Amerigroup RealSolutions in healthcare	**Reimbursement Policy**

Subject: Modifier 25: Significant, Separately Identifiable Evaluation and Management Service by the Same Physician on the Same Day of the Procedure or Other Service

Effective Date: **11/01/12**	Committee Approval Obtained: **06/06/16**	Section: **Coding**

*****The most current version of the Reimbursement Policies can be found on our provider website. If you are using a printed version of this policy, please verify the information by going to htts://providers.amerigroup.com. Under Quick Tools, select Reimbursement Policies > Medicaid/Medicare. Note: State-specific exemptions may apply. Please refer to the Exemptions section below for specific exemptions based on your state. *****

These policies serve as a guide to assist you in accurate claim submissions and to outline the basis for reimbursement if the service is covered by a member's Amerigroup benefit plan. The determination that a service, procedure, item, etc. is covered under a member's benefit plan is not a determination that you will be reimbursed. Services must meet authorization and medical necessity guidelines appropriate to the procedure and diagnosis as well as to the member's state of residence. You must follow proper billing and submission guidelines. You are required to use industry standard, compliant codes on all claim submissions. Services should be billed with CPT codes, HCPCS codes and/or revenue codes. The codes denote the services and/or procedures performed. The billed code(s) are required to be fully supported in the medical record and/or office notes. Unless otherwise noted within the policy, our policies apply to both participating and nonparticipating providers and facilities.

If appropriate coding/billing guidelines or current Reimbursement Policies are not followed, Amerigroup may:

- Reject or deny the claim
- Recover and/or recoup claim payment

Amerigroup reimbursement policies are developed based on nationally accepted industry standards and coding principles. These policies may be superseded by mandates in provider or state contracts, or state, federal or CMS contracts and/or requirements. System logic or setup may prevent the loading of policies into the claims platforms in the same manner as described; however, Amerigroup strives to minimize these variations.

Amerigroup reserves the right to review and revise our policies periodically when necessary. When there is an update, we will publish the most current policy to this site.

Policy	Amerigroup allows limited reimbursement for physician claims billed with Modifier 25 unless provider, state, federal or CMS contracts and/or requirements indicate otherwise. Reimbursement is based on 100 percent of the applicable fee schedule or contracted/negotiated rate for the significant, separately identifiable Evaluation and Management (E&M) service performed by

	the same provider on the same day of the original service or procedure if the following criteria are met: • The appropriate level of E&M service is billed. • Modifier 25 is appended to the E&M service, which is above and beyond the other service or procedure provided (including usual preoperative and postoperative care associated with the procedure). • The reason for the E&M service is clearly documented in the member's medical record. • The documentation supports that the member's condition required the significantly separate E&M service. Failure to use Modifier 25 correctly may result in denial of the E&M service. Amerigroup reserves the right to perform postpayment review of claims submitted with Modifier 25.
Exemptions	• Amerigroup in Florida allows reimbursement for an E&M visit resulting in the decision to perform a surgical procedure when billed with Modifier 25, in accordance with the Agency for Health Care Administration (AHCA) Medicaid Services Coverage and Limitations Handbook.
History	• Biennial review approved 06/06/16: Definition section updated • Effective 12/31/15: Exited Florida Medicare • Effective 12/31/14: Exited Maryland Medicare • Biennial review approved 06/09/14: Policy template updated • Effective 06/01/14: Exited Ohio • Removed Louisiana exemption 03/26/13: Disclaimer statement updated • Biennial review approved and effective 11/01/12: Policy template updated; Louisiana exemption added • Biennial review approved 08/30/10: Florida exemption added; postpayment review language added; Definitions, Background, and Related Policies sections updated; policy template updated • Review approved 11/10/08: Background section/policy template updated • Initial committee approval and effective date: 03/02/06
References and Research Materials	This policy has been developed through consideration of the following: • CMS • State Medicaid • Amerigroup state contracts • Optum Learning: Understanding Modifiers, 2016 edition • AMA: Coding with Modifiers, 5th edition

Definitions	• **Modifier 25:** "Use modifier 25 to indicate that on the day a procedure identified by a CPT code, 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. A significant, separately identifiable E&M service is defined or substantiated by documentation that satisfies the relevant criteria for the respective E&M service to be reported. 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 modifier 25 to the appropriate level of E&M service." (AMA: Coding with Modifiers, 5th edition) • **Reimbursement Policy Definitions**
Related Policies	• Modifier 57: Decision for Surgery • Modifier Usage • Preventive and Sick Visits on the Same Day
Related Materials	• None