Reimbursement Policy

Subject: **Modifiers 25 and 57**	
Policy Number: **G-06003**	Policy Section: **Coding**
Last Approval Date: **08/10/2022**	Effective Date: **04/27/2022**

**** 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.anthem.com/kentucky-provider/claims/reimbursement-policies. ****

Disclaimer

These policies serve as a guide to assist you in accurate claims submissions and to outline the basis for reimbursement by Anthem Blue Cross and Blue Shield Medicaid (Anthem) if the service is covered by a member's benefit 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, Anthem may:

- Reject or deny the claim.
- Recover and/or recoup claim payment.
- Adjust the reimbursement to reflect the appropriate services and/or procedures performed.

Anthem reimbursement policies 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 These policies may be superseded by mandates in provider, state, federal or CMS contracts and/or requirements.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 setup may prevent the loading of policies into the claims platforms in the same manner as described; however, Anthem strives to minimize these variations.

Anthem 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 our provider website.

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Policy

Anthem allows separate reimbursement for a significant, separately identifiable Evaluation and Management (E&M) provided on the day of a procedure when it is billed with Modifier 25 or an E&M service that results in an initial decision to perform surgery on the day prior to or the day of with a Modifier 57 unless provider, state, federal, or CMS contracts and/or requirements indicate otherwise.

Anthem only allows reimbursement for one E&M service per day by the same provider to the same member.

Modifier 25

Anthem will allow separate reimbursement for E&M performed on the same of a major surgery (90-day global period) or minor surgery (0- or 10-day global period) when billed with a Modifier 25.

Reimbursement is based on 100% of the applicable fee schedule or contracted/negotiated rate for the significant, separately identifiable E&M service performed by the same provider on the same day of the original service or procedure if all 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. Anthem reserves the right to perform post-payment review of claims submitted with Modifier 25.

Modifier 57

Anthem will allow separate reimbursement for an E&M visit provided on the day prior to or the day of a major surgery (90-day global period) when it is billed with Modifier 57 to indicate the E&M visit resulted in the initial decision to perform the major surgical procedure.

Reimbursement for the E&M visit is based on 100% of the applicable fee schedule or contracted/negotiated rate. Anthem reserves the right to request medical records for review to support payment for the E&M visit.

Failure to use this modifier when appropriate may result in denial of the claim for the visit.

Non-reimbursable

Anthem will not allow reimbursement for services billed with Modifier 57 in the following circumstances:

- An E&M visit the day before or day of the surgery when the decision to perform the surgery was made prior to the E&M visit
- An E&M visit for minor surgeries (0- or 10-day global period) – since the decision to perform a minor surgery is usually reached the same day or day before the procedure, it is considered a routine preoperative service

- A service billed with CPT code other than an E&M code

Related Coding

Standard correct coding applies

Policy History

08/10/2022	Review approved: no changes
04/27/2022	review approved and effective: combined policy for Modifier 57 and Modifier 25, policy name updated to Modifiers 25 and 57: Evaluation and Management with Global Procedures, the following policy was retired and added to Modifier 25: Significant, Separately Identifiable Evaluation and Management Service by the Same Physician on the Same Day of the Procedure or Other Service; retired Policy number 06-107: Modifier 57: Decision for surgery
07/15/2019	Update due to regulatory directive: One E&M per day language added, effective
09/28/2017	Review approved 09/28/17 and effective 04/01/19: Modifier 25 description language updated and major surgery policy language added
06/06/2016	Review approved: policy template updated
06/08/2014	Review approved: policy template updated
01/01/2014	Initial approval and effective

References and Research Materials

This policy has been developed through consideration of the following:

- CMS
- State Medicaid
- State contracts

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. 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.
Modifier 57	Used to indicate an E&M service that resulted in the initial decision to perform a surgery on the day of a major procedure or service.
General Reimbursement Policy Definitions	

Related Policies and Materials

Global Surgical Package
Modifier Usage
Preventive Medicine and Sick Visits on the Same Day
Preventive Services and Other E&M