Anthem Blue Cross and Blue Shield
Commercial Professional Reimbursement Policy

Subject: Evaluation and Management Services and Related Modifiers -25 & -57	
IN Policy: 0026	**Effective: 02/01/2018**

Coverage is subject to the terms, conditions, and limitations of an individual member's programs or products and policy criteria listed below. This reimbursement policy also applies to Employer Group Retiree Medicare Advantage programs.

Description

The Evaluation and Management (E/M) Service Code Section of the *Current Procedural Terminology* (CPT®′) codebook is divided into different types of E/M services. There are broad categories, such as office/outpatient visits, inpatient hospital visits, consultations, preventive medicine services, etc.

For each level of E/M services there are certain identifying factors that are all present for most E/M categories. They are:

- A unique code number
- A specified place and/or type of service
- A defined content of service
- The nature of the presenting problem
- The time typically required to perform the service

For E/M services, the nature of the visit, the amount of provider work, and the documentation required varies by type of service, place of service, the patient's medical status, or other code criteria. This policy addresses the circumstances surrounding the appropriate reporting of an E/M visit code, the related modifiers 25 and 57, and the eligibility of these modifiers for separate reimbursement.

Modifier 25: **Significant, Separately Identifiable Evaluation and Management (E/M) Service**
The Health Plan allows modifier 25 to be used by the provider when the patient's condition requires a significant, separately identifiable E/M service above and beyond the usual pre and post-procedure work on the same day as a procedure or other service (e.g., a problem oriented E/M service with a preventive medicine service). A different diagnosis is not required.

Modifier 57: Decision for Surgery
The Health Plan allows modifier 57 to be used by the provider when an E/M service results in the initial decision to perform a major surgical procedure.

This policy documents the Health Plan's reimbursement and reporting requirements for E/M services and related modifiers 25 and 57.

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The Health Plan accepts modifiers 25 and 57 for claims processing, but not always to determine compensation. These two modifiers are important to the adjudication of the claim because their use may result in overriding a specific edit in the Health Plan's claims editing systems.

The Health Plan requires that all documentation and reporting requirements for billing an E/M service be followed as indicated in our reimbursement policies. For additional detailed information, please refer to the following reimbursement policies:

- Claim Editing Overview
- Documentation and Reporting Guidelines for Evaluation and Management Services
- Global Surgery

I. Modifier 25

a. Same Day Medical Visit:

When performing any surgery or other medical procedure, there is a certain amount of pre and post procedural evaluation and management work that is expected to be performed as well. Reimbursement for this E/M work is included in the payment for the primary service. When this usual pre/post procedure work is rendered without a significant, separately identifiable E/M service, it is not appropriate to report an E/M visit code, nor is it appropriate to report an E/M visit code with modifier 25.

The Health Plan's claim editing systems identifies when an E/M visit is reported by the same provider on the same day as a minor surgery ("0" or "10" day global period) or an endoscopic, diagnostic or therapeutic procedure (e.g., dialysis; chemotherapy; osteopathic manipulative treatment). Since the work value of an E/M service is included within the global reimbursement for a procedure, the E/M code is not eligible for separate reimbursement when identified as a "same day medical visit."

However, when "a significant, separately identifiable evaluation and management service" is performed on the same day as a minor surgery ("0 or "10" day global period) or an endoscopic, diagnostic or therapeutic procedure, and this evaluation and management service is reported with modifier 25, our claim editing system will override the same day medical visit edit, and the E/M service may be eligible for separate reimbursement.

