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How to Choose Between Modifiers 25 and 57

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When reporting an evaluation and management (E&M) service on the same claim with another service or procedure, you must append either modifier 25 "*Significant, separately identifiable evaluation and management service by the same physician or other qualified healthcare professional on the same day of the procedure or other service,*" or modifier 57, "*Decision for surgery*" to the E&M service code.

Modifier Identifies Separate Nature of E&M Service

Identifying a significant, separately billable E&M service is easier if the provider documents the history, exam and MDM in the patient's chart, and records the procedure note on a different sheet attached to the chart, or in a different section within the EHR (although separate documentation is *not* a requirement).

Note: *Some E&M services may be reported using time — rather than history, exam, and MDM — if counseling or coordination of care comprise more than half of the total visit time. In such a case, you may use CPT "reference times," along with patient status and place of service, to determine an appropriate E&M service level.*

Modifiers 25 and 57 alert the payer, "This is not a bundled E&M service, but rather a separately billable service supported by medical necessity and clinical documentation." If you fail to append the proper modifier, the insurer will assume the billed E&M service is incidental to other services reported, and will not pay for it.

Supporting a Separate E&M Service

Typically, medical necessity and clinical documentation will support a separately billable E&M service when the patient presents with a new problem that requires evaluation and treatment. Or, the patient presents with an established problem that has worsened and requires further evaluation and a change in treatment plan. When an E&M service leads to an unplanned, same-day procedure, documentation must establish that the decision to perform procedure was made during the encounter.

Each CPT code reported must be linked to a diagnosis substantiated in the medical record. CMS Transmittal R954CP establishes that an 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."

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Global Period Determines Correct E&M Modifier

CMS and nearly all private payers classify non-E&M procedures as either "major" or "minor." This information is crucial to determine whether modifier 25 or modifier 57 is appropriate to append to the E&M service code reported.

Major procedures have a 90-day global period. All other procedures (e.g., those with a zero-day, 10-day, or other assigned global period) are minor procedures. You can find a global period look-up tool on the CMS website: cms.gov/apps/physician-fee-schedule/overview.aspx.

Append Modifier 25 for Minor Procedures

If the provider furnishes a minor procedure and a separate E&M on the same date of service (at the same or a separate encounter), append modifier 25 to the E&M service code. Examples of minor procedures include many injections.

Turn to 57 for Major Procedures

Append modifier 57 to a separately identifiable E&M service that occurs on either the same day *or the day before*, a major surgical procedure, and that results in the decision to perform the surgery, per Medicare's *Claims Processing Manual*, section 40.2.

CPT guidelines do not allow separate payment for a E&M service to clear a patient for surgery, after the decision for surgery has been made, stating, "Evaluation and management services subsequent to the decision for surgery on the day before and/or day of surgery (including history and physical)" are "included in addition to the operation per se."