Modifier 25

Purpose

This policy is intended to ensure correct provider reimbursement and serves only as a general resource regarding Molina Healthcare's reimbursement policy for the services described in this policy. It is not intended to address every aspect of a reimbursement situation, nor is it intended to impact care decisions. This policy was developed using nationally accepted industry standards and coding principles. In a conflict, federal and state guidelines, as applicable, and the member's benefit plan document supersede the information in this policy. Also, to the extent of conflicts between this policy and the provider contract language, the Provider contract language will prevail. Coverage may be mandated by applicable legal requirements of a State, the Federal government or the Centers for Medicare and Medicaid Services (CMS). References included were accurate at the time of policy approval. If there is a state exception, please refer to the state exception table listed below.

Policy Overview

Modifier 25 is utilized to indicate that a patient's condition necessitated a distinct and substantial evaluation and management (E/M) service, in addition to any other procedure or service performed by the same physician or qualified healthcare professional (QHP) on the same date.

This edit identifies claim lines that contain an E/M code submitted without Modifier 25 on the same date of service as a minor surgical procedure (000- or 010-day global period).

The Centers for Medicare & Medicaid Services (CMS) includes payment in the global surgical package of a minor surgery (000- or 010-day global period) for the initial consultation or the evaluation of the problem done on the same date of service as the procedure. The initial service may be reported in addition to the minor procedure on the same date of service only if it is determined to be beyond the normal pre- and
post-operative work required for the procedure. Modifier 25 should be appended to the E/M service code to indicate that it was a significant, separately identifiable service from the procedure.

- Modifier 25 is used to facilitate billing of E/M services on the day of a procedure for which separate payment may be made.
- It is used to report a significant, separately identifiable E/M service by the same physician on the day of a procedure.
- Modifier 25 should only be appended to E/M codes.

All minor procedures include an E/M component as an integral part of the procedure for reviewing the patient's health and the medical necessity. CMS and the Relative Value Update Committee assign relative value units (RVU) for minor procedures.
The data elements included in the relative value unit (RVU) for the minor procedure encompass the inherent pre-service work, the intra-service time, and the post-procedure work usually performed each time the procedure is rendered; therefore, the E/M should not be reported separately unless the E/M is significant and separately identifiable.

The key requirement of a "significant and separately identifiable" E/M service is that the work for the E/M service is substantially more and different than the typical preoperative and postoperative E/M work included in the minor procedure. For example, the patient's condition required work above and beyond the

minor procedure being provided, or there is a separate condition unrelated to the minor procedure.

Modifier 25 indicates that additional reimbursement is needed to account for significantly more E/M work beyond the usual pre-service, intra-service, and post-procedure care. The additional E/M service should stand alone as a separate problem-focused E/M. If the diagnosis is the same, the E/M should reflect that the physician performed a service beyond the usual work associated with the procedure.

According to the American Medical Association (AMA):

Pre- and post-operative services typically associated with a procedure include the following and cannot be reported with a separate E/M services code:

- Review of the patient's relevant past medical history
- Assessment of the problem area to be treated by surgical or other service
- Formulation and explanation of the clinical diagnosis
- Review and explanation of the procedure to the patient, family, or caregiver
- Discussion of alternative treatments or diagnostic options
- Obtaining informed consent
- Providing postoperative care instructions
- Discussion of any further treatment and follow up after the procedure."

Reimbursement Guidelines

Molina Healthcare may conduct a review of emergency room claims involving injection and infusion procedures billed with Modifier 25 in conjunction with an evaluation and management (E/M) code. The purpose of this review is to verify whether the injections and/or infusions were distinct from the evaluation and management service provided for the patient's primary diagnoses during their emergency room visit.

If the review identifies incorrect usage of Modifier 25, Molina Healthcare will not reimburse charges for injections and infusions. Payment will be made solely for the evaluation and management (E/M) code. Molina Healthcare will follow the standard appeal process.

Supplemental Information

Definitions

Term	Definition
CMS	The Centers for Medicare & Medicaid Services. It is a federal agency within the United States Department of Health and Human Services that administers the Medicare program and works in partnership with state governments to administer Medicaid, the Children's Health Insurance Program (CHIP), and health insurance portability standards.
Modifier 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, is

	used when distinct services are performed on the same day

State Exceptions

State	Exception

Documentation History

Type	Date	Action
Initial Creation Date	5/16/2023	New Policy
Revised Date	09/01/2023	Updated links
Revised Date	12/12/2024	Combine 2 Molina Policies updated template
Revised Date	08/04/2025	Updated Template

References

References This policy was developed using:

• CMS
• State Medicaid Regulatory Guidance
• State Contracts

Reference	Link
CMS	https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c12.pdf
CMS	https://www.cms.gov/files/document/medicare-ncci-policy-manual-2023-chapter-12.pdf https://www.cms.gov/files/document/medicare-ncci-policy-manual-2023-chapter-11.pdf
Professional Society Guidelines and Other Publications	https://www.ama-assn.org/system/files/reporting-CPT-modifier-25.pdf

***CODING DISCLAIMER**. Codes listed in this policy are for reference purposes only and may not be all-inclusive. Deleted codes and codes which are not effective at the time the service is rendered may not be eligible for reimbursement. Listing of a service or device code in this policy does guarantee coverage. Coverage is determined by the benefit document. Molina adheres to Current Procedural Terminology (CPT®), a registered trademark of the American Medical Association (AMA). All CPT codes and descriptions are copyrighted by the AMA; this information is included for informational purposes only. Providers and facilities are expected to utilize industry standard coding practices for all submissions. When improper billing and coding is not followed, Molina has the right to reject/deny the claim and recover claim payment(s). Due to changing industry practices, Molina reserves the right to revise this policy as needed.*