louisiana healthcare connections

Payment Policy: Clinical Validation of Modifier 25

Reference Number: LA.PP.013
Product Types: ALL
Effective Date: 08/2020
Last Review Date: 06/2023

Coding Implications
Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Policy Overview

The misuse of modifiers that override correct coding edits represent challenges for payers. Louisiana Healthcare Connections performs a prepayment clinical claims review on all procedures billed with modifier -25. A registered nurse reviews the information on the claim, along with the member and provider's claim history to determine whether it is likely that the modifier was used correctly for the circumstances of the patient on that date of service. The Health Plan and its vendors use published guidelines from CPT and CMS to determine whether the modifier was used correctly.

Both CPT and CMS in the NCCI policy manual specify that by using modifier -25 the provider is indicating 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". Additional CPT guidelines state that this significant and separately identifiable service must be "above and beyond" the other service provided or beyond the usual preoperative and postoperative care associated with the procedure that was performed.

The NCCI policy manual states that "If a procedure has a global period of 000 or 010 days, it is defined as a minor surgical procedure (for example, osteopathic manipulative therapy and chiropractic manipulative therapy have global periods of 000). The decision to perform a minor surgical procedure is included in the value of the minor surgical procedure and should not be reported separately as an E/M service. However, a significant and separately identifiable E/M service unrelated to the decision to perform the minor surgical procedure is separately reportable with modifier 25. The E/M service and minor surgical procedure do not require different diagnoses. If a minor surgical procedure is performed on a new patient, the same rules for reporting E/M services apply. The fact that the patient is "new" to the provider is not sufficient alone to justify reporting an E/M service on the same date of service as a minor surgical procedure. NCCI does contain some edits based on these principles, but the Medicare Carriers and A/B MACs processing practitioner service claims have separate edits as well.

Reimbursement

Claims Reimbursement Edit

The Health Plan's code auditing software will flag all provider claims billed with modifier -25 for prepayment clinical validation. Clinical validation occurs *prior to claims payment.* Once a claim has been clinically validated, it is either released for payment or denied for incorrect use of the modifier.

Rationale for Edit
Modifier -25 should 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."

Prepayment Clinical Claims review
A significant, separately identifiable E/M service is defined or substantiated by documentation that satisfies the relevant criteria for the respective E/M service to be reported. If claim history or assigned diagnosis codes do not indicate that significant, separately identifiable services were performed, Louisiana Healthcare Connections covers the primary procedure or other service and denies the secondary E/M billed with Modifier -25.
To avoid incorrect denials, providers should assign all applicable diagnosis codes that indicate the need for additional E/M services.

Utilization
Appeals/Reconsiderations
In the event that claims documentation is insufficient to support billing modifier -25, the provider will receive a denial determination on their explanation of payment (EOP). The provider may submit an appeal or reconsideration request according to the guidelines outlined in the provider manual. Please submit all pertinent medical records for the date of service and procedures billed. *Medical records should not be submitted* on the first time claims submission as first time claim review consists only of a review of the information documented on the claim and in the member/provider history. Medical records should only be submitted once the provider receives a denial and wishes to request a reconsideration or appeal

Documentation Requirements
The following guidelines are used to determine whether modifier -25 was used appropriately. If any one of the following conditions is met then reimbursement for the E/M service is recommended

- If the E/M service is the first time the provider has seen the patient or evaluated a major condition
- A diagnosis on the claim indicates that a separate medical condition was treated in addition to the procedure that was performed
- The patient's condition is worsening as evidenced by diagnostic procedures being performed on or around the date of services
- If a provider bills supplies or equipment, on or around the same date, that are unrelated to the procedure performed but would have required an E/M service to determine the patient's need

Coding and Modifier Information
This payment policy references Current Procedural Terminology (CPT®). CPT® is a registered trademark of the American Medical Association. All CPT® codes and descriptions are copyrighted 2022, American Medical Association. All rights reserved. CPT codes and CPT descriptions are from current manuals and those included herein are not intended to be all-inclusive and are included for informational purposes only. Codes referenced in this payment policy are for informational purposes only. Inclusion or exclusion of any codes does not

guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

Modifier	Descriptor
-25	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

Related Documents or Resources

1. Centers for Medicare and Medicaid Services, CMS Manual System and other CMS publications and services.
2. Centers for Medicare and Medicaid Services, National Correct Coding Initiative (NCCI) publications.
3. American Medical Association, Current Procedural Terminology (CPT®) and associated publications and services.

References

1. *Current Procedural Terminology (CPT®)*, 2022
2. *HCPCS Level II*, 2022
3. *International Classification of Diseases*, Tenth Revision, Clinical Modification (ICD-10-CM), 2022
4. *ICD-10-CM Official Draft Code Set*, 2022

Revision History	Revision Date	Approval Date
Converted corporate to local policy.	08/15/2020	
Annual Review; Removed clinical and added payment policy in "Important Reminder" section	08/26/2022	
Annual Review; dates in reference section updated	06/30/2023	9/13/2023

Important Reminder

This payment policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this payment policy; and other available clinical information. LHCC makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this payment policy. This payment policy is consistent with standards of medical practice current at the time that this payment policy was approved.

The purpose of this payment policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable LHCC administrative policies and procedures.

This payment policy is effective as of the date determined by LHCC. The date of posting may not be the effective date of this payment policy. This payment policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this payment policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. LHCC retains the right to change, amend or withdraw this payment policy, and additional clinical policies may be developed and adopted as needed, at any time.

This payment policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This payment policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this payment policy are independent contractors who exercise independent judgment and over whom LHCC has no control or right of control. Providers are not agents or employees of LHCC.

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POLICY AND PROCEDURE APPROVAL

The electronic approval retained in RSA Archer, Centene's P&P management software, is considered equivalent to an actual signature on paper.

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