Modifier -25 – Significant, Separately Identifiable E/M Service

Last Updated: 11/11/2026 **Last Reviewed:** 11/19/2026 **Originally Effective:** 1/1/2000
Last update includes payment policy changes, subject to 28 TAC §3.3703(a)(20)(D)? No
If yes, Texas Last Update Effective Date: n/a
Policy #: RPM028

Scope

Companies: Moda Partners, Inc. and its subsidiaries & affiliates (All)
Claim Forms: CMS1500 & CMS1450 (paper and electronic versions)
Provider Contract Status: Any
Claim Dates: All

Reimbursement Guidelines

A. General

Modifier 25 is valid only with Evaluation and Management (E/M) procedure codes, based on the modifier definition. When appended to surgical codes, medicine procedures, diagnostic tests, and other ineligible services, the line item will be denied as an invalid modifier combination. [C]

B. Separate Reimbursement Requirements

E/M service codes submitted with modifier 25 appended will be considered separately reimbursable when all the following apply:

1. The clinical edit is eligible for a modifier bypass (e.g., per edit rationale, CCI modifier indicator = "1", etc.).
2. The modifier and the code have been submitted in accordance with AMA CPT book guidelines, CPT Assistant guidelines, CMS/NCCI Policy Manual guidelines, and any applicable specialty society guidelines.
   a. If a procedure-to-procedure (PTP) edit has a correct coding modifier indicator (CCMI) of "0", the Column Two code is not eligible for payment even when an NCCI PTP-associated modifier is appropriately appended.
      i. When a preventive visit and a problem-oriented E/M code are billed together, modifier 25 needs to be appended to the problem-oriented visit procedure code.
      ii. When an E/M is billed with another procedure code listed in the CCI, two separately sourced edits may apply, requiring an additional modifier on the column II code.
   b. If the CCMI of a PTP edit is "1", the edit may be bypassed, and the Column Two code of the edit may be eligible for payment if an NCCI PTP-associated modifier is appropriately appended to one of the codes. [11]
   c. If both codes in a code pair edit have the same NCCI PTP-associated anatomic modifier, the edit will not be bypassed unless one code also includes a modifier indicating the reason for the bypass. [11]
   d. When billing E/M and psychotherapy services together on the same day by the same provider: [G]
      i. Psychotherapy add-on codes 90833, 90836, and 90838 must be used.
      ii. The E/M must be significant and separately identifiable in the medical record documentation.
3. The procedure code is eligible for separate reimbursement according to the status indicators on the CMS fee schedule for the relevant provider type (physician fee schedule, ASC, OPPS, etc.).
4. The medical record supports the use of modifier 25 and documents all required key components of the E/M service.

C. Documentation Requirements

When a preventive visit and a problem-oriented E/M code are billed together, the medical record must clearly document each service so that both are separately identifiable and the significance can be evaluated.

Appending modifier -25 indicates that the patient's records supports the distinct, significant, and separately identifiable E/M service and will be provided promptly upon request.

D. E/M Service Billed with a Procedure, Same Date of Service

1. Surgical procedures and some non-surgical services include physician involvement or supervision and integral pre-service and post-service work; therefore, a separate E/M service is not normally reimbursed. A separate E/M service may be considered when the patient's condition requires care beyond the work ordinarily associated with the procedure and modifier -25 is appended to the E/M code. Documentation supporting the significant, separately identifiable E/M service may not include the usual pre-service, intra-service, or post-service work associated with other same-day procedures.
2. CPT guidelines for specific code categories highlight certain services where special attention should be given to the concept of an E/M integral to the procedure. These include vaccine administration, chemotherapy, acupuncture, etc.
3. Chapter one of the National Correct Coding Initiative Policy Manual states that the E/M service for deciding to perform minor surgery is included in the procedure. An E/M service for a different problem not addressed or treated by the procedure may qualify for modifier 25. These guidelines apply to all procedure codes with a global days indicator of "000," "010," or "XXX" on the CMS Physician Fee Schedule, including, but is not limited to:
    a. Many Category III procedure codes.
    b. Unlisted surgical procedure codes.
    c. Services which would otherwise not be considered "surgical procedures," such as:
        i. Osteopathic manipulative treatment (OMT) (98925-98929)
        ii. Chiropractic manipulative treatment (CMT) (98940-98942)
        iii. Trimming of dystrophic nails, any number (G0127)
        iv. Application of steri-strips or equivalent (G0168)
4. A global days indicator of "000" or "010" means the procedure's RVU includes assessing the problem, determining the need for and appropriateness of the procedure, evaluating the patient's candidacy, discussing risks and benefits, obtaining informed consent, and performing the procedure. A separate E/M service with modifier 25 must address issues beyond those treated by the procedure. The CCI Policy Manual example is a complete neurological exam for head trauma beyond the evaluation of a sutured head laceration. [8, 14] The same principles apply to non-suture procedures.
5. The medical record must clearly separate the procedure documentation from the significant, separately identifiable E/M service. If both services appear in one visit entry without separation, such as a sub-heading, the E/M service does not meet the "separately identifiable" requirement.

