Network Notification

Date: January 21, 2013 **Number: OH-P-2013-01**

To: Ohio Facilities

From: CareSource

Subject: Outpatient Facility claims & Requirement of Modifier 25

Effective: March 1, 2013

The purpose of this document is to outline the edit that is specific to billing of office visits and procedure without the Modifier 25.

Policy

CareSource ("CS") will reimburse facilities for outpatient billings in which an Evaluation and Management ("E/M") service and related procedure are billed for the same date with the same patient, provided they use modifier 25. Otherwise the billing will be denied stating the following: **The procedure code is inconsistent with the modifier used or a required modifier is missing**.

Definitions

A "significant, separately identifiable" E/M service is one with separate documentation of the components of an E/M service.

- Documentation should be extensive enough that the additional service is readily identifiable.
- The E/M service must require additional history, exam, knowledge, skill, work time, and/or risk above and beyond what is usually required for the procedure.
- None of the documentation components required to report an E/M service may support the performance of the procedure itself; there must be separately identifiable documentation to report the procedure.

** This policy is not a guarantee of payment. Benefits may be subject to limitations &/or qualifications and will be determined when the claim is received for processing.

Provider Billing Guidelines

Modifier 25 is used to indicate that, on the day of a procedure or service identified by a CPT code, 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.

Reporting an E/M service with modifier 25 is only appropriate if one of the following conditions have been met:

- **The patient requires evaluation "above and beyond" what is typically expected as part of the evaluation prior to the procedure.**
- **The patient's condition has changed or worsened and the patient needs to be reevaluated.**
- **The patient presents with a new, separate problem than what prompted the procedure.**

By definition, the "above and beyond" requires that the evaluation be more than problem focused.

Example #1: *Scalp laceration and concussion*

A patient comes to the Emergency Department with a scalp laceration and the physician examines the scalp and sutures the laceration. Only the laceration code should be reported. However, if the physician performs a neurologic examination to determine whether the patient has sustained a concussion, the service is more extensive than what is typically required for a simple suture; the E/M should be reported with a modifier 25.

Example #2: *Skin lesions*

A patient comes in with a small lesion which is suspicious for skin cancer. Examination of the lesion and the decision to excise it is included in code 11601 and would not be separately billable. However, if examination of the lymph nodes in the area or examination of other areas of the skin for additional lesions was needed, the documentation of the extra examination would constitute a billable E/M service which would be reported with modifier 25.

Modifier 25 is only needed when the E/M service is performed by the same physician in a hospital setting on the same date as another service described with a separate CPT code. If an E/M service is the only service performed on that date, modifier 25 is not appropriate.

Modifiers should never be changed or added to claims unless the documentation has been reviewed and the use of the modifier is appropriate based on the documentation.

Related Polices & References

Medicare Claims Processing Manual Chapter 12 §§ 30.3.7, 40.2(A)(4)

CareSource policy – Evaluation and Management Services that Require Modifier 25.

Document History

December 17, 2012: Original documentation**.**

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