TOP CODING ERROR Q3 2025: A1C & Lipid +Modifier -25 & -59 in Primary Care Coding Guide (NCCI-Compliant – 2025)

MODIFIER -25
Definition: A significant, separately identifiable Evaluation & Management (E/M) service provided on the same date as another service by the same provider.
MODIFIER -59
Definition: Identifies a distinct procedural service from another
Modifier -59 is not for separating E/M from diagnostics.
Practical Explanation for Modifier -59
Modifier -59 tells the payer: "Yes, I did two procedures on the same day, and they were separate and necessary — not part of the same work."
When to think about it:

- You did two of the same procedures (like X-rays on both wrists)
- You repeated a test for medical reasons (like two glucose tests on the same day)

Best way to remember:
If you're doing something twice, Flu A+ B and the CPT codes are the same (87804, 87804-59)
NOTE ON QW modifiers on CLIA waived test are hard coded into Athena, so while they are required, they are not included here to allow focus on items that cannot be hard coded.

COMMON PRIMARY CARE SCENARIOS

Clinical Scenario	CPT Codes	Modifier Use	Explanation
Office Visit for wrist pain + wrist X-ray	99213, 73100	None	Not bundled; no modifier needed.
Office Visit + X-ray of Left & Right Wrists	99213-25, 73100-LT, 73100 -RT-59	-25 on E/M, -59 on 2nd X-ray	E/M is separately identifiable; second wrist X-ray needs -59 ***because the same CPT is used for left and right***.
Office Visit + EKG	9921393000	-25 on E/M	Not bundled with NCCI. Modifier -25 is needed to distinguish between visit content.
Office Visit + Spirometry + EKG	99213-25, 94010, 93000	-25 on E/M only	No NCCI edits between tests; no -59 needed.
Office Visit + Flu POCT + COVID POCT	99213-25, 87804, 87426	-25 on E/M only	No bundling between 87804 & 87426 per NCCI; no -59 needed.
Office Visit + Immunizations (e.g., Tdap)	99213-25, 90471, 90715	-25 on E/M	Use -25 if the visit included evaluation beyond the vaccine itself.
Office Visit + Urine Dipstick (Lab)	99213-25, 81002	-25 on E/M	No bundling: use -25 if the visit involves a broader assessment.
Repeat Glucose Tests, 2 separate times	82947, 82947-91	-59 on 2nd test	NCCI edit bundles of same-day duplicates; -59 needed on second.
Office Visit + Glucose POCT	99213-25, 82947	-25 on E/M only	No bundling: E/M is separately identifiable.
Office Visit + Strep Test + Flu Test	99213-25, 87880, 87804	-25 on E/M only	Not bundled per NCCI; no -59 needed.
Office Visits + Cepheid Xpert® Xpress SARS-CoV-2/Flu/RSV assay	99213 +87637-		
Office Visits+ Arthrocentesis	99213 – 20600	-25 on E/ M Only	99213 is bundled with code 20600, but a modifier is allowed

	Appropriate dx codes for A1C 83036 and Lipid 80061				
	CPT	**ICD-10**	**Description**	**Age**	**Frequency**
1	80061	Z13.220, Z13.6	Screening for lipid disorders	≥18	Medicare/ MA limited to every 5 yrs. No limit for other plans ASCVD Risk <10% over 10 yrs
2	80061	E78. *, E66. *, E03, E05, K85, K86.1, E08-E13, N18, Z33.1, K83.1, K74.5, E75.22	Lipid disorders	Any	As clinically needed
3	80061	E11. *, R73.03	Diabetes, prediabetes	Any	As clinically needed
4	83036	Z13.1	Diabetes mellitus screening	≥18	Medicare (q12 months) BCBS: Q3 years, all others as needed
5	83036	R73.03, E11., *E10*.	Prediabetes or diabetes	Any	As clinically needed

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Based on CMS NCD policy 190.23 and LCD L36358 combined with the most used covered diagnosis code for CPG claims in Q2 2025. All services that are billed with lab services billed under codes section 2 ,3 & 5 may have a cost share applied because these tests are considered diagnostic when billed with these diagnosis codes

ICD-10 Support for 83036 & 80061

CPT Code	Condition Category	ICD-10 Codes (Examples Indicating Coverage)
83036 (HbA1c)	Diabetes / Prediabetes Screen	E11.* (Type 2 Diabetes Mellitus), R73.01 (Impaired fasting glucose), R73.02 (Prediabetes), Z13.1 (Encounter for diabetes screening) Centers for Medicare & Medicaid ServicesAAPC
80061 (Lipid Panel)	Cardiovascular / Metabolic Risk	Z13.6 (Encounter for screening for cardiovascular disorders), Z13.220 (Encounter for screening for lipoid disorders), E78.* (Disorders of lipoprotein metabolism), I10 (Hypertension), R79.9 (Abnormal blood chemistry) MedicareQuest DiagnosticsTebra

Medicare

- **Preventive Screening**: A lipid panel (80061) is covered **once every five years** under the cardiovascular screening benefit (with ICD-10 code Z13.6) Medicare.
- **Chronic Condition Management**: For patients on dietary or pharmacologic therapy:
  - Up to **six panels** in the **first year** may be medically necessary.
  - Subsequent measurements (e.g., LDL or total cholesterol) may be covered **up to three times per year** after treatment goals are met Centers for Medicare & Medicaid ServicesQuest Diagnostics.
- **Other Conditions**: In cases such as non-specific liver abnormalities, panels may be covered **up to twice per year** Quest Diagnostics.

Summary Table

Payer	Frequency Limit for Lipid Panel (80061)
Medicare	Once every 5 years (preventive); up to 6x in first year if on therapy; up to 3x/year after goals met; <2x/year for liver issues
UHC	No set limit — clinical judgment guides frequency
BCBSTX	No frequency limit specified publicly
Aetna	No frequency limit specified; must meet medical necessity standards
Cigna	No frequency limit specified publicly; varies by plan

Presented by RCM Sara Brown 06/27/2025