There are occasions that warrant both a patient encounter and a surgical or other significant procedure, but it may be difficult to determine when both services can be charged. According to authoritative coding guidance and Medicare regulations, the global surgical package includes all necessary services normally furnished before (preoperative), during (intraoperative) and after (postoperative) a procedure by the surgeon or by members of the same group within the same specialty. The global surgical package applies to physician (or qualified nonphysician healthcare professional) services in any setting, including inpatient hospital, outpatient hospital, Ambulatory Surgical Center (ASC) and physician office. When all criteria are met for separate payment of the patient visit and procedure, it may be necessary to append a modifier to the evaluation and management (E/M) code. The CPT Manual defines modifier 25 as follows:

Significant, separately identifiable evaluation and management services by the same physician or other qualified healthcare professional on the same day other procedure or other service: It may be necessary to indicated 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 or 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

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1 CPT® Assistant, March 2012
be reported. 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 modifier 25 to the appropriate level of E/M service.

The Office of Inspector General (OIG) published a report titled “Use of Modifier 25” in November 2005, which reviewed provider application of modifier 25; this report includes:

Thirty-five percent of claims using modifier 25 that Medicare allowed in 2002 did not meet program requirements, resulting in $538 million in improper payments. Medicare should not have allowed payment for these claims because the E/M services were not significant, separately identifiable, and above and beyond the usual preoperative and postoperative care associated with the procedure; or because the claims failed to meet basic Medicare documentation requirements.

For coding purposes, the main difficulty surrounds identifying when the patient evaluation represents a “significant, separately identifiable service.” BlueCross BlueShield of Alabama states that a separate payable visit is problem-oriented and stands alone as a billable service. Medical record documentation should clearly support substantial patient evaluation work not usually performed when deciding whether or not to perform the surgical or other procedure.

PROFESSIONAL APPLICATION OF MODIFIER 25

CPT® Assistant, March 2012 provides details of services included in the surgical or significant medical procedure, such as dictating procedure notes, talking with the family or other physicians, writing orders, evaluating the patient prior to or immediately after the procedure and typical follow-up care. This document also provides the following instructions for reporting a significant, separate encounter with modifier 25:

- Was the physician’s evaluation and management of the problem significant and beyond the normal preoperative and postoperative work? If yes, then an E/M service may be reported with modifier 25 appended. If not, it is not appropriate to report an E/M service with modifier 25 appended, as the service is included as part of the surgical package.
- Was the procedure or service scheduled before the patient encounter? If yes, then it would not be medically necessary to report an E/M service unless the patient had other concerns or problems that were addressed during the same encounter.

Medicare developed the National Correct Coding Initiative (NCCI) Policy Manual to promote consistent and correct coding, and reduce inappropriate payments. Chapter 1 of this guide states:

If a procedure has a global period of 000 or 010 days, it is defined as a minor surgical procedure. In general E&M services on the same date of service as the minor surgical procedure are included in the payment for the procedure. The decision to perform a minor surgical procedure is included in the payment for the minor surgical procedure and should not be reported separately as an E&M service. However, a significant and separately identifiable E&M service unrelated to the decision to perform the minor surgical procedure is separately reportable with modifier 25. The E&M service and minor surgical procedure do not require different diagnoses. If a minor surgical procedure is performed on a new patient, the same rules for reporting E&M services apply. The fact that the patient is “new” to the provider is not sufficient alone to justify reporting an E&M

For coding purposes, the main difficulty surrounds identifying when the patient evaluation represents a “significant, separately identifiable service.”
service on the same date of service as a minor surgical procedure.

Procedures with a global surgery indicator of "XXX" are not covered by these rules. Many of these "XXX" procedures are performed by physicians and have inherent pre-procedure, intra-procedure and post-procedure work usually performed each time the procedure is completed. This work should never be reported as a separate E&M code. Other "XXX" procedures are not usually performed by a physician and have no physician work relative value units associate with them. A physician should never report a separate E&M code with these procedures for the supervision of others performing the procedure or for the interpretation of the procedure. With most "XXX" procedures, the physician may, however, perform a significant and separately identifiable E&M service on the same date of service which may be reported by appending modifier 25 to the E&M code.

Therefore, visits by the same physician or qualified nonphysician healthcare professional on the same day as a minor surgery or endoscopy are included in the global package, unless documentation supports a significant, separately identifiable service from the surgical procedure. For major procedures, preoperative visits after the decision is made to operate are included in the surgical package. Chapter 9 of the National Correct Coding Policy adds:

When physician interaction with a patient is necessary to accomplish a radiographic procedure, typically occurring in invasive or interventional radiology, the interaction generally involves limited pertinent historical inquiry about reasons for the examination, the presence of allergies, acquisition of informed consent, discussion of follow-up, and the review of the medical record. In this setting, a separate evaluation and management service is not reported. As a rule, if the medical decision making that evolves from the procurement of the information from the patient is limited to whether or not the procedure should be performed, whether comorbidity may impact the procedure, or involves discussion and education with the patient, an evaluation/management code is not reported separately. If a significant, separately identifiable service is rendered, involving taking a history, performing an exam, and making medical decisions distinct from the procedure, the appropriate evaluation and management service may be reported.

