https://www.wpsgha.com/wps/portal/mac/site/claims/guides-and-resources/modifier-25/!ut/p/z0/fY2xDoIwFEV_BQfG5hWMhBWNhhiIxsFgF1NLxafQQltE_150cjCO9-See4FBAUzxO1bcoVa8HvOBRcdtmkZpENNsE-aUJvlqP13G2TzeBbAG9r8wLuC161gCTGjl5MNBMbTW-wTlPKmqGu3Fp063KIgYmTQ-FTXHxvq06rGUlnBVEiOt7o2QI210iWeUhoSz90Fo8kVeAWu5uxBUZw3FLw-Kb6-9sdNzSCYvZpT_Pw!!/#

Definition: Significant, separately identifiable evaluation and management (E/M) service by the **same physician*** on the day of a procedure

***Same physician** - Medicare regulation states: "Physicians in the same group practice who are in the same specialty must bill and be paid as though they were a single physician."

All E/M services provided on the same day as a procedure are part of the procedure and Medicare only makes separate payment if an exception applies.

Appropriate Usage

- Modifier 25 indicates that on the day of a procedure, the patient's condition required a significant, separately identifiable E/M service, above and beyond the usual pre and post-operative care associated with the procedure or service performed.
- Use Modifier 25 with the appropriate level of E/M service.
- The procedure performed has a global period listed on the Medicare Fee Schedule Relative Value File. This global period could be 000, 010, or 090 days.
- An E/M service may occur on the same day as a procedure and within the post-operative period of a previous procedure. Medicare allows payment when the documentation supports the 25 modifier and the 24 modifier (unrelated E/M during a post-operative period.)
- Use Modifier 25 in the rare circumstance of an E/M service the day before a major surgery that is not the decision for surgery and represents a significant, separately identifiable service.

Inappropriate Usage

- A physician other than the physician* performing the procedure.
- Documentation shows the amount of work performed is consistent with that normally performed with the procedure.

The following statements are false

- I can always use this modifier when I did not plan the procedure.
- I can always use this modifier when the diagnoses are different.
- I can never use this modifier when the diagnoses are the same.

Procedure codes:

- G0181-G0182 Care Plan Oversight Supervision
- 92002-92014 E/M Ophthalmology
- 99201-99499 E/M all locations

Wound Care Today- this example is also discussed and presented as Follow Up visit.

Scenario 4: When a procedure, such as debridement of subcutaneous tissue, was performed on the patient's first visit to the PBD, the physicians/QHPs and the PBD always reported a clinic visit/E&M code and the subcutaneous tissue debridement code. The compliance officer does not think a clinic visit/E&M code is always justified. Who is correct?

Scenario 4: When a minor procedure is performed, an E&M/clinic visit code should only be reported when a significant and separately identifiable E&M service (unrelated to the decision to perform a minor surgical procedure) is performed by the same physician/QHP on the same day the procedure is performed. The National Correct Coding Initiative Policy Manual for Medicare Services states that "The fact that the patient is 'new' to the provider is not sufficient alone to justify reporting an E&M service on the same date of service as a minor surgical procedure."[1]

https://www.wpsgha.com/wps/portal/mac/site/claim-review/guides-and-resources/post-pay-wound-care/!ut/p/z0/fYxLCsIwFABPFF5asXSrogRpaFeSvo082hiDkoR8Kt7enMDlMMMAggJ0tFlD2XpH78ozdvdJiE40PR_GVnJ-kJfb7twPx7HZwxXwf1APbZQnaQAD5Sez7uFBmWJXnRi5lUWdfImLTqCCT5kF-rKPL9UsFDWEF84_tcS_EQ!!/

Post Pay Wound Care

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Jurisdictions: **J8A**

You currently have jurisdiction J5A selected, however this page only applies to these jurisdiction(s): J8A.

CMS has authorized WPS GHA to conduct service specific post pay reviews. Data analysis indicates potential aberrancies related to wound care services (CPT code 11042). In accordance with the WPS GHA Local Coverage Determination (LCD) L37228 Wound Care, we will conduct medical review of these services. We expect the documentation to support the medical necessity of the current wound care plan. For wound care services by a Physical Therapist (PT), we expect a written order specifying the type of debridement by the referring physician prior to initiation of care.

Documentation Guidance for a Successful Review of Wound Care

Documentation to support the wound care services are for a covered condition

Plan of care including treatment goals

Ongoing evidence of plan effectiveness

Wound dimensions pre and post debridement

Physician orders

Physician progress notes

Photographic documentation of wounds, if applicable

Treatment records

Advanced Beneficiary Notice of Noncoverage (ABN), if applicable

Any additional documentation needed to support Medicare guidelines

Wound Care Resources

LCD L37228
Service Specific Post Pay Reviews
Medical Review Calculator
Use the WPS GHA Portal to Submit Documentation