E. Multiple E/M Services

Under CPT and CMS guidelines, only one E&M service code per patient, physician, and day is eligible for reimbursement, with limited exceptions: [7, 9, 10]

1. If the patient is seen for a single visit or encounter:
    a. One preventive medicine service (99381 – 99397) may be reported with one problem-oriented E/M service when the following criteria are met:
        i. During a preventative medicine examination, a pre-existing problem or newly identified abnormality may support separate reimbursement when it requires the additional work of a problem-oriented E/M service. In that case, appended modifier 25 to the established patient outpatient E/M code (99211-99215).

1) Effective May 1, 2023, the separate reimbursement for the problem-oriented E/M will be reduced by 50% for some states and plans. See "Preventive Medicine & Problem-Oriented E/M Visits, Same Day" for specific scope and details. [F]
2) Note the documentation requirements previously mentioned above.

ii. When a preventive medicine service and a problem-oriented E/M service are reported together, the documentation must clearly separate the history, examination, and medical decision-making for the problem or abnormality. Preventive service documentation may not be used to support the problem-oriented E/M code; the problem specific documentation must independently support the selected level of service and required key components.

iii. For Medicare Advantage members only:
1) The following procedure codes are also valid preventive medicine service codes:
a) G0402 (*Initial preventive physical examination; face-to-face visit, services limited to new beneficiary during the first 12 months of Medicare enrollment*).
All the following terms are used by CMS to describe the visit represented by G0402. All of these are synonymous.
i) Welcome to Medicare Exam (WME)
ii) Initial Wellness Visit (IWV)
iii) Initial Preventative Exam (IPPE)
b) Annual Wellness Visit (AWV):
i) G0438 [*Annual wellness visit; includes a personalized prevention plan of service (PPS), initial visit*]
ii) G0439 [*Annual wellness visit, includes a personalized prevention plan of service (PPS), subsequent visit*]
c) G0468 [*Federally qualified health center (FQHC) visit, initial preventive physical exam (IPPE) or annual wellness visit (AWV)*]. Only one unit of G0468 may be billed per plan benefit year.
d) G0101 (Cervical or vaginal cancer screening; pelvic and clinical breast examination).
2) A Medicare Advantage member may have multiple preventive services per plan benefit year.
a) One preventive visit from each of the following categories is allowable per plan benefit year:
i) Medicare wellness visit (either G0402, G0438, or G0439).
ii) Annual Preventive Physical Exam (99381 – 99397).
iii) Gynecological visit exam (G0101)
b) A problem-oriented visit may be billed on the same day as a preventive visit. All of the separate reimbursement requirements must be met.

b. For a problem-oriented visit that is not a comprehensive preventive medicine visit, report only one E/M service code. Do not report separate E/M codes for individual problems using modifier 25. Select the E/M code and level that represents all problems addressed during the visit, supported by documentation of the exam, history, and medical decision-making for each problem.

c. During a single problem-oriented visit involving multiple concerns, the provider may prioritize the most urgent needs and schedule a later visit to address less urgent health concerns, based solely on workflow and time, not coding or financial considerations.

