Commercial Reimbursement Policy

Subject: **Modifier 25 and 57 - Professional**	
Policy Number: **C-09011**	Policy Section: **Coding**
Last Approval Date: **04/01/2024**	Effective Date: **07/01/2024**

Disclaimer

These reimbursement policies serve as a guide to assist you in accurate claims submissions and to outline the basis for reimbursement if the service is covered by a member's 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 Current Procedure Terminology (CPT) codes, Healthcare Common Procedure Coding System (HCPCS) codes and/or revenue codes. These codes denote the services and/or procedures performed and when billed, must be fully supported in the medical record and/or office notes. Unless otherwise noted within the policy, our reimbursement policies apply to both participating and non-participating professional providers and facilities.

If appropriate coding/billing guidelines or current reimbursement policies are not followed, we may:

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

These reimbursement policies may be superseded by mandates in provider, state, federal or Centers for Medicare and Medicaid Services (CMS) contracts and/or requirements. We strive to minimize delays in policy implementation. If there is a delay, we reserve the right to recoup and/or recover claims payment to the effective date, in accordance with the policy. We reserve the right to review and revise these policies when necessary. When there is an update, we will publish the most current policy to the website.

Policy

The Health Plan allows separate reimbursement for a significant, separately identifiable Evaluation and Management (E&M), when billed with modifiers 25 and 57, based on the guidelines within this policy unless provider, state, federal contracts and/or mandates indicate otherwise.

Modifier 25-Reimbursable

Same Day Medical Visit:

The Health Plan will allow separate reimbursement for E/Ms performed on the same day of a minor surgery (0- or 10-day global period) or an endoscopic, diagnostic, or therapeutic procedure, and this evaluation and management service when billed with a modifier 25.

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.

Same Day Evaluation and Management and Preventive Exam Visit:
The Health Plan allows separate reimbursement for preventive medicine exams and problem-oriented E/M services performed on the same day by the same provider. Reimbursement is allowed under the following conditions:

- Modifier 25 is required to be appended to either the problem oriented or the preventive/wellness exam E/M codes.
- The problem-oriented E/M code will be reduced by 50%
- Appropriate diagnosis codes must be billed for the respective visits.

Nonreimbursable
The Health Plan will not allow reimbursement for services billed with Modifier 25 in the following circumstances:

- CPT code 99211 when billed with Modifier 25
- Two separate E/M services when more than one E/M service is reported on the same day with the same provider/group.

Modifier 57-Reimbursable
The Health Plan will allow separate reimbursement for an Evaluation and Management (E/M) visit provided on the day prior to or the day of a major surgery (90-day global period) when it is billed with Modifier 57 to indicate the E/M visit resulted in the initial decision to perform the major surgical procedure.

Reimbursement for the E/M visit is based on 100% of the applicable fee schedule or contracted/negotiated rate. [Health Plan] reserves the right to request medical records for review to support payment for the E/M visit.

Failure to use this modifier when appropriate may result in denial of the claim for the visit.

Nonreimbursable
The Health Plan will not allow reimbursement for services billed with Modifier 57 in the following circumstances:

- An E/M visit the day before or day of the surgery when the decision to perform the surgery was made prior to the E/M visit

- An E/M visit for minor surgeries (0- or 10-day global period) – since the decision to perform a minor surgery is usually reached the same day or day before the procedure, it is considered a routine preoperative service
- A service billed with CPT code other than an E/M code

Related Coding

Standard correct coding applies

Policy History

04/01/2024	Review approved 04/01/2024 and effective 07/01/2024: updated Modifiers Impacting Adjudication code list to not allow reimbursement for CPT® code 99211 when appended with a modifier 25; removed *Evaluation and Management Services and Related Modifiers* from policy title
09/15/2020	Review approved and effective: minor administrative changes made to the policy body.
06/01/2019	Review approved: updated policy template; codes removed from policy body added to coding section; description section removed
03/23/2018	Review approved: updated policy language; E/M and minor surgery reduction language removed
12/28/2017	Review approved: updated policy language: E/M and minor surgery reduction language updated to reflect 25%
08/31/2017	Adopted by Reimbursement Policy Oversight and Governance; E/M and minor surgery 50% reduction language added
02/07/2017	Review approved: no changes made to policy
02/02/2016	Policy language updated: Section: More than One Same Day Evaluation and Management Service: • Added: G0402 (initial preventive physical examination) not eligible for reimbursement when reported with Preventive E/M codes (99381-99397). Section: Same Day Evaluation and Management and Preventive Exam Visit: • Added: G0402 or annual wellness exam (G0438 or G0439) reported with problem-oriented E/M. Both are eligible for separate reimbursement if modifier 25 is on either code. The E/M step-down (50%) applies to the problem-oriented E/M.
05/05/2015	Policy language updated: Section I. Modifier 25: Item b. More than One Same Day Evaluation and Management Service: Added a sentence to the last paragraph in this section" *"This edit will also apply to annual wellness visits when reported with preventive medicine evaluation and management services… "*
08/05/2014	Policy language updated:

	• Policy Section I. a. (Modifier 25; Same Day Medical Visit); 3rd paragraph **-** Changed the wording *"allow separate reimbursement for the E/M service"* to read "*the E/M service may be eligible for separate reimbursement"*. • Policy Section I. c. (Modifier 25; Same Day Evaluation and Management and Preventive Exam Visit) - Numerous minor changes were made in this section for clarity and to make the language consistent with AMACPT wording. Policy Section II (Modifier 57)-The wording in this section was revised and simplified for clarity.
10/01/2013	Review approved: policy language updated: removed section E: New Patient Evaluation and Management. topic is already covered in the Claim Editing Overview policy (EPRP-0027).
05/01/2012	Policy language updated: Section I. Modifier 25: A. Same Day Medical Visit**:** followed suit with the modifier policy by removing the entire statement pertaining to E/M with dermatologic procedures: added: Section D. Same Day Screening Services with Preventive (G0101 and G0102) and/or Problem-Oriented E/M Service.
11/01/2011	Policy language updated: changed the statement: *"The duplicity in practice expense . . ."* to read as "The duplication of indirect practice expense . . .
10/05/2010	Review approved: no changes made to the policy body
10/06/2009	Initial approval and effective

References and Research Materials

This policy has been developed through consideration of the following:

- Optum EncoderPro 2024
- Centers for Medicare and Medicaid Services (CMS)

Definitions

Modifier 25: Significant, Separately Identifiable Evaluation and Management (E/M) Service	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.
Modifier 57: Decision for Surgery	Decision for Surgery
General Reimbursement Policy Definitions	

Related Policies and Materials

Bundled Services and Supplies - Professional
Documentation and Reporting Guidelines for Evaluation and Management Services - Professional
Global Surgery - Professional

Modifier Rules - Professional
Screening Services with Evaluation & Management Services - Professional

Use of Reimbursement Policy

State and federal law, as well as contract language, including definitions and specific inclusions/exclusions, take precedence over Reimbursement Policy and must be considered first in determining eligibility for coverage. The member's contract benefits in effect on the date that services are rendered must be used. Reimbursement Policy is constantly evolving and we reserve the right to review and update these policies periodically.