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TEXAS Health and Human Services

TEXAS Medicare Medicaid PLAN Your Health Plan ★ Your Choice

	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: **10/01/17**	Committee Approval Obtained: **04/03/17**	Section: **Coding**

*****The most current version of our 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/TX.*****

These policies serve as a guide to assist you in accurate claims submissions and to outline the basis for reimbursement by Amerigroup STAR+PLUS MMP (Medicare-Medicaid Plan) if the service is covered under the Amerigroup STAR+PLUS MMP 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 STAR+PLUS MMP may:

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

Amerigroup STAR+PLUS MMP reimbursement policies for Amerigroup STAR-PLUS MMP 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 These policies may be superseded by mandates in provider, state, federal or CMS contracts and/or requirements.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 set up may prevent the loading of policies into the claims platforms in the same manner as described; however, Amerigroup STAR+PLUS MMP strives to minimize these variations.

Amerigroup STAR+PLUS MMP 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 STAR+PLUS MMP 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. We reserve the right to perform postpayment review of claims submitted with Modifier 25.
History	• Initial review approved **04/03/17** and effective **10/01/17**
References and Research Materials	This policy has been developed through consideration of the following: • CMS policies • Texas Health and Human Services Commission (HHSC) • Amerigroup STAR+PLUS MMP contract with HHSC • Optum Learning: Understanding Modifiers, 2014 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; the E&M service may be prompted by the symptom or condition for which the procedure and/or service was performed, so separate diagnoses codes are not required to report E&M codes on the same date; E&M services are not separately reimbursed from surgical and procedural services since these require appropriate provider involvement • **General Reimbursement Policy Definitions**
Related Policies	• Modifier 57: Decision for Surgery • Modifier Usage • Preventive Medicine and Sick Visits on the Same Day
Related Materials	• None