

**Use of Modifier 25**  
**for**  
**Reporting of Emergency Department Facility Fees**

Much discussion has taken place since the implementation of Medicare's Outpatient Prospective Payment System (OPPS). One of the most controversial and confusing issues regards the use of Modifier -25 as it pertains to hospital services provided in the Emergency Department. There have been two transmittals from CMS on this subject – **Transmittal A-00-40** posted in July of 2000 and Transmittal A-01-80 posted in June of 2001. All subsequent discussion on this subject has referred to these two transmittals.

First let's look at **Transmittal (A-00-40)**. The following definition of Modifier -25 is given:

***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.

**CPT- 4: Definition of Modifier -25**

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..."

Under the guidelines section of this transmittal, numerical point #3 states the following:

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)

The above point would indicate that the use of modifier -25 is somehow different when used in the **Emergency Department** because it is **“always appended to codes 99281 – 99285 when reported on the same date as a diagnostic medical/surgical and/or therapeutic medical/surgical procedure(s).** This is a standalone point in the guidelines identifying the Emergency Department E&M codes used to report **facility fees** in the department. The point is made due to the fact that there is always a separately identifiable E&M service recorded by the ED physician since these patients have never been seen by that physician and any procedure done requires a separate E&M service.

There was initial confusion as to the use of this modifier for hospital use so CMS posted **Transmittal A-01-80** in June of 2001 for clarification. Point C under general guidelines in this transmittal states the following:

- C. Although we stated in Transmittal A-00-40 that Medicare requires that modifier –25 **“always be appended to the Emergency Department E/M codes when provided . . .”** the Outpatient Code Editor (OCE) only requires the use of modifier –25 on an E/M code when it is reported with a procedure code that has a status indicator of “S” or “T.” Nevertheless, such an edit does not preclude the reporting of modifier –25 on E/M codes that are reported with procedure codes that are assigned to other than “S” or “T” status indicators, if the procedure meets the definition of “significant, separately identifiable E/M service.”

Note the OCE will continue to process claims for those procedure codes that are assigned to other than “S” or “T” status indicators if it is reported with an E/M code and a modifier –25.

This was the only clarification published on this subject, and it still seems that the use of modifier 25 as it pertains to reporting hospital facility fees (E&M codes) under the OPPTS in the Emergency Department is different. The only real clarification in Transmittal A-01-80 pertains to the fact that modifier -25 need only be added to the facility fee codes when the procedure has a status indicator of “S” or “T”. Since CPT codes in the range of 70010-79999 (X-Rays) have a status indicator of “X” it appears that it is not necessary to append Modifier 25 to the facility code (99281-99285 and 99291) when an X-Ray is the only procedure done. The last sentence of the transmittal is a little baffling. The phrase “if the procedure meets the definition of significant, separately identifiable E/M service” does not seem to make sense. It is unclear how a “procedure” can meet the definition of an E/M service.

## Conclusion

In conclusion, it appears that guidance from CMS indicates that under OPSS rules, hospitals should **always append Modifier 25 to the Emergency Department facility fee codes (99281-99285) when any procedure having a status indicator of “S” or “T” is performed.** Unfortunately there appears to be some indication from the OIG that hospitals are misusing this modifier, and in some instances, penalizing the hospital for this misuse.

Until there is absolute, crystal-clear guidance on the proper use of this modifier as it pertains to facility coding in the Emergency Department, hospitals are at risk of being penalized due to a misinterpretation. Clarification from the FI (MAC) is imperative and hospitals should seek this as soon as possible to avoid any future problems.

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