The Health Plan follows the criteria outlined in *Coding with Modifiers*, Grider, Deborah, 4th edition ©2011, to determine when extra work is significant. The patient's medical record must support the following:

- "Does the complaint or problem stand alone as a billable service?"
- "Did the physician perform and document the key components of an E/M service for the complaint or problem?"
- "Is there a different diagnosis for a significant portion of the visit? Or if the diagnosis is the same, was extra work above and beyond the usual preoperative and postoperative work associated with the procedure. [1]"

b. More than One Same Day Evaluation and Management Service:

The Health Plan follows CMS guidelines documented in the Medicare Claims Processing Manual, Chapter 12, section 30.6.5 which states that: "If more than one evaluation and management (face-to-face) service is provided on the same day to the same patient by the same physician or more than one physician in the same specialty in the same group, only one evaluation and management service may be reported unless the

evaluation and management services are for unrelated problems. Instead of billing separately, the physicians should select a level of service representative of the combined visits and submit the appropriate code for that level."

In most circumstances, only one E/M service is eligible for reimbursement on the same day for the same patient by the same provider. Therefore, when more than one E/M service is reported by the same physician or other qualified health care provider of the same specialty in the same provider group for the same patient on the same day, separate reimbursement is not allowed for the lesser level or additional same level E/M service code. Providers should select a level of service representative of the combined services and submit the appropriate code for that level. The Health Plan does not accept modifier 25 when it is reported by the same provider on the same day for two separate E/M services unless one of the services is for a preventive exam as outlined in section C. below. In addition, the initial preventive physical examination (G0402), or annual wellness visits (G0438 and G0439) will not be eligible for reimbursement when reported with preventive medicine evaluation and management services (99831-99397). (See also our Bundled Services and Supplies reimbursement policy.)

c. Same Day Evaluation and Management and Preventive Exam Visit:
There are occasions when during the course of performing a preventive examination, an abnormality or preexisting problem is encountered or a concern is voiced by the patient which requires significant additional work to be performed by the provider in order to render the key components of a problem oriented E/M service (e.g. history, exam, medical decision making). Therefore, when a problem oriented E/M service (CPT codes 99201-99215) is performed by the same provider on the same day as a preventive medical exam (CPT codes 99381-99387, 99391-99397), initial preventive physical examination (G0402), or annual wellness exam (G0438 or G0439) and the provider appends modifier 25 to either the problem oriented E/M or the preventive/wellness exam codes, both codes may be eligible for separate reimbursement. However, the specific diagnosis code for the condition encountered and evaluated must be reported with the line item problem-oriented visit to support the services reported. The routine/preventive medicine diagnosis code is to be reported with the preventive visit code.

In addition, the Health Plan recognizes that there is duplication of the indirect practice expense when performing both the preventive/wellness exam and the problem oriented E/M during the same encounter. The duplication of indirect practice expense may include, but is not limited to, scheduling the visits, staffing, obtaining vital signs, lighting, and supplying the examination room for both the preventive exam and the problem oriented E/M. Therefore, based on the guidelines above, when the problem oriented E/M is eligible for separate reimbursement, the maximum allowance for the reported problem oriented E/M code will be reduced by 50%.

d. Same Day Screening Services with Preventive and/or Problem Oriented Evaluation and Management Service:
The Health Plan considers screening services (e. g., G0101, G0102) a component of a preventive exam and/or a problem oriented E/M service when rendered on the same date of service. Therefore, screening services are not eligible for separate reimbursement even when the E/M service is reported with modifier 25. Screening services should be taken into account when determining the correct level of the problem oriented E/M service. (See also our Screening Services with Evaluation & Management Services reimbursement policy.)

II. Modifier 57

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The Health Plan's global surgical reimbursement for major surgical procedures with a 90-day global period includes E/M services performed one day preoperatively or on the same day as the surgical procedure. However, when the decision for surgery occurs one day preoperatively or on the same day as the major surgical procedure and the E/M service is reported with the "decision for surgery" modifier 57, our claim editing system will override the global surgical package edit and the E/M service may be eligible for separate reimbursement.

[1]Grider, Deborah J., *Coding with Modifiers*, A Guide to Correct CPT® and HCPCS Level II Modifier Usage Fourth Edition, Copyright 2011 by the American Medical Association, pg. 54