REIMBURSEMENT POLICY STATEMENT
Arkansas PASSE

Policy Name & Number	Date Effective
Modifier 25-AR PASSE-PY-1370	11/01/2023-09/30/2024
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.

Archived

Table of Contents

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

A. Subject
Modifier 25

B. Background
Reimbursement policies are designed to assist providers when submitting claims to CareSource. They are routinely updated to promote accurate coding and provide policy clarification. These proprietary policies are not a guarantee of payment. Reimbursement for claims may be subject to limitations and/or qualifications. Reimbursement will be established based upon a review of the actual services provided to a member and will be determined when the claim is received for processing. CareSource may verify the use of any modifier through prepayment and post-payment edit or audit.

Reimbursement modifiers are a two-digit code that provide a way for physicians and other qualified health care professionals to indicate that a service or procedure has been altered by some 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 procedure or other service. There must be documentation that substantiates the use of modifier -25 provided 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 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. This modifier is not used to report an E/M service that resulted in a decision to perform surgery. See modifier -57 for 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

Archived

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 that provide 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 the AMA that provides a standard language for coding and billing products, supplies, and services not included in the CPT codes.
- **Modifier** – Two-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 clinical validation or prepayment medical record coding review.
   a. For prepayment review, once the claim has been clinically validated, it is either released 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 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 outcome 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. Appending modifier -25 to an E/M service is considered inappropriate in the following circumstances:

Archived

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.

E. Conditions of Coverage

Reimbursement is dependent upon, but not limited to, submitting approved HCPCS and CPT codes along with appropriate modifiers, if applicable. In the absence of state specific instructions, CMS guidelines 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.

F. Related Policies/Rules

Modifier 59

G. Review/Revision History

	DATE	ACTION
Date Issued	08/17/2022	New Policy
Date Revised	08/02/2023	Annual Review: updated references. Approved at Committee
Date Effective	11/01/2023	

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

Archived

Date Archived	09/30/2024	This Policy is no longer active and has been archived. Please note that there could be other Policies that may have some of the same rules incorporated and CareSource reserves the right to follow CMS/State/NCCI guidelines without a formal documented Policy.

H. References

1. Appropriate use of Modifier 25. American College of Cardiology. Accessed July 24, 2023. www.acc.org
2. *Chapter 1 – General Correct Coding Policies for National Correct Coding Initiative Policy Manual for Medicare Services*. Centers for Medicare and Medicaid Services; 2022. Accessed July 24, 2023. www.cms.gov
3. CPT Modifier 25. Palmetto GBA. Accessed July 24, 2023. www.palmettogba.com
4. *Medicare Claims Processing Manual Chapter 12 – Physicians/Nonphysician Practitioners*. Centers for Medicare and Medicaid Services; 2023. Accessed July 24, 2023. www.cms.gov
5. Chaplain S. Are you using Modifier 25 correctly. American Academy of Professional Coders. Published March 25, 2022. Accessed July 24, 2023. www.aapc.com

Archived