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: **04/01/19**	Committee Approval Obtained: **09/28/17**	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 https://providers.amerigroup.com. Under Quick Tools, select Reimbursement Policies > Medicaid. 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 These policies may be superseded by mandates in provider, state, federal or CMS contracts and/or requirements.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 separate reimbursement for significant, separately identifiable Evaluation and Management (E&M) services billed with Modifier 25 unless provider, state, federal or CMS contracts and/or requirements indicate otherwise.

	Reimbursement is based on 100% of the applicable fee schedule or contracted/negotiated rate for the significant, separately identifiable E&M service performed by the same provider on the same day of the original service or procedure if all 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	• The following markets do not allow separate reimbursement for E&M services billed with Modifier 25 on the same day as a major surgery (90 day period):
	  ○ Amerigroup Georgia, Inc.
	  ○ Amerigroup New Jersey, Inc.
	  ○ Amerigroup Texas, Inc. and Amerigroup Insurance Company
	• Amerigroup New Jersey, Inc. allows separate reimbursement for E&M services billed with Modifier 25 on the same day as a minor surgery when the diagnosis code used is different from the diagnosis code for the minor surgery.

History	• Review approved 09/28/17 and effective 04/01/19: Modifier 25 description language updated; Georgia exemption added • Effective 05/01/19: New Jersey and Texas exemptions added • Biennial review approved 06/06/16: Policy template updated • Biennial review approved 06/09/14: Policy template updated • Effective 03/26/13: Disclaimer statement updated • Biennial review approved and effective 11/01/12: Policy template updated • Biennial review approved 08/30/10: Policy language updated; policy template updated • Review approved 11/10/08: Background section/policy template updated • Initial approval effective 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:** used to indicate that on the day a procedure or service was performed, the member's condition required a significant, separately identifiable E&M service above and beyond the original service, or above and beyond the usual preoperative and postoperative care associated with the original procedure; 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. • **General Reimbursement Policy Definitions**
Related Policies	• Global Surgical Package • Modifier 57: Decision for Surgery • Modifier Usage • Preventive Medicine and Sick Visits on the Same Day
Related Materials	• None