

Program Memorandum**Intermediaries**

**Department of Health and
Human Services (DHHS)
HEALTH CARE FINANCING
ADMINISTRATION (HCFA)**

Transmittal A-00-40**Date: JULY 20, 2000****CHANGE REQUEST 1250****SUBJECT: Further Information on the Use of Modifier -25 in Reporting Hospital Outpatient Services**

Due to numerous questions raised about the correct usage of modifier -25 under the Hospital Outpatient Prospective Payment System (OPPS), this Program Memorandum (PM) provides additional clarifying information. Modifier -25 was effective June 5, 2000 for hospital use. Refer to PM A-00-07 (CR 1079), dated February 2000.

NOTE: The effective date and the implementation date for use of modifiers has not changed.

Background

Payment for a diagnostic (with the exception of pathology and laboratory) and/or therapeutic procedure(s) (code ranges 10040-69990, 70010-79999 and 90281-99140) includes taking the patient's blood pressure, temperature, asking the patient how he/she feels and getting the consent form signed. Since payment for these types of services is already included in the payment for the procedure, it is not appropriate to bill for an Evaluation and Management (E/M) service separately.

However, there are circumstances when it is appropriate to report an E/M service code in addition to the procedures provided on the same date, provided the key components (i.e. history, examination and medical decision making) are met.

The Current Procedural Terminology (CPT-4) manual gives the definition of modifier -25 as follows:

(From CPT-4, copyright American Medical Association)

“Significant, Separately Identifiable Evaluation and Management Service by the Same Physician on the Same Day of the Procedure or Other Service.”

Further explanation of the modifier is given as follows:

“The physician may need to indicate that on the day of 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. 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 reporting of the E/M services on the same date. This circumstance may be reported by adding the modifier ‘ -25’ to the appropriate level of E/M service...”

HCFA Pub. 60A

Guidelines

1. Should a separately identifiable E/M service be provided on the same date that a diagnostic and/or therapeutic procedure(s) is performed, information substantiating the E/M service must be clearly documented in the patient's medical record, to justify use of the modifier –25.
2. Modifier –25 may be appended only to E/M service codes and then only for those within the range of 99201-99499. For outpatient services paid under OPSS, the relevant code ranges are:

99201-99215	(Office or Outpatient Services)
99281-99285	(Emergency Department Services)
99291	(Critical Care Services)
99241-99245	(Office or Other Outpatient Consultations)

NOTE: For the reporting of services provided by hospital outpatient departments, off-site provider departments, and provider-based entities, all references in the code descriptors to “physician” are to be disregarded.

Example: A patient reports for pulmonary function testing in the morning and then attends the hypertension clinic in the afternoon.

The pulmonary function tests are reported without an E/M service code. However, an E/M service code with the modifier –25 appended should be reported to indicate that the afternoon hypertension clinic visit was not related to the pulmonary function testing.

3. Medicare requires that modifier –25 **always be appended to the emergency department (ED)E/M code (99281-99285)** when provided on the same date as a diagnostic medical/surgical and/or therapeutic medical/surgical procedure(s).

Example #1: A patient is seen in the ED with complaint of a rapid heartbeat. A 12-lead ECG is performed.

In this case, the appropriate code(s) from the following code ranges can be reported:

99281-99285	(Emergency Department Services) with a modifier –25
93005	(Twelve lead ECG)

Example #2: A patient is seen in the ED after a fall. Lacerations sustained from the fall are repaired and radiological x-rays are performed.

In this case, the appropriate code(s) from the following code ranges can be reported:

99281-99285	(Emergency Department Services) with a modifier –25
12001-13160	(Repair/Closure of the Laceration)
70010-79900	(Radiological X-ray)

Example #3: A patient is seen in the ED after a fall, complaining of shoulder pain. Radiological x-rays are performed.

In this case, the appropriate code(s) from the following code ranges can be reported:

99281-99285	(Emergency Department Services) with a modifier –25
70010-79900	(Radiological X-ray)

NOTE: Using example #3 above, if a subsequent ED visit is made on the same date, but no further procedures are performed, appending modifier –25 to

that subsequent ED E/M code is NOT appropriate. However, in this instance, since there are two ED E/M visits to the same revenue center (45X), condition code G0 (zero) must be reported in form locator 24 or the corresponding electronic version of the UB92.

4. Since payment for taking the patient's blood pressure, temperature, asking the patient how he/she feels, and obtaining written consent is included in the payment for the diagnostic and/or therapeutic procedure, it is not appropriate to report a separate E/M code for these types of service.
5. When the reporting of an E/M service with modifier -25 is appropriate (that is, the documentation of the service meets the requirements of the specific E/M service code), it is not necessary that the diagnosis code for which the E/M service was rendered be different than the diagnosis code for which the diagnostic medical/ surgical and/or therapeutic medical/surgical procedure(s) was performed

Summary for Use of Modifier -25 in Association with Hospital Outpatient Services

- Modifier -25 applies only to E/M service codes and then only when an E/M service was provided on the same date as a diagnostic medical/surgical and/or therapeutic medical/surgical procedure(s). In other words, modifier -25 does not apply when no diagnostic medical/surgical and/or therapeutic medical/surgical procedure(s) is performed.
- It is not necessary that the procedure and the E/M service be provided by the same physician/practitioner for the modifier -25 to apply in the facility setting. It is appropriate to append modifier -25 to the qualifying E/M service code whether or not the E/M and procedure were provided by the same professional.
- The diagnosis associated with the E/M service does not need to be different than that for which the diagnostic medical/surgical and/or therapeutic medical/surgical procedure(s) was provided.
- It is appropriate to append modifier -25 to ED codes 99281-99285 when these services lead to a decision to perform diagnostic medical/surgical and/or therapeutic medical/surgical procedure(s).

Modifier -25 was effective and implemented for hospital use on June 5, 2000 (see PM A-00-07). This PM provides additional informational only in understanding how this modifier should be used; therefore, this PM does not change the original effective and implementation dates.

These instructions should be implemented within your current operating budget.

This PM may be discarded after July 1, 2001.

Providers are to contact their appropriate fiscal intermediary only.