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

Last Updated: 9/10/2025 **Last Reviewed: 9/10/2025** **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) **Provider Contract Status:** Any

Claim Forms: CMS1500 & CMS1450 (paper and electronic versions) **Claim Dates:** All

This policy applies to professional providers only. (CMS1450/UB for CAHs)

Reimbursement Guidelines

A. General

Modifier 25 is considered valid on Evaluation and Management (E/M) procedure codes only (based on modifier definition). Modifier 25 is not considered valid when appended to surgical codes, medicine procedures, diagnostic tests and procedures, etc. and 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 the correct coding modifier indicator (CCMI) of a procedure-to-procedure (PTP) edit is "0", the Column Two code is not eligible for payment even if an NCCI PTP-associated modifier is appropriately appended.
      i. When a preventive visit and a problem-oriented E/M code are billed together, the 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 so an additional modifier may be required 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 the 2 codes of a code pair edit have the same NCCI PTP-associated anatomic modifier, the edit will not be bypassed unless an additional NCCI PTP-associated modifier is appended to 1 of the codes indicating the reason to bypass the edit. [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 records documentation supports the appropriate use of modifier 25. All the required key components of the E/M service with modifier 25 appended must be documented in the medical record.

C. Documentation Requirements

The documentation of the preventive E/M visit and the documentation of the significant, separately identifiable problem-oriented E/M service must clearly identify the problem oriented service in the medical record to fulfill the requirements of "separately identifiable."

The submission of modifier -25 appended to a procedure code indicates that documentation is available in the patient's records which will support the distinct, significant, separately identifiable nature of the evaluation and management service submitted with modifier -25, and that these records will be provided in a timely manner for review upon request.

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

1. All surgical procedures and some non-surgical procedural services include a certain degree of physician involvement or supervision, pre-service work, and post-service work which is integral to that service. For those procedures and services, a separate E/M service is not normally reimbursed. However, a separate E/M service may be considered for reimbursement if the patient's condition required services above and beyond the usual care associated with the procedure or service provided and modifier -25 is appended to the E/M code. None of the usual pre-service, intra-service, or post-service work associated with the other procedure(s) performed on the same day may be included in the documentation to support the key components of the significant, separately identifiable E/M service.
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. The National Correct Coding Initiative Policy Manual, chapter one, also addresses that minor surgical procedures include the decision for surgery E/M service; E/M of a different problem/issue not addressed or treated by the procedure would be eligible for consideration of 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. This includes, 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. By assigning a global days indicator of "000" or "010," CMS is indicating that the RVU for the procedure includes reimbursement for the assessment of the problem, determining that the procedure is necessary, evaluating whether the procedure is appropriate and the patient is a good candidate, discussing the risks and benefits, and obtaining informed consent, as well as performing the procedure. To support reporting a separate E/M with modifier 25, the evaluation must extend beyond what will be treated by the procedure. The example given in the CCI Policy Manual is documenting a complete neurological exam for head trauma, which extended beyond evaluating the head laceration which was sutured. [8] The same principles apply to non-suture procedures.
5. The documentation of the procedure and the documentation of the significant, separately identifiable E/M service must be clearly separate and distinct in the medical record to fulfill the requirements of "separately identifiable." If both services are mixed in a single visit entry without any separation (e.g.,

under a sub-heading) to identify the separate and distinct nature of the services, then the requirement for a "separately identifiable" service has not been met.

E. Multiple E/M Services

Per CPT and CMS guidelines, only one E&M service code per patient, per physician, per 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, if the following criteria is met:
      i. When, in the process of performing a preventative medicine examination, a pre-existing problem is addressed or an abnormality is encountered and the problem/abnormality *is significant enough to require the additional work of the key components of a problem-oriented E&M service*, the problem-oriented outpatient established patient E/M service code (99211 – 99215) with modifier 25 appended is eligible for separate reimbursement in addition to the preventive visit service.
         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 is reported in combination with problem-oriented E/M service, the visit documentation must clearly indicate the separate history, exam, and medical decision-making components related to the problem or abnormality being addressed. No portion of the preventive service documentation may be used to support the problem-oriented E/M code selected; the documentation related to the problem must stand on its own to support the level of service and key components of the procedure code.
      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. If the patient is seen for a problem-oriented visit (for any reason other than a comprehensive preventive medicine visit), then only one E/M service procedure code may be reported. The individual problems may not be coded under separate E/M visit procedure codes using modifier 25. Select an appropriate E/M code and level of service representative of the evaluation and management of all problems and issues addressed during the entire visit. Proper documentation of the exam, history, and medical decision-making for each problem addressed is essential to support the code selection.

c. When a patient presents for a single problem-oriented visit with multiple health concerns, depending upon the remaining patients and procedures scheduled for that day, it may be necessary to prioritize the most pressing needs to address during the current visit, and then schedule a second visit to address the less urgent health concerns. This is solely a provider's workflow and time-management decision, not a coding or financial decision.

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. 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 scheduled office visit occurs in the morning for upper respiratory infection and 4 hours later an unscheduled visit for a fall with injured knee.
      ii. Modifier 25 would be appended to the second visit. Additional information regarding the two separate times should be supplied in box 19 of the claim form, or the equivalent field in the electronic claims submission process.
      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. Modifier XE (separate encounter) would appear to be a more specific modifier to use in this instance, but modifiers -X{EPSU} were created by CMS as specific subsets of modifier 59. Since modifier 59 is not appropriate to use with E/M services, modifier XE should not be used for a separate encounter E/M service either.

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]
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]
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]

#	Improper Use of Modifier 25 Example Scenario	Correct Code(s)	Coding Rationale
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
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

Acronym	Definition
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.

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.

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
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.

Date	Summary of Update
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]