2. For two separate visits or encounters:
a. If the patient is seen elsewhere and admitted to the hospital, all services at the original visit and care at the hospital are included in the initial hospital E/M service. [7]

b. When two separate visits occurred at different times of day and for unrelated problems that could not be anticipated or addressed during the same encounter: [10]
   i. For example, a patient has a scheduled morning office visit for an upper respiratory infection and returns 4 hours later after a fall with an injured knee.
   ii. Append modifier 25 to the second visit and report the two visit times in box 19 of the claim form or the equivalent electronic claim field.
   iii. ***Note:*** If the patient mentions the second problem at the first visit, and the provider asks the patient to return later in the day for the assessment of the second problem, then all evaluation and management services provided that day would be included in the selection of a single E/M service code.
   iv. Although modifier XE denotes a separate encounter, CMS created the -X{EPSU} modifiers as subsets of modifier 59. Because modifier 59 does not apply to E/M services, modifier XE should not be used for a separate E/M encounter.

F. Appropriate Use of Modifier 25

#	Appropriate Use of Modifier 25 Example Scenario	Correct Code(s)	Coding Rationale
1	An established patient is seen for periodic follow-up for hypertension and diabetes. During the visit, the patient asked the physician to address right knee pain which developed after recent yard work. The physician performed a problem-focused history and exam of the patient's hypertension and diabetes, and adjusted medications. Then the physician evaluated the knee and performs an arthrocentesis.	99212-25 20610	The evaluation of the knee problem is included in the arthrocentesis reimbursement. The presenting problem for the visit was other than the knee problem. A separate evaluation of the hypertension and diabetes was performed[4] (and would have been performed if the knee problem did not exist), making the use of modifier 25 appropriate.
2	An established patient is seen for a 2.0 finger laceration, which is closed with a simple repair. The patient also asks the physician to evaluate sinus problems, which is addressed with an expanded problem-focused history and exam and low medical decision making.	12001 99213-25	The patient presented to the provider with two problems. A surgical procedure was performed, and a separate E/M service was performed to address the second problem. The visit notes clearly document the assessment and treatment of the two problems separately. [4]

#	Appropriate Use of Modifier 25 Example Scenario	Correct Code(s)	Coding Rationale
3	A new patient presents with head trauma, loss of consciousness at the scene, and a 4.2 cm scalp laceration. The physician determines the laceration requires sutures, confirms the allergy and immunization status, obtains informed consent, and performs a simple repair. Due to the loss of consciousness, the physician also performs a full neurological examination with an expanded problem-focused history, expanded problem-focused examination, and medical decision making of low complexity.	12002 99202-25	The possible neurological damage from the head trauma extended beyond the laceration which was repaired. The full neuro exam, history, and medical decision making outside of the laceration issues are separate and distinct, significantly separate, and well documented to support the use of modifier 25. [8]

G. Improper Use of Modifier 25

#	Improper Use of Modifier 25 Example Scenario	Correct Code(s)	Coding Rationale
4	An established patient returns to the orthopedic physician with escalating right knee pain 6 months post a series of Hyaluronan injections. After evaluating the knee and the patient's medical suitability for the procedure (meds, vitals, etc.), the physician determines a second series of hyaluronan injections is needed and performs the first of three intra-articular injections.	20610	It would not be appropriate to bill the E/M visit with modifier 25, because the focus of the visit is related to the knee pain, which precipitated the injection procedure. The evaluation of the knee problem and the patient's medical suitability for the procedure is included in the injection procedure reimbursement/RVU, per CMS NCCI Policy Manual. [8]
5	A 63-year-old woman presents with complaint of multiple skin lesions on her arms. The physician determines these are actinic keratosis and recommends removal. Informed consent was obtained. A total of 12 lesions were removed with cryosurgery.	17110	The office visit is considered part of the surgery service and therefore not separately reimbursable. The use of modifier 25 is not appropriate because the E/M service did not go above and beyond the usual preoperative service. [4] Also, since 17110 has a global period of 010 days, the decision for surgery E/M services on the same date of service as the minor surgical procedure are not eligible to be reported with modifier 57 either but are included in the payment for the surgery procedure. [2]

