

Modifier 25 Audit Worksheet

Find out if you're over-using it (risk) or under-using it (lost revenue).

Why audit it: modifier 25 is one of the most frequently reviewed modifiers by the OIG and payers. Practices get it wrong in both directions — billing E/M visits that aren't separate (risk), and skipping E/M visits that are (lost revenue).

The rule on one page

- **CPT definition:** a significant, separately identifiable E/M service by the same physician or other qualified health professional on the same day as a procedure or other service.
- **Minor procedures (0- or 10-day global):** the decision to perform the procedure and the routine pre-procedure evaluation are already paid in the procedure (CMS/NCCI). An E/M is billable only for work beyond that.
- **Major procedures (90-day global):** the decision for surgery the day before or day of uses **modifier 57**, not 25.
- **A different diagnosis is not required** — but the documentation must show separate, significant work.
- **Preventive + problem visit:** bill the preventive service and the problem-oriented E/M with modifier 25 when a real problem needs extra work. The same applies with the Medicare AWW (G0438/G0439).
- **G2211 note:** Medicare generally doesn't pay the G2211 add-on on an E/M with modifier 25 — except, starting in 2025, when the other same-day service is an AWW, vaccine administration, or a Medicare Part B preventive service.

Scenarios: supported or not?

Scenario	Modifier 25?	Why
Scheduled knee injection; no other complaint	No	Pre-procedure evaluation is part of the injection
Knee injection + new uncontrolled hypertension evaluated, meds changed	Yes	Separate problem, separate work, documented
Lesion examined and removed same visit; nothing else addressed	No	Decision to remove is included in the procedure
Annual physical + diabetes not at goal, insulin adjusted	Yes	Preventive code + problem E/M-25 for the additional work only
Annual physical; chronic conditions listed as 'stable, continue meds'	Usually no	Minimal work usually fits inside the preventive service
Decision for hip replacement made at visit the day before surgery	No — use 57	Major procedure (90-day global)

The audit worksheet (20 + 10 claims)

Pull 20 recent claims with modifier 25, plus 10 same-day procedure claims **without** an E/M (to find missed revenue). Use an internal claim ID — no patient names.

Columns: A = separate problem or significant extra work documented? · B = work goes beyond the procedure's pre/post evaluation? · C = E/M level supported by the note? · Result = S (supported), N (not supported), M (missed opportunity)

[illegible]

Your score	Formula	Result	Target
Error rate	$N \div \text{claims reviewed with modifier 25}$	____ %	Under 10%
Missed opportunities	Count of M	____	0

Provider documentation tips

- Separate the note: a heading for the procedure and a distinct section for the E/M problem.

- State the extra work in plain words: what was evaluated, what was decided, what changed.
- Link the E/M diagnosis clearly — and give each chronic condition its own MEAT support so it also holds up for risk adjustment.
- Sign with credentials and date. Unsigned notes fail both a modifier 25 review and a RADV audit.

Sample statement for the E/M section

"In addition to the procedure above, I evaluated [problem], which required [history/exam/decision-making]. This was a significant, separately identifiable service. — [Provider name, credentials], [date]"

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Educational material based on the CPT modifier definition, the NCCI Policy Manual for Medicare Services, and the Medicare Physician Fee Schedule. Payer policies vary; not legal advice.