As indicated, if the purpose of the encounter is simply to explain the procedure, obtain informed consent and acquire pertinent history and related information, there is no separate visit to charge. Chapter 9 also includes the following specialty-specific guideline:

In radiation oncology, evaluation and management CPT® codes are not separately reportable except for an initial visit at which time a decision is made whether to proceed with the treatment. Subsequent evaluation and management services are included in the radiation treatment management CPT® codes.

This section of the Policy Manual illustrates the need research more than modifier 25 guidelines in order to make the determination to bill a separate patient visit service.
HOSPITAL APPLICATION OF MODIFIER 25

When a patient visit is performed in the hospital outpatient department, the physician or nonphysician practitioner bills and receives reimbursement for the professional service only. The hospital then charges the insurer for the practice expense technical component for this service; this is commonly referred to as the hospital clinic visit. Each technical patient encounter is reimbursed with an Ambulatory Payment Classification (APC) allowance, in the same manner as other outpatient procedures. With the implementation of the Outpatient Prospective Payment System (OPPS) in August 2000, CMS issued guidelines for the reporting of hospital clinic visit codes and effective January 1, 2014, CMS collapsed these technical clinic visits into a single HCPCS Level II code:

G0463 Hospital outpatient clinic visit for assessment and management of a patient

Payors other than Medicare should be contacted to obtain their policy, since many non-governmental insurers continue to accept the new patient (codes 99201-99205) and established patient (codes 99211-99215) E/M codes for hospital clinic visits. The Medicare Benefit Policy Manual, Chapter 6, defines a hospital technical visit:

A hospital outpatient “encounter” is a direct personal contact between a patient and a physician, or other person who is authorized by State licensure law and, if applicable, by hospital or CAH (Critical Access Hospital) staff bylaws, to order or furnish hospital services for diagnosis or treatment of the patient.

As indicated, the definition of the hospital technical service is not considered to be a “nurse visit;” nurses are not separately reimbursed for patient visits in any practice setting. In all correspondence regarding charges for clinic visits, CMS has stated that the facility should base the technical charge on all hospital resources utilized during the outpatient encounter. For example, items such as room use, overhead costs, nursing services, nutrition services, patient navigators, social work, pain management assessments and scheduling diagnostic tests may be included in the technical patient visit service performed.

CMS also provides the following information relating to billing both a service or procedure and patient encounter service during the same treatment session:

Billing a visit code in addition to another service merely because the patient interacted with hospital staff or spent time in a room for that service is inappropriate. A hospital may bill a visit code, based on the hospital’s own coding guidelines, which must reasonably relate the intensity of hospital resources to the different levels of HCPCS codes. Services furnished must be medically necessary and documented.

If the purpose of the encounter is simply to explain the procedure, obtain informed consent and acquire pertinent history and related information, there is no separate visit to charge.

vii http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Downloads/OPPS_QandA.pdf

“ If the purpose of the encounter is simply to explain the procedure, obtain informed consent and acquire pertinent history and related information, there is no separate visit to charge. ”
The objective of the MSE is to determine whether or not an emergency medical condition exists. This does not mean that all EMTALA screenings must be equally extensive. If the nature of the individual’s request makes it clear that the medical condition is not of an emergency nature, the MSE is reflective of the individual presenting complaints or symptoms.

A hospital may, if it chooses, have protocols that permit a QMP (qualified medical personnel) (e.g., registered nurse) to conduct specific MSEs if the nature of the individual’s request for examination and treatment is within the scope of practice of the QMP (e.g., a request for a blood pressure check and that check reveals that the patient’s blood pressure is within normal range). Once the individual is screened and it is determined the individual has only presented to the ED for a nonemergency purpose, the hospital’s EMTALA obligation ends for that individual at the completion of the MSE. Hospitals are not obligated under EMTALA to provide screening services beyond those needed to determine that there is no EMC.

This means that there is no requirement for an extensive or separate patient evaluation on all patients presenting to the Emergency Department. The American College of Emergency Physicians (ACEP) adds:

An E/M service that represents a separately identifiable service (e.g., to rule out additional injuries, screening for physiologic etiology, or manage an illness) can always be reported with a procedure. If, however, performance and documentation only addresses the surgical procedure and does not provide an overall evaluation of the patient’s condition, history of injury, review of related and/or additional systems, comorbidities, allergy status and management options, only the surgical procedure may be reported. As a result, documentation of a medically necessary, significant, separately identifiable patient visit is required in all practice settings when modifier 25 will be appended to obtain separate reimbursement for the encounter.

Any individual with a medical condition that presents to a hospital’s ED [Emergency Department] must receive an MSE that is appropriate for their medical condition.