#	Improper Use of Modifier 25 Example Scenario	Correct Code(s)	Coding Rationale
6	A new patient was hit by a falling icicle and presents with a 2.2 cm laceration of the forehead. The physician determines the laceration requires sutures, confirms the allergy and immunization status, obtains informed consent, and performs a layered, intermediate repair. No loss of consciousness was reported by those at the scene and the patient reports no dizziness or blurred vision, so the physician does not perform a full neurological examination.	12051	The physician is not concerned about possible neurological damage based on the information supplied, so no full neurological exam was performed. The additional exam questions to determine this are not significant and separately identifiable as key components of an E/M service extending beyond the laceration which was repaired. The documentation does not support the use of modifier 25 with an E/M code. [8]
7	The patient returns to the office to review the results of the MRI of the left elbow. The results of the MRI were reviewed, and treatment options were discussed. PARQ was then held regarding further diagnostic as well as potentially therapeutic options including corticosteroid injection. The patient elected to proceed with the injection which was then performed.	20605	It would not be appropriate to bill the E/M visit with modifier 25, because the focus of the visit is related to the elbow pain, which precipitated the injection procedure. The evaluation of the elbow MRI results and the patient's medical suitability for the injection procedure, discussion of treatment options, risks, benefits, PARQ is ALL included in the injection procedure reimbursement/RVU, per CMS NCCI Policy Manual. [8]

Definitions

Acronyms/Abbreviations

Acronym	Definition
AMA	American Medical Association
ASC	Ambulatory Surgery Center
AWV	Annual Wellness Visit
CCI	Correct Coding Initiative (see "NCCI")
CCMI	Correct Coding Modifier Indicator
CMS	Centers for Medicare and Medicaid Services
CPT	Current Procedural Terminology
E/M E&M E & M	Evaluation and Management (Abbreviated as "E/M" in CPT book guidelines, sometimes also abbreviated as "E&M" or "E & M" in some CPT Assistant articles and by other sources.)
FQHC	Federally qualified health center
HCPCS	Healthcare Common Procedure Coding System (acronym often pronounced as "hick picks")
IPPE	Initial Preventive Physical Examination

Acronym	Definition
IWV	Initial Wellness Visit
MRI	Magnetic Resonance Imaging
NCCI	National Correct Coding Initiative (aka “CCI”)
OMT	Osteopathic Manipulative Treatment
OPPS	Outpatient Prospective Payment System
PARQ	Procedures, Alternatives, Risks, Questions (This acronym is used for documenting informed consent prior to a procedure, especially a surgical procedure)
PPS	Personalized Prevention Plan of Service
PTP	Procedure-To-Procedure (a type of CCI edit)
RPM	Reimbursement Policy Manual (e.g., in context of “RPM052” policy number, etc.)
RVU	Relative Value Unit
TAC	Texas Administrative Code
UB	Uniform Bill
WME	Welcome to Medicare Exam

Definition of Terms

Term	Definition
Preventive Medicine Visit	A preventive medicine visit is a specific category of E/M service that is an “annual physical” or routine comprehensive preventive medicine examination. The service includes an age-appropriate history and examination, family and social history, assessment of risk factors, routine maintenance of ongoing prescriptions and some existing conditions, and counseling/anticipatory guidance/risk factor reduction interventions. [12,13]
Problem-Oriented E/M Visit	An E/M service focused on a chief complaint or current illness/problem which is addressed or resolved. The service includes a medically appropriate history and physical examination. The level of service is determined and selected based upon the extent of medical decision-making (MDM) or time spent. [12]

Modifier Definitions

Modifier	Modifier Description & Definition
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:** 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 a significant, separately identifiable E/M service above and beyond the other service provided or beyond the usual preoperative and postoperative care associated with the procedure that was performed. 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 (see **Evaluation and Management Services Guidelines** for instructions on determining the level of E/M service.) The E/M service may be prompted by the symptoms or condition for which the procedure and/or service was provided. As such, different diagnoses are not required for reporting of the E/M services on the same day. The circumstances may be reported by adding modifier 25 to the appropriate level of E/M service. **Note:** This modifier is not used to report an E/M service that resulted in a decision to perform surgery. See modifier 57. For significant, separately identifiable non-E/M services, see modifier 59.

