REIMBURSEMENT POLICY STATEMENT
Indiana Medicaid

Policy Name & Number	Date Effective
Modifier 25-IN MCD-PY-1362	12/01/2023
Policy Type	
REIMBURSEMENT	

Reimbursement Policies prepared by CareSource and its affiliates are intended to provide a general reference regarding billing, coding and documentation guidelines. Coding methodology, regulatory requirements, industry-standard claims editing logic, benefits design and other factors are considered in developing Reimbursement Policies.

In addition to this Policy, Reimbursement of services is subject to member benefits

The REIMBURSEMENT Policy Statement detailed above has received due consideration as define

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A. The initial decision to perform a major procedure is made during an E/M service that occurs on the day before or the day of a major procedure. A major surgical procedure has a 1-day pre-operative period and a 90-day post-operative period.
B. The E/M service is reported by a qualified professional provider who did not perform the procedure.
C. The E/M service is performed on a different day than the procedure.
D. The modifier is reported with an E/M service that is within the usual pre-operative or post-operative care associated with the procedure.
E. The modifier is reported with a non-E/M service.
F. The reason for the office visit was strictly for the minor procedure since reimbursement for the procedure includes the related pre-operative and post-operative service.
G. The professional provider performs ventilation management in addition to an E/M service.
H. The preventative E/M service is performed at the same time as a preventative care visit (eg, a preventative E/M service and a routine gynecological exam performed on the same date of service by the same professional provider). Since both services are preventative, only one should be reported.
I. The routine use of the modifier is reported without supporting clinical documentation.

E. Conditions of Coverage

Reimbursement is dependent upon, but not limited to, submitting approved HCPCS and CPT codes along with appropriate modifiers, if applicable. In the absence of state specific instructions, CMS guidelines will apply. Please refer to the individual fee schedule for appropriate codes.

Providers must follow proper billing, industry standards, and state compliant codes on all claims submissions. The use of modifiers must be fully supported in the medical record and/or office notes. Unless otherwise noted within the policy, this policy applies to both participating and nonparticipating providers and facilities.

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F. Related Policies/Rules

Modifiers

G. Review/Revision History

	DATE	ACTION
Date Issued	08/17/2022	New Policy
Date Revised	08/02/2023	Annual Review: updated references. Approved at Committee
Date Effective	12/01/2023	

The REIMBURSEMENT Policy Statement detailed above has received due consideration as defined in the REIMBURSEMENT Policy Statement Policy and is approved.