EMTALA

In 1986 Congress enacted the Emergency Medical Treatment and Labor Act (EMTALA) to ensure public access to emergency services regardless of the ability to pay. Section 1867 of the Social Security Act (SSA) imposes specific obligations on Medicare participating hospitals that offer emergency services to provide a medical screening examination (MSE) when a request is made for examination or treatment for an emergency medical condition (EMC), regardless of the patient’s ability to pay. Hospitals are then required to provide stabilizing treatment or appropriate transfer for patients with EMCs. Medicare states:

Any individual with a medical condition that presents to a hospital’s ED [Emergency Department] must receive an MSE that is appropriate for their medical condition.
SUMMARY

If there is a significant, separately identifiable visit performed on the same date as a procedure, modifier 25 may be appended to report this circumstance in all practice settings. Remember that local Medicare contractor or other payor guidelines take precedence over general coding guidelines and should be carefully reviewed. Complete documentation of all services performed and appropriate use of modifier 25 can ensure that patient encounters and procedures performed on the same day are correctly reimbursed. Considering the many auditing entities watching for mistakes in this area, it is worth the extra effort to make sure that all compliance guidelines are being followed.
MODIFIER 25 SETTLEMENTS
Following are some of the relevant settlements relating to the incorrect application of modifier 25 by the hospital or professional practice:

**EASTON HOSPITAL AGREED TO PAY THE GOVERNMENT $454,866 TO RESOLVE ALLEGATIONS OF IMPROPER MEDICARE CLAIMS.**
The settlement states “In this matter, the government determined that Easton Hospital incorrectly attached modifier 25 to Medicare claims that led Medicare to pay the hospital for evaluation and management services that were not significant and separately identifiable from the underlying procedure for which Medicare also paid the hospital.”

**ST. LUKE’S UNIVERSITY HEALTH NETWORK AGREED TO PAY THE GOVERNMENT $1,029,791 TO RESOLVE ALLEGED IMPROPER MEDICARE CLAIMS.**
According to the Department of Justice release “Medicare does not normally allow additional payments for such services performed by a provider on the same day as a procedure unless the service is significant, separately identifiable and above and beyond the usual preoperative and postoperative care associated with the procedure.”

**ONCOLOGY PRACTICE TO PAY $4.1 MILLION TO SETTLE FALSE CLAIMS ACT INVESTIGATION.**
The settlement includes “The civil settlement resolves the United States’ investigation into Georgia Cancer Specialists’ practices relating to billing for evaluation and management (E&M) services on the same day as a related procedure.”

**DERMATOLOGY PHYSICIANS AND PRACTICE TO PAY $1.9 MILLION TO SETTLE FALSE CLAIMS ACT INVESTIGATION INTO OVERBILLING MEDICARE FOR EVALUATION AND MANAGEMENT SERVICES.**
The Department of Justice release states “Providers are not permitted to bill both E&M services and a procedure on the same day under the Medicare program’s regulations unless a significant, separately identifiable service has been performed.”
“HHS-OIG has identified the inappropriate billing of E&M services as a national issue costing taxpayers billions of dollars.”

**SUFFIELD DOCTOR PAYS $379,764 TO SETTLE ALLEGATIONS UNDER THE FALSE CLAIMS ACT.**
The Federal Bureau of Investigation release states “Medicare does not normally allow additional payments for evaluation and management services performed by a provider on the same day as a procedure because it is expected that most procedures involve some pre-procedure and post-procedure care that is part of the payment for that procedure.”

“HHS-OIG has identified the inappropriate billing of E&M services as a national issue costing taxpayers billions of dollars.”
## EXAMPLES

A patient becomes dizzy, falls and lacerates his head. The physician fully evaluates the reason for the patient’s dizziness in addition to suturing the head wound. An E/M with modifier 25 can be billed in addition to the wound repair procedure code.

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 she has noticed a new pigmented lesion on the right upper thigh area. The physician evaluates and excises this new lesion. Both an E/M with modifier 25 and the excision of the lesion can be billed.

A patient trips, falls and injures his knee, requiring sutures. The patient is seen in the Emergency Department and the wound is sutured. The patient evaluation of the injured knee is included in the simple repair of the 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 patient evaluation is included in the acne surgery.

If a physician determines that a new patient with head trauma requires sutures, confirms the allergy and immunization status, obtains informed consent, and performs the repair, an E/M service is not separately reportable. However, if the physician also performs a medically reasonable and necessary full neurological examination, an E/M service may be separately reportable.

The patient presents for quarterly follow-up. The physician sees her and looks over the blood work drawn that day. Laboratory tests show the patient is anemic and iron reserves are very low, so an intravenous iron infusion is ordered and performed. The physician documents that the patient has noticed some rectal bleeding this week and he orders additional studies to determine the cause of the bleeding and if this could be contributing to the anemia. The patient encounter would be reported with modifier 25 in this instance, since documentation supports a significant, separate patient encounter in addition to the intravenous infusion.

The physician examines a new patient for upper respiratory infection. During the examination, the patient reports difficulty hearing from his left ear. The physician completes documentation of a comprehensive respiratory evaluation and removal of cerumen. The patient encounter would be reported with modifier 25, since documentation supports an extensive, separate patient encounter.

Note that in these examples, the timing of the services is not the issue. What matters is whether the office visit is a significant, separately identifiable service from the procedure being performed. Sometimes that line is easy to recognize; at other times it is strictly a judgment call. The documentation from the physician should be as clear as possible, especially in the assessment and plan so that a reasonable determination can be made.