REIMBURSEMENT POLICY STATEMENT
Marketplace

Policy Name & Number	Date Effective
Modifier 25-MP-PY-1363	06/01/2026
Policy Type	
REIMBURSEMENT	

Reimbursement Policies prepared by CareSource and its affiliates are intended to provide a general reference regarding billing, coding and documentation guidelines. Coding methodology, regulatory requirements, industry-standard claims editing logic, benefits design and other factors are considered in developing Reimbursement Policies.

In addition to this Policy, Reimbursement of services is subject to member benefits and eligibility on the date of service, medical necessity, adherence to plan policies and procedures, claims editing logic, provider contractual agreement, and applicable referral, authorization, notification and utilization management guidelines. Medically necessary services include, but are not limited to, those health care services or supplies that are proper and necessary for the diagnosis or treatment of disease, illness, or injury and without which the patient can be expected to suffer prolonged, increased or new morbidity, impairment of function, dysfunction of a body organ or part, or significant pain and discomfort. These services meet the standards of good medical practice in the local area, are the lowest cost alternative, and are not provided mainly for the convenience of the member or provider. Medically necessary services also include those services defined in any federal or state coverage mandate, Evidence of Coverage documents, Medical Policy Statements, Provider Manuals, Member Handbooks, and/or other policies and procedures.

This Policy does not ensure an authorization or Reimbursement of services. Please refer to the plan contract (often referred to as the Evidence of Coverage) for the service(s) referenced herein. If there is a conflict between this Policy and the plan contract (i.e., Evidence of Coverage), then the plan contract (i.e., Evidence of Coverage) will be the controlling document used to make the determination. CareSource and its affiliates may use reasonable discretion in interpreting and applying this Policy to services provided in a particular case and may modify this Policy at any time.

According to the rules of Mental Health Parity Addiction Equity Act (MHPAEA), coverage for the diagnosis and treatment of a behavioral health disorder will not be subject to any limitations that are less favorable than the limitations that apply to medical conditions as covered under this policy.

This policy applies to the following Marketplace(s):			
☒ **Georgia**	☒ **Indiana**	☒ **Ohio**	☒ **West Virginia**

Table of Contents

A. Subject 2
B. Background 2
C. Definitions 2
D. Policy 3
E. State-Specific Information 4
F. Conditions of Coverage 4
G. Related Policies/Rules 4
H. Review/Revision History 4
I. References 5

A. Subject
Modifier 25

B. Background
Reimbursement modifiers are 2-character codes used by physicians and other qualified health care professionals to indicate that a primary service or procedure has been altered due to a specific circumstance. Modifier 25 is used to report an Evaluation and Management (E/M) service on a day when another service was provided to the patient by the same physician or other qualified health care professional. The American Medical Association (AMA) Current Procedural Terminology (CPT) book defines modifier 25 as a significant, separately identifiable evaluation and management service by the same physician or other qualified health care professional on the same day of the primary procedure or other service. There must be documentation that substantiates the use of modifier 25 included in the medical record.

It may be necessary to indicate that on the day a procedure or service identified by a CPT code was performed, the patient's condition required a medically necessary, significant, and 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. A significant, separately identifiable E/M service that is medically necessary is defined or substantiated by documentation that satisfies the relevant criteria for the respective E/M service to be reported (see E/M 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. This modifier is not used to report an E/M service that resulted in a decision to perform surgery; see modifier 57 for service that resulted in a surgical decision. For significant, separately identifiable non-E/M services, see modifier 59.

Although CareSource accepts the use of modifiers, their use does not guarantee reimbursement. Some modifiers increase or decrease the reimbursement rate, while others do not affect the reimbursement rate. CareSource may verify the use of any modifier through prepayment and post-payment edit or audit. Using a modifier inappropriately can result in the denial of a claim or an incorrect reimbursement for a product or service. All information regarding the use of these modifiers must be made available upon CareSource’s request. CareSource uses published guidelines from CPT and the Centers for Medicare & Medicaid Services (CMS) to determine whether the modifier was used correctly.

C. Definitions
- **American Medical Association (AMA)** – A professional association of physicians and medical students that maintains the Current Procedural Terminology coding system.

- **Current Procedural Terminology (CPT®)** – Codes that are issued, updated, and maintained by the AMA, providing a standard language for coding and billing medical services and procedures.
- **Healthcare Common Procedure Coding System (HCPCS)** – Codes that are issued, updated, and maintained by CMS, providing a standard language for coding and billing products, supplies, and services not included in the CPT codes.
- **Modifier** – A 2-character code used along with a CPT or HCPCS code to provide additional information about the service or procedure rendered.

D. Policy

I. CareSource reserves the right to review any submission at any time to ensure correct coding standards and guidelines are met.