Related Policies

A. "Moda Health Reimbursement Policy Overview." Moda Health Reimbursement Policy Manual, RPM001.
B. "Clinical Editing." Moda Health Reimbursement Policy Manual, RPM002.
C. "Valid Modifier to Procedure Code Combinations." Moda Health Reimbursement Policy Manual, RPM019.
D. "Modifiers XE, XS, XP, XU, and 59 - Distinct Procedural Service." Moda Health Reimbursement Policy Manual, RPM027.
E. "Gynecologic or Annual Women's Exam Visit & Use of Q0091 (Pap, Pelvic, & Breast Visit)." Moda Health Reimbursement Policy Manual, RPM044.
F. "Preventive Medicine & Problem-Oriented E/M Visits, Same Day." Moda Health Reimbursement Policy Manual, RPM078.
G. "Evaluation and Management (E/M) Services With Psychotherapy Services." Moda Health Reimbursement Policy Manual, RPM081.
H. "Modifier 57 – Decision For Surgery." Moda Health Reimbursement Policy Manual, RPM029.

Resources

1. American Medical Association. "Appendix A – Modifiers." *Current Procedural Terminology (CPT)*. Chicago: AMA Press.
2. CMS. *National Correct Coding Initiative Policy Manual*. Chapter 1 General Correct Coding Policies, § E, "Modifiers and Modifier Indicators."
3. American Medical Association. "Appropriate Use of Modifier -25." *CPT Assistant,* September 1998: 4.
4. Grider, Deborah J. Coding with Modifiers: A Guide to Correct CPT and HCPCS Level II Modifier Usage. Chicago: AMA Press, 2004, pp. 59-71.
5. American Medical Association. "Modifiers, 25 (Q&A)". CPT Assistant. Chicago: AMA Press, January 2008, p. 9.
6. American Medical Association. "Osteopathic Manipulative Treatment guidelines and Chiropractic Manipulative Treatment guidelines." *Current Procedural Terminology (CPT)*. Chicago: AMA Press.

7. American Medical Association. “Initial Hospital Care.” *Current Procedural Terminology (CPT). Chicago: AMA Press.*
8. CMS. *National Correct Coding Initiative Policy Manual*. Chapter 1 General Correct Coding Policies, § D, “Evaluation and Management (E&M) Services.”
9. CMS. *Medicare Claims Processing Manual* (Pub. 100-4). Chapter 12 – Physician Practitioner Billing, § 30.6.5.
10. CMS. *Medicare Claims Processing Manual* (Pub. 100-4). Chapter 12 – Physician Practitioner Billing, § 30.6.7.B.
11. CMS. “Instructions for Codes With Modifiers.” *Medicare Claims Processing Manual* (Pub. 100-4). Chapter 23 – Fee Schedule Administration and Coding Requirements, § 20.9.1.1.
12. American Medical Association (AMA). “Preventive Medicine Services.” *CPT Assistant.* Winter 1994 issue, p. 21.
13. American Medical Association (AMA). “Preventive Medicine Services.” *CPT Assistant.* July 2009 issue, p. 7.
14. CMS. “Modifier 25.” *National Correct Coding Initiative Policy Manual*. Chapter 1 General Correct Coding Policies, § E, “Modifiers and Modifier Indicators.”

Policy History

Reminder: The most current version of our reimbursement policies can be found on our provider website. If you are using a printed or saved electronic version of this policy, please verify the current information by going to: https://www.modahealth.com/medical/policies_reimburse.shtml

Date	Summary of Update
11/19/2026	Related Policies & Resources updated. Minor rewording. No policy changes.
9/10/2025	Clarified Scope includes CMS1450/UB for CAHs revenue codes 0960-0978. Clarified needed position of modifier 25. Clarified billing Psychotherapy with E/M codes. Acronyms, Related Policies, & Resources updated. Definition of Terms added. Coding Guidelines & Sources section retired; see Resources for information. Background Information section retired. Formatting updates. No policy changes.
5/8/2024	Clarified use of modifiers CMS Manual information. Reworded preventive & problem-oriented E/M, same encounter guidelines for clarification. Acronyms & Resources updated. No policy changes.
2/8/2023	Related new policy RPM078 added & mentioned; RPM078 is subject to TAC 28. Related Policies updated. Formatting updates.
7/13/2022	Policy History section: Added. Entries prior to 2022 omitted (in archive storage). Formatting updates. No policy changes.
7/10/2013	Policy document initially approved by the Reimbursement Administrative Policy Review Committee & initial publication.
1/1/2000	Original Effective Date (with or without formal documentation). Policy based on AMA & CMS guidelines for modifier 25. [1, 2, 3, 5, 8, 9, 10]