encounter within code parameters).
- CPT coding guidelines do not require different diagnoses for the E/M service and the additional procedure or service performed to be reported.
- Modifier 25 should not be used to report an E/M service that results in a decision to perform surgery (modifier 57 should be reported in this instance).
- Modifier 25 should only be used when the E/M service is significantly and separately identifiable from the procedure or other service performed on the same date.
- The significantly and separately identifiable E/M service(s) provided must be properly documented in the medical record.