II. Provider claims billed with modifier 25 may be flagged for either a prepayment or post-payment medical record coding review.
   A. For prepayment review, once the claim line has been validated, it is either processed for payment or denied for incorrect use of the modifier.
   B. For post-payment review, once the review has been completed, a decision is made based on the submitted documentation. If the claim line is not supported by the documentation, CareSource will recover the payment, when applicable.

III. It is the responsibility of the submitting provider to submit accurate documentation to substantiate the coding of their claim. Failure to submit accurate and complete documentation may result in a denial. If the documentation does not support the claims submission, this will also result in a claims denial.

IV. Standard appeal rights apply for both pre- and post-payment findings and outcomes of the review.

V. Modifier 25 may only be used to indicate 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.” If documentation does not support the use of modifier 25, the code may be denied.

VI. Other CareSource policies may overlap with this topic. Refer to the Preventive Evaluation and Management Services and Acute Care Visit on Same Date of Service policy for specific information on reimbursement practices for E/M and acute care regarding modifier 25.

VII. Appending modifier 25 to an E/M service is considered inappropriate in the following circumstances:
   A. The initial decision to perform a major procedure is made during an E/M service that occurs on the day before or the day of a major procedure. A major surgical procedure has a 1-day pre-operative period and a 90-day post-operative period.

B. The E/M service is reported by a qualified professional provider other than the qualified professional provider who performed the procedure.
C. The E/M service is performed on a different day than the procedure.
D. The modifier is reported with an E/M service that is within the usual pre-operative or post-operative care associated with the procedure.
E. The modifier is reported with a non-E/M service.
F. The reason for the office visit was strictly for the minor procedure since reimbursement for the procedure includes the related pre-operative and post-operative service.
G. The professional provider performs ventilation management in addition to an E/M service.
H. The preventative E/M service is performed at the same time as a preventative care visit (eg, a preventative E/M service and a routine gynecological exam performed on the same date of service by the same professional provider). Since both services are preventative, only one should be reported.
I. The routine use of the modifier is reported without supporting clinical documentation.
J. CareSource will not reimburse CPT 99211 when billed with modifier 25.

E. State-Specific Information

NA

F. Conditions of Coverage

Reimbursement is dependent upon, but not limited to, submitting approved HCPCS and CPT codes along with appropriate modifiers, when applicable. In the absence of state specific instructions, CMS guidelines on modifier 25 will apply. Please refer to the individual fee schedule for appropriate codes.

Providers must follow proper billing, industry standards, and state compliant codes on all claims submissions. The use of modifiers must be fully supported in the medical record and/or office notes. Unless otherwise noted within the policy, this policy applies to both participating and nonparticipating providers and facilities.

In the event of any conflict between this policy and a provider's contract with CareSource, the provider's contract will be the governing document.

G. Related Policies/Rules

Modifiers
Preventive Evaluation and Management Services and Acute Care Visit on Same Date of Service

H. Review/Revision History

	DATE	ACTION
Date Issued	07/20/2022	New Policy
Date Revised	08/02/2023	Annual Review: updated references. Approved at Committee

The REIMBURSEMENT Policy Statement detailed above has received due consideration as defined in the REIMBURSEMENT Policy Statement Policy and is approved.

	07/17/2024 07/16/2025 03/11/2026	Review: updated references, approved at Committee Review: added D.VI.J and K, updated references. Approved at Committee Review: removed G2211, clarified review process in D.II, added related policies section D.VI, removed first Background paragraph. Approved at Committee.
Date Effective	06/01/2026	
Date Archived		

I. References

1. American Medical Association. Reporting CPT modifier 25. *CPT Assistant (Online).* 2023;33(11):1-12. Accessed February 26, 2026. www.ama-assn.org
2. Appropriate use of modifier 25. American College of Cardiology. Accessed February 26, 2026. www.acc.org
3. Chaplain S. Are you using modifier 25 correctly. American Academy of Professional Coders. March 25, 2022. Accessed February 26, 2026. www.aapc.com
4. *Chapter 1 – General Correct Coding Policies for Medicare National Correct Coding Initiative Policy Manual*. Centers for Medicare and Medicaid Services; 2026. Accessed February 26, 2026. www.cms.gov
5. Evaluation and Management Services Guide. Centers for Medicare and Medicaid Services; 2024. MLN006764. Accessed February 26, 2026. www.cms.gov
6. Felger TA, Felger M. Understanding when to use modifier -25. *Fam Pract Manag*. 2004;11(9):21-22. Accessed February 26, 2026. www.aafp.org
7. *Medicare Claims Processing Manual Chapter 12 – Physicians/Nonphysician Practitioners*. Centers for Medicare and Medicaid Services; 2025. Accessed February 26, 2026. www.cms.gov