BlueCross BlueShield of Alabama

Name of Policy:
Modifier 25

Policy #: 330
Category: Administrative
Latest Review Date: October 2008
Policy Grade: Not Applicable

Background:
As a general rule, benefits are payable under Blue Cross and Blue Shield of Alabama health plans only in cases of medical necessity and only if services or supplies are not investigational, provided the customer group contracts have such coverage.

The following Association Technology Evaluation Criteria must be met for a service/supply to be considered for coverage:

1. *The technology must have final approval from the appropriate government regulatory bodies;*
2. *The scientific evidence must permit conclusions concerning the effect of the technology on health outcomes;*
3. *The technology must improve the net health outcome;*
4. *The technology must be as beneficial as any established alternatives;*
5. *The improvement must be attainable outside the investigational setting.*

Description of Procedure or Service:
Per the American Medical Association's (AMA) Current Procedural Terminology (CPT®), modifier 25 is used when an evaluation and management (E/M) service is **separate from** that required for the procedure and a **clearly documented, distinct, significant separately identifiable** service was rendered.

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. Depending on the level of visit billed, documentation for the E/M service should include the following components:

- History
  - Chief complaint
  - History of present illness
  - Review of system
  - Past, family, social history

- Physical Examination
- Medical Decision Making
    - Diagnoses and management options
    - Diagnostic procedures ordered and review

Policy:

Effective for dates of service on or after January 21, 2009:

Use of Modifier 25 **meets** Blue Cross and Blue Shield of Alabama's medical criteria for coverage when **all the following criteria** are met:

- E/M involves **separate and unique** conditions, services, procedures, incisions, excisions or anatomical sites;
- Procedure and medically necessary E/M occur on the same day by the same provider;
- A decision is made to perform a minor procedure. A minor surgical procedure is one that has a global aftercare period of 0-10 days based on universally recognized standards;
- The E/M service is above and beyond the usual preoperative, intraoperative, or postoperative care associated with the procedure that was performed and is in no way related to the procedure code submitted:
- E/M visit is problem oriented and stands alone as a billable service.

Use of Modifier 25 **does not meet** Blue Cross and Blue Shield of Alabama's medical criteria for coverage when:

- An E/M code is billed with major surgical procedures, spinal manipulations, or polysomnography. A major surgical procedure is one that has a global aftercare period of more than 10 days based on universally recognized standards; or
- Lab or x-ray services are the only other services provided in addition to the E/M; or
- The sole reason of the visit was for the procedure; or
- The E/M service is not above and beyond the primary purpose of the patient encounter; or
- Documentation does not support the definition of the modifier; or
- To bypass a fragmented coding edit.

For additional information on coverage for Modifier 25 please refer to:

https://www.bcbsal.org/codingEdits/coding.cfm

Blue Cross and Blue Shield of Alabama does not approve or deny procedures, services, testing, or equipment for our members. Our decisions concern coverage only. The decision of whether or not to have a certain test, treatment or procedure is one made between the physician and his/her patient. Blue Cross and Blue Shield of Alabama administers benefits based on the members' contract and corporate medical policies. Physicians should always exercise their best medical judgment in providing the care they feel is most appropriate for their patients. Needed care should not be delayed or refused because of a coverage determination.

Key Points:

Per the 2008 CPT, "A modifier provides the means to report or indicate that a service or procedure that has been performed has been altered by some specific circumstance but not changed in its definition or code. Modifiers also enable health care professionals to effectively respond to payment policy requirements established by other entities".

AMA instructions for using modifier 25 are: "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….The E/M service may be prompted by the symptom or conditions for which the procedure ans/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 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".

Examples of appropriate use of modifier 25:
A patient becomes dizzy, falls, hits his/her head and requires sutures to the head wound. The physician evaluates the reason for the patient's dizziness in addition to suturing the head wound. An E/M with modifier 25 can be billed with the procedure code for repair of skin wound.

A patient is being followed by a dermatologist for rosacea. During a scheduled visit to reorder medication for the rosacea, the patient mentions to the physician that he/she has noticed a new pigmented lesion on the upper thigh area. The physician excises the lesion. Both an E/M and excision of a lesion could be billed under these circumstances.

A patient comes to the physician with a complaint of bunions. The patient is examined and surgery is recommended and scheduled. While examining the patient, the physician also notices the patient has yellow, thickened toenails. A prescription is given and the toenails are debrided. The patient was seen and treated for separately identifiable services and both the E/M and parring procedure can be billed.

Examples of inappropriate use of modifier 25:
A patient trips, falls, and hits his/her knee and requires sutures to the wound. The patient is seen in his/her primary care physician's office and for sutures to the wound. The E/M services would be included in the simple repair of skin wound.

A patient is being followed by a dermatologist for acne. The patient is seen, medication is ordered and acne cysts are injected. The E/M service would be included in the acne surgery.

A patient comes to the physician with yellow, thickened toenails. These are débrided and a prescription given. The E/M service of evaluating the patient and making a decision to debride the nails is included it the payment for the procedure.

Key Words:
Modifier 25

Approved by Governing Bodies:
Not applicable

Benefit Application:
Coverage is subject to member's specific benefits. Group specific policy will supersede this policy when applicable.

ITS: Home Policy provisions apply
AT&T contracts: No special consideration
FEP contracts: Not applicable
Wal-Mart: Special benefit consideration may apply. Refer to member's benefit plan.
Pre-certification requirements: Not applicable
Pre-determination requirements: Not applicable

Coding:
Modifier 25 Significant, Separately Identifiable Evaluation and Management Service by the Same Physician on the Same Day of the procedure or Other Service

References:

1. American Medical Association *Current Procedural Terminology* 2008
2. Grinder DJ. *Coding with Modifiers*. American Medical Association; Third ed. 2007.

Policy History:
Medical Policy Group, October 2008 **(2)**
Medical Policy Administration Committee, November 2008
Available for comment October 22-December 5, 2008
