Anthem Blue Cross and Blue Shield Healthcare Solutions | Medicaid Managed Care

Reimbursement Policy

Subject: **Modifiers 25 and 57: Evaluation and Management with Global Procedures**	
Policy Number: **G-06003**	Policy Section: **Coding**
Last Approval Date: **05/22/2024**	Effective Date: **05/22/2024**

**** Visit our provider website for the most current version of the reimbursement policies. If you are using a printed version of this policy, please verify the information by going to **providers.anthem.com/nv**. ****

Disclaimer

These reimbursement policies serve as a guide to assist you in accurate claims submissions and to outline the basis for reimbursement if Anthem covered the service for the 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 Current Procedure Terminology® (CPT) codes, Healthcare Common Procedure Coding System (HCPCS) codes, and/or revenue codes. These codes denote the services and/or procedures performed and, when billed, must be fully supported in the medical record and/or office notes. Unless otherwise noted within the policy, our reimbursement policies apply to both participating and non-participating professional 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.

These reimbursement policies may be superseded by mandates in provider, state, federal, or Centers for Medicare & Medicaid Services (CMS) contracts and/or requirements. Anthem strives to minimize delays in policy implementation. If there is a delay, we reserve the right to recoup and/or recover claims payment to the effective date in accordance with the policy. We reserve the right to review and revise these policies when necessary. When there is an update, we will publish the most current policy to the 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.

Modifier 25

Anthem will allow separate reimbursement for E/Ms performed on the same day of a major surgery (90-day global period) or minor surgery (0-day 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.

Nonreimbursable

Anthem will not allow reimbursement for services billed with Modifier 25 in the following circumstances:

- CPT® code 99211 when billed 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.

Nonreimbursable

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-day 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	
05/22/2024	Review approved and effective: updated policy title from Modifiers 25 and 57
08/10/2022	Review approved 08/10/2022 and effective 04/01/2023: Policy language updated to indicate that CPT code 99211 is not eligible for reimbursement with modifier 25.
04/27/2022	Review approved and effective: Combined policies Modifier 57: Decision for surgery (06-013) and Modifier 25: Significant, Separately Identifiable Evaluation and Management Service by the Same Physician on the Same Day of the Procedure or Other Service (06-003) and renamed combined policy to Modifiers 25 and 57 (G-06003).
02/01/2018	Policy template updated effective
09/28/2017	Review approved and effective: Modifier 25 description language updated.
06/06/2016	Review approved: Policy template updated.
06/09/2014	Review approved: Policy template updated.
03/26/2013	Effective: Disclaimer statement updated.
11/01/2012	Review approved and effective: Policy template updated.
08/30/2010	Review approved: Policy language updated; Policy template updated.
02/01/2009	Initial approval and effective.

References and Research Materials
This policy has been developed through consideration of the following: • CMS • State contract • State Medicaid

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

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