Significant-Separately Identifiable Evaluation and Management Service (Modifier 25)

Reimbursement Policy ID: RPC.0009.FLEX

Recent review date: 01/2024

Next review date: 10/2025

AmeriHealth Caritas Next reimbursement policies and their resulting edits are based on guidelines from established industry sources, such as the Centers for Medicare & Medicaid Services (CMS), the American Medical Association (AMA), state and federal regulatory agencies, and medical specialty professional societies. Reimbursement policies are intended as a general reference and do not constitute a contract or other guarantee of payment. AmeriHealth Caritas Next may use reasonable discretion in interpreting and applying its policies to services provided in a particular case and may modify its policies at any time.

In making claim payment determinations, the health plan also uses coding terminology and methodologies based on accepted industry standards, including Current Procedural Terminology (CPT); the Healthcare Common Procedure Coding System (HCPCS); and the International Classification of Diseases,10th Revision, Clinical Modification (ICD-10-CM), and other relevant sources. Other factors that may affect payment include medical record documentation, legislative or regulatory mandates, a provider's contract, a member's eligibility in receiving covered services, submission of clean claims, and other health plan policies, and other relevant factors. These factors may supplement, modify, or in some cases supersede reimbursement policies.

This reimbursement policy applies to all health care services billed on a CMS-1500 form or its electronic equivalent, or when billed on a UB-04 form or its electronic equivalent.

Policy Overview

This policy describes requirements for billing of significant, separately identifiable Evaluation and Management (E/M) services by providers contracted with AmeriHealth Caritas Next.

AmeriHealth Caritas Next recognizes modifier 25 for significant, separately identifiable E/M services, consistent with CPT/HCPCS terminology and National Correct Coding Initiative (NCCI) policy.

Exceptions

Modifier 25 should not be used for E/M services that resulted in the decision to perform a surgical procedure on the same date.

Modifier 25 should not be used for surgical procedures or other non-E/M services.

Reimbursement Guidelines

AmeriHealth Caritas Next utilizes NCCI procedure-to-procedure (PTP) edits to prevent payment of procedures that normally should not be reported together. Only if clinically appropriate should the NCCI-associated modifier for significant, separately identifiable E/M service, recognized as modifier 25, be used to bypass a PTP edit:

- The most comprehensive CPT/HCPCS code(s) for the complete service performed must be reported. E/M services performed on the same date as a surgical procedure and that are considered preoperative or otherwise inclusive to the global surgical package, particularly the decision to perform a minor surgical procedure, should not be separately reported.
- Clinical documentation must support that significant, separately identifiable E/M services were performed. Different diagnoses alone do not justify significant, separately identifiable E/M services.

Refer to CPT/HCPS manuals for complete descriptions of procedures as well as the complete definition of significant, separately identifiable E/M services. Refer to NCCI coding policy manuals for policies and to NCCI edit files for modifier indicators assigned to PTP coding edits.

Definitions

Modifier 25 – significant, separately identifiable E/M
Modifier 25 indicates a 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. 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 (see Evaluation and Management Services Guidelines for instructions on determining level of E/M service). 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.

Global surgical package
Payment for a surgical procedure includes the preoperative, intraoperative, and postoperative services routinely performed by the surgeon or by members of the same group with the same specialty. Physicians in the same group practice who are in the same specialty must bill and be paid as though they were a single physician. Claims for services considered to be directly related to pre-procedure, intra-procedure, and post-procedure work are included in the global reimbursement and will not be paid separately.

Minor surgery

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A minor surgery is a procedure code with a 0- or 10-day global postoperative period.

Edit Sources

I. Current Procedural Terminology (CPT) and associated publications and services
II. Healthcare Common Procedure Coding System (HCPCS),
III. International Classification of Diseases and Related Health Problems (ICD-10)
IV. Centers for Medicare & Medicaid Services (CMS) National Correct Coding Initiative (NCCI): https://www.cms.gov/medicare-medicaid-coordination/national-correct-coding-initiative-ncci
V. Centers for Medicare & Medicaid Services (CMS) Global Surgery Booklet: https://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnproducts/downloads/globallsurgery-icn907166.pdf

Attachments

N/A

Associated Policies

N/A

Policy History

04/2024	Revised preamble
01/2024	Reimbursement Policy Committee Approval
08/2023	Policy Implemented by AmeriHealth Caritas Next removed from Policy History section
01/2023	Template revised • Revised preamble • Removal of Applicable Claim Types table • Coding section renamed to Reimbursement Guidelines • Added Associated Policies section