



Modifier 25

POLICY

To ensure that Magnolia Health Plans (Magnolia) providers have knowledge and understanding of the reimbursement methodology and claims adjudication process on claims billed with an E/M code with modifier 25 in addition to a procedure on the same date of service. This policy is effective for claims processed on or after January 1, 2013, regardless of the service date.

POLICY DEFINITION

Claims submitted to Magnolia are adjudicated using the HCI claim editing system. HCI edits are clinically reviewed by a team of expert coders/clinicians using claim information such as diagnoses and procedures in addition to the patient's overall history to determine separate payment for the office visit.

If the claim information and patient history do not support that a significantly separately identifiable procedure was performed unrelated to the surgical procedure, the modifier 25 is not supported and the service denies as unbundled from the surgical procedure.

If after clinical review, if it is determined the modifier 25 was not clinically supported in the claims information, then the provider may exercise his appeal rights by submitting supporting documentation indicating a significantly separately identifiable procedure was performed above and beyond the scope of the components within the surgical procedure.

BILLING GUIDELINES

Modifier -25 should be used to indicate a significant, separately identifiable Evaluation and Management (E/M) service by the same physician on the same day of the procedure or other service.

Modifier -25 should be appended to E/M service codes only. It should not be appended to codes located in the Surgical, Radiology, Laboratory/Pathology, or Medicine Section of the CPT manual.

Modifier -25 should be used to indicate a significant, separately identifiable E/M service in the following circumstances:

Modifier -25 should be appended to the E/M service code when an E/M service is performed on the same day as a procedure or service to indicate that the patient's condition required a significantly, separately identifiable E/M service above and beyond the other service provided or beyond the usual preoperative and postoperative care associated with the procedure that was performed.

- Modifier -25 should be used to indicate that an E/M service is above and beyond the normal, uncomplicated preoperative and postoperative care usually associated with a surgical procedure.
- Modifier -25 should be used to indicate a significant, separately identifiable E/M service performed on the same day as another procedure which includes pre-service and post-service work.



Rationale: An E/M service is not routinely billed on the same day as these procedure codes. If a significant, separately identifiable E/M service is performed on the same day, modifier -25 should be appended to the E/M code.

Modifier -25 should not be used to indicate a significant, separately identifiable E/M service in the following circumstances:

- Modifier -25 is not needed if the service is performed outside of the surgical procedure's global period (preoperative and postoperative period).
- Do not append modifier -25 to the critical care and neonatal intensive care codes (99291-99298) when these services are performed during the preoperative and postoperative period of a surgical procedure. The critical care and the neonatal intensive care codes are by nature significant, separately identifiable services. These codes are never bundled with the surgical procedure codes.
- Do not use modifier -25 on postoperative visits when the surgical procedure has no postoperative follow-up days. Postoperative visits for procedures with no postoperative follow-up days will be allowed

CODING

CPT/HCPCS Codes: Magnolia Health Plan may specify CPT/HCPCS Codes to assist provider with identifying a CPT/HCPCS Code typically used to report a given service. In most instances CPT/HCPCS Codes are purely advisory; unless specified in the policy services reported under other CPT/HCPCS Codes are equally subject to this payment policy. Complete absence of all CPT/HCPCS Codes indicates that coverage is not influenced by CPT/HCPCS Code and the policy should be assumed to apply equally to all CPT/HCPCS Codes.

ICD-9-CM Procedure Code: Magnolia Health Plan may specify ICD-9 CM Procedure Codes to assist providers with identifying a code typically used to report a given service. Absence of an ICD-9 CM code does not guarantee that the policy does not apply to that procedure. Complete absence of all ICD-9 CM code indicates that coverage is not influenced by the ICD-9 CM code and the policy should be assumed to apply equally to all claims.

ICD-9 Codes that Support Medical Necessity: The correct usage of an ICD-9 CM code listed in the "ICD-9 Codes that Support Medical Necessity" section does NOT guarantee coverage or reimbursement of a service. The service must be reasonable & necessary in the specific case and must meet the criteria as outlined in this payment policy.

REFERENCES

National Correct Coding Initiative (NCCI)

American Medical Association CPT Manual