HCC Department Coding Newsletter

Arizona Priority Care™

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MONTHLY CODING SPOTLIGHT

MODIFIER 25

Modifier 25 is used to report a significant, separately identifiable Evaluation and Management (E/M) service by the same physician or other health qualified health care professional on the same day of a procedure or other service.

It may be necessary to indicate that on the day a procedure or service identified by a CPT code was performed, the patient's condition required additional workup beyond the standard necessary for the service provided. This additional service must be substantiated in the documentation and satisfy the relevant criteria for the respective service to be reported.

⇒ *WHAT IS SIGNIFICANT / ABOVE & BEYOND?*

- Purpose / intent of the visit
- Additional / unrelated education
- Development of a treatment plan
- Additional work time
- Medical necessity for both E/M and procedure
- A different diagnosis is not required when the service was caused or prompted by symptoms or conditions for which the service was provided.

MODIFIER 25 AT A GLANCE

Per CMS guidelines, modifier -25 should always be appended to the office visit CPT code and not the procedure or injection CPT code.

The following code ranges may be appended with modifier -25

- 99201-99215 (office or outpatient services)
- 99241-99245 (office or other outpatient consultations) -these codes are no longer reimbursable by Medicare or Medicare Advantage Plans

⇒ Do not use modifier -25 to report a decision to perform surgery—use modifier -59

⇒ You can use modifier -25 for **New Patient** CPT codes when an E/M service is performed the same day as an in-office minor procedure or injection. Rationale being, the patient is new to the practice therefore additional workup and assessment will be required since there is no known medical history for this patient.
*Guidelines may vary per health plan

⇒ For established patients the guidelines for reporting an office visit CPT code along with a minor procedure or injection are very specific. The documentation must clearly support the reason why an office visit should be reported

⇒ *Over-utilization of modifier -25 for an established patient is the #1 flag for Fee For Service audits per CMS

Example:

Question: Patient complains of a troublesome lesion, provider performs an evaluation including history and exam and determines to remove it at that visit.

Should modifier -25 be used?

Answer: No. Even though the decision to remove the lesion was made after the evaluation, there does not appear to be an evaluation above and beyond what is usually required for the minor surgical procedure.