Payment Policy: Problem Oriented Visits Billed with Surgical Procedures

Reference Number: CC.PP.052
Date of Last Revision: 06/2026

Coding Implications
Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Policy Overview
Under modifier -25 correct coding principles, a patient may be seen by the physician for a problem-oriented evaluation and management (E&M) service on the same day of a procedure with a 0-, 10- or 90- day global surgical period if the physician indicates that the service is a significant and separately identifiable E&M service that is above and beyond the usual pre- and post-operative work associated with the procedure.

The purpose of this policy is to prevent duplicate payments that occur when a provider is reimbursed for resources not directly consumed during the provision of a service. Furthermore, to define payment criteria for problem-oriented visits when billed on the same day as a surgical procedure with a 0-, 10- or 90- day global period when making payment decisions and administering benefits.

Application
Physicians and other qualified health professionals.

Policy Description
Modifier -25 represents a significant and separately identifiable E&M service by the same physician or other qualified health care professional on the same day of the procedure or other service.

A physician or other qualified health professional may submit both a problem-oriented E&M CPT® code and a surgical procedure code on the same date of service for the same member/enrollee. Once clinically validated (see ***CC.PP.013 "Clinical Validation of Modifier -25"***) if the problem-oriented E&M represents a significant and separately identifiable E&M procedure or service, the problem-oriented procedure code will be reimbursed at a reduced rate.

Reimbursement
Providers do not incur duplicate indirect expenses with the problem-oriented E&M service when there is a surgical procedure on the same date of service. For example, obtaining vital signs, scheduling the visits, staffing, lighting, and supplying the examination room costs are not incurred twice by the provider. Reimbursement should not be duplicated for these services.

The health plan conducts a clinical claims review of E&M and surgery coding combinations when a problem-oriented visit is billed with a surgical procedure with a -0, -10 or -90 day global surgical procedure regardless if the modifier -25 is present.

If the problem-oriented visit is appended with modifier -25 or without modifier -25, and clinical claims review supports a significant and separately identifiable E&M service; the health plan will reimburse the surgical procedure plus 50 percent of the problem-oriented E&M code.

If the E&M service resulted in the decision to perform surgery, then modifier -57 should be appended to the E&M procedure code for consideration of payment when the decision for surgery was made within the global surgical period.

Documentation Requirements
The following guidelines will be used to determine whether or not coding principles for E&M services on the same date as a surgical procedure were used appropriately. If any one of the following conditions is met, then reimbursement for the E/M service is recommended:

- If the E/M service is the first time the provider has seen the patient or evaluated a major condition
- A diagnosis on the claim indicates that a separate medical condition was treated in addition to the procedure that was performed
- The patient's condition is worsening as evidenced by diagnostic procedures being performed on or around the date of services
- If a provider bills supplies or equipment, on or around the same date, that are unrelated to the procedure performed but would have required an E/M service to determine the patient's need

Coding and Modifier Information
This payment policy references Current Procedural Terminology (CPT®). CPT® is a registered trademark of the American Medical Association. All CPT® codes and descriptions are copyrighted 2025, American Medical Association. All rights reserved. CPT codes and CPT descriptions are from current manuals and those included herein are not intended to be all-inclusive and are included for informational purposes only. Codes referenced in this payment policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

CPT/HCPCS Code	Descriptor
99202	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using total time on the date of the encounter for code selection, 15 minutes must be met or exceeded.
99203	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.

CPT/HCPCS Code	Descriptor
99204	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, 45 minutes must be met or exceeded.
99205	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using total time on the date of the encounter for code selection, 60 minutes must be met or exceeded.
99212	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using total time on the date of the encounter for code selection, 10 minutes must be met or exceeded.
99213	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using total time on the date of the encounter for code selection, 20 minutes must be met or exceeded.
99214	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.
99215	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using total time on the date of the encounter for code selection, 40 minutes must be met or exceeded.
G0463	Hospital outpatient clinic visit for assessment and management of a patient

Modifier	Descriptor
25	Significant, Separately Identifiable Evaluation and Management Service by the Same Physician on the Same Day of the Procedure or Other Service
57	Decision for Surgery

Definitions

Global Surgical Procedure
Procedures with a 0-, 10- or 90- day postoperative period. This period includes follow up office visits during the period after the surgery has been performed and that are related to recovery from the surgery.

Problem-Oriented Evaluation and Management Service
An abnormality or a preexisting condition that is encountered during the process of a patient's preventative E&M service that is significant enough to require additional work by the physician to perform the key components of a problem-oriented E&M service.

Related Policies

Policy Name	Policy Number
Clinical Validation of Modifier 25	CC.PP.013

References

1. *Current Procedural Terminology (CPT)®*, 2025
2. *HCPCS Level II*, 2026
3. CMS Medicare Claims Processing Manual, Chapter 12, Physicians and Nonphysician Practitioners

Revision History	
08/09/2017	Original Policy Draft
12/11/2017	Added the following codes and descriptions (99201-99205)
04/24/2019	Conducted review, verified codes, updated policy
04/26/2020	Conducted review, verified codes, updated policy and removed eff date
04/26/2021	Conducted review, deleted 99201 and updated all other codes to reflect revised guidelines
04/26/2022	Conducted annual review, updated policy dates, removed product type
04/17/2023	Conducted annual review, verified codes, updated copyright dates
06/16/2024	Conducted annual review, verified codes and updated descriptions to reflect current terminology, updated policy
06/26/2025	Conducted annual review, verified codes and updated CPT descriptors to reflect current terminology, updated policy
06/05/2026	Conducted annual review, updated revision and copyright dates. Updated "member" to "member/enrollee." Changed "Last Review Date" in header to "Date of Last Revision."

Important Reminder
For the purposes of this payment policy, "Health Plan" means a health plan that has adopted this payment policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any other of such health plan's affiliates, as applicable.

The purpose of this payment policy is to provide a guide to payment, which is a component of the guidelines used to assist in making coverage and payment determinations and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage and payment determinations and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage,

certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable plan-level administrative policies and procedures.

This payment policy is effective as of the date determined by Health Plan. The date of posting may not be the effective date of this payment policy. This payment policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this payment policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. Health Plan retains the right to change, amend or withdraw this payment policy, and additional payment policies may be developed and adopted as needed, at any time.

This payment policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care and are solely responsible for the medical advice and treatment of members/enrollees. This payment policy is not intended to recommend treatment for members/enrollees. Members/enrollees should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this policy are independent contractors who exercise independent judgment and over whom Health Plan has no control or right of control. Providers are not agents or employees of Health Plan.

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Note: For Medicaid members/enrollees, when state Medicaid coverage provisions conflict with the coverage provisions in this payment policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this payment policy.

Note: For Medicare members/enrollees, to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs and LCDs should be reviewed prior to applying the criteria set forth in this payment policy. Refer to the CMS website at http://www.cms.gov for additional information.

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