Payment Policy: Clinical Validation of Modifier 25

Reference Number: CC.PP.013
Product Types: ALL
Effective Date: 01/01/2013
Last Review Date: 12/01/2022

Coding Implications
Revision Log

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

Policy Overview

The misuse of modifiers to override correct coding edits represent challenges for payers. Centene performs **prepayment clinical claim review** on all services billed with modifier -25. A clinician reviews the information on the claim and the member and provider's claim history to determine whether it is likely that the modifier was used correctly for the clinical circumstances. CPT and CMS guidelines are used to determine whether the modifier was used correctly.

Both CPT and CMS specify that by using modifier -25 a provider indicates that a "significant, separately identifiable evaluation and management service (*was provided*) by the same physician on the same day of the procedure or other service". Additional CPT guidelines state that this separately identifiable service must be "above and beyond" the other service provided or beyond the usual pre- and postoperative care associated with the service performed.

The NCCI policy manual states that "If a procedure has a global period of 000 or 010 days, it is defined as a minor surgical procedure (for example, osteopathic manipulative therapy and chiropractic manipulative therapy have global periods of 000). The decision to perform a minor surgical procedure is included in the value of the minor surgical procedure and should not be reported separately as an E/M service. However, a significant and separately identifiable E/M service unrelated to the decision to perform the minor surgical procedure is separately reportable with modifier -25. The E/M service and minor surgical procedure do not require different diagnoses. These guidelines are also applicable for new patients; the fact that the patient is "new" to the provider is not sufficient to justify reporting an E/M service on the same date of service as a minor surgical procedure. NCCI contains some edits based on these principles, but Medicare Carriers and A/B MACs processing practitioner service claims have separate edits as well.

Reimbursement

Claims Reimbursement Edit

Code auditing software flags all claims billed with modifier -25 for prepayment clinical validation. Once a claim has been validated, it is released for payment or denied due to incorrect modifier use.

Prepayment Clinical Claims review

A significant, separately identifiable E/M service is substantiated by documentation that satisfies the criteria for the service reported. If claim history or diagnosis codes do not indicate that a separately identifiable service was performed, the primary procedure will be reimbursed, and the secondary E/M billed with modifier -25 will be denied. To avoid incorrect denials, providers should assign all applicable diagnosis codes that indicate the need for additional E/M services.

Appeals/Reconsiderations

In the event that claim documentation is insufficient to support billing modifier -25, the provider will receive a denial determination on the explanation of payment (EOP). The provider may submit an appeal/reconsideration request according to provider manual guidelines. All pertinent medical records for the date of service and procedures billed should be submitted. ***Medical records should not be submitted*** on first time claims, as initial claim review only considers information documented on the claim and in the member/provider history. Records should only be submitted if the provider receives a denial and wishes to request a reconsideration or appeal.

Documentation Requirements

The following guidelines are used to determine whether modifier -25 was used appropriately. If any of the following conditions is met, reimbursement for the E/M service is recommended.

- The E/M 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 service
- A provider bills supplies/equipment on or around the same date that are unrelated to the procedure performed but would require 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 2022, 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.

Modifier	Descriptor
-25	Significant, separately identifiable evaluation and management service by the same physician or other qualified health care professional on the same day of the procedure or other service

References

1. *Current Procedural Terminology (CPT®)*, 2022
2. *HCPCS Level II*, 2022
3. *International Classification of Diseases*, Tenth Revision, Clinical Modification, 2022
4. *ICD-10-CM Official Draft Code Set*, 2022
5. *Centers for Medicare and Medicaid Services (CMS) National Correct Coding Initiative (NCCI) policy manual*

Revision History	
01/10/2017	Converted to corporate template and conducted annual review.
02/7/2017	Removed duplicate sentence in policy overview and made punctuation corrections.
02/24/2018	Update policy, updated resources, verified modifier, and conducted review.
03/25/2019	Conducted Review, verified codes, Updated policy
11/01/2019	Annual Review completed
11/01/2020	Annual Review completed
11/12/2021	Annual Review completed; no policy changes required
12/01/2022	Annual Review completed; no major updates required

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. This payment policy is not intended to recommend treatment for members. Members 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.

Providers, members and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members and their representatives agree to be bound by such terms and conditions by providing services to members and/or submitting claims for payment for such services.

Note: For Medicaid members, 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, 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.