Modifier -25 is used to indicate an Evaluation and Management (E/M) service on the same day when another service was provided to the patient by the same physician. More specifically, the AMA CPT book defines this modifier as a Significant, Separately Identifiable Evaluation and Management Service on the Same Day of the Procedure or Other Service. It may be necessary to indicate that on the day a procedure identified by a CPT code was performed, the patient's condition required a significant, separately identifiable E/M service that went beyond the usual preoperative and postoperative care associated with the procedure that was performed.

CMS requires that modifier 25 should only be appended to evaluation and management services and only when these services are provided by the same physician, to the same patient, on the same day as another procedure or service.

How to determine significant and separately identifiable services

Significant and separately identifiable services are any E/M service that is above and beyond the usual preoperative and postoperative care and medical decision making associated with the procedure.

The specific components of the preoperative and postoperative work of procedures are included in the data elements used by the Relative Value Update Committee and the Centers for Medicare & Medicaid Services for the assignment of relative value units to minor procedures.

If the services provided in the E/M visit are more than this ***typical*** pre- and post-service work, they can be considered significant and separately reportable.

ASPS believes that providing medically necessary, distinct services on the same date allows physicians to provide efficient, high quality care.

Below are examples of an appropriate use of modifier -25:

Example 1: A patient is referred to the plastic surgeon by their primary care physician for a slow growing mass on their back. After the surgeon completes the in-office consultation, review of records, and physical examination, the mass is thought to be a subcutaneous lipoma. An in-office excision of the subcutaneous mass and repair is then performed.

Example 2: A patient is referred to the plastic surgeon by the primary care physician for possible carpal tunnel syndrome. After the surgeon completes the in-office consultation and physical examination, multiple treatment options are presented to the patient who opts for a steroid injection. The injection procedure is then performed in the office.

There are certain situations when using modifier -25 are not appropriate such as:

- When billing for services performed during a postoperative period if related to the previous procedure.
- The patient came to the office for a scheduled procedure only.
- On any E/M service on the day of a 90-day global procedure
- If only an E/M service is provided and no other procedure is performed
- If a minimal procedure is performed that is not significant or separately identifiable.

Recent changes to Payment Policy for Modifier -25

In October of 2017, Anthem announced that they would be reducing payment by 50% for E/M services that were historically eligible for separate reimbursement when reported by the same provider on the same day as a minor surgery.

A resolution was introduced and subsequently passed at the AMA House of Delegates in November 2017 that prompted the AMA to take action on this issue. The AMA sent a letter to Anthem requesting that the company immediately halt plans to implement its modifier 25 payment reduction policy. Information was provided that clarified how the recommendations of the AMA/Specialty Society Relative Value Scale Update Committee (RUC) does not include duplicative physician work or practice expense for procedures typically billed with an E&M service on the same date. The AMA also provided Anthem with further supportive data on those procedures for which practice expense already has been reviewed by the RUC and, using Medicare payment data, shared many procedure codes for which implementation of the proposed policy would result in ***negative*** physician payments after accounting for direct expenses. Anthem agreed to review the data provided by the AMA and respond with any changes to its planned policy.

Anthem announced on December 22, 2017 that they have delayed implementation of the reduction policy until March 1, 2018 and reduced the reduction to E/M from 50% to 25%. Anthem also confirmed that this will be impacting all states in which they operate, though Georgia and Virginia will go into effect upon contract renewal, not March 1.

While the delay is a win because it shows that Anthem has realized the evidence being presented by the AMA and Medical Societies requires them to further examine the policy, ASPS and the AMA will continue our advocacy efforts against the modified policy as it will undoubtable create undue stress and difficulty not only for the provider but patients as well.