



Manual:	Reimbursement Policy		
Policy Title:	Modifier -25 - Significant, Separately Identifiable E/M Service		
Section:	Modifiers		
Subsection:	None		
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Scope

This policy applies to all Commercial medical plans, Medicare Advantage plans, and Oregon Medicaid plans.

Reimbursement Guidelines

A. General

Modifier 25 is considered valid on Evaluation and Management (E/M) procedure codes only (based on modifier definition). Modifier 25 is not considered valid when appended to surgical codes, medicine procedures, diagnostic tests and procedures, etc. and the line item will be denied as an invalid modifier combination. (*RPM019^B*)

B. Separate Reimbursement Requirements

E/M service codes submitted with modifier 25 appended will be considered separately reimbursable when all the following apply:

1. The clinical edit is eligible for a modifier bypass (e.g. per edit rationale, CCI modifier indicator = "1", etc.).
2. The modifier and the code have been submitted in accordance with AMA CPT book guidelines, CPT Assistant guidelines, CMS/NCCI Policy Manual guidelines, and any applicable specialty society guidelines.
3. The procedure code is eligible for separate reimbursement according to the status indicators on the CMS fee schedule for the relevant provider type (physician fee schedule, ASC, OPPS, etc.).
4. The medical records documentation supports the appropriate use of modifier 25. All the required key components of the E/M service with modifier 25 appended must be documented in the medical record.

C. Documentation Requirements

The submission of modifier -25 appended to a procedure code indicates that documentation is available in the patient's records which will support the distinct, significant, separately identifiable nature of the evaluation and management service submitted with modifier -25, and that these records will be provided in a timely manner for review upon request.

D. E/M Service Billed With a Procedure, Same Date of Service

1. All surgical procedures and some non-surgical procedural services include a certain degree of physician involvement or supervision, pre-service work, and post-service work which is integral to that service. For those procedures and services, a separate E/M service is not normally reimbursed. However, a separate E/M service may be considered for reimbursement if the patient's condition required services above and beyond the usual care associated with the procedure or service provided and modifier -25 is appended to the E/M code. None of the usual pre-service, intra-service, or post-service work associated with the other procedure(s) performed on the same day may be included in the documentation to support the key components of the significant, separately identifiable E/M service.
2. CPT guidelines for specific code categories highlight certain services where special attention should be given to the concept of an E/M integral to the procedure. These include vaccine administration, chemotherapy, acupuncture, etc.
3. The National Correct Coding Initiative Policy Manual, chapter one, also addresses that minor surgical procedures include the decision for surgery E/M service; E/M of a different problem/issue not addressed or treated by the procedure would be eligible for consideration of modifier 25. These guidelines apply to all procedure codes with a global days indicator of "000" or "010" on the CMS Physician Fee Schedule. This includes services which would otherwise not be considered "surgical procedures," such as:
 - a. Osteopathic manipulative treatment (OMT) (98925-98929)
 - b. Chiropractic manipulative treatment (CMT) (98940-98942)
 - c. Trimming of dystrophic nails, any number (G0127)
 - d. Application of steri-strips or equivalent (G0168)
4. By assigning a global days indicator of "000" or "010," CMS is indicating that the RVU for the procedure includes reimbursement for the assessment of the problem, determining that the procedure is necessary, evaluating whether the procedure is appropriate and the patient is a good candidate, discussing the risks and benefits, and obtaining informed consent, as well as performing the procedure. To support reporting a separate E/M with modifier 25, the evaluation must extend beyond what will be treated by the procedure. The example given in the CCI Policy Manual is documenting a complete neurological exam for head trauma, which extended beyond evaluating the head laceration which was sutured. (CMS⁸) The same principles apply to non-suture procedures.
5. The documentation of the procedure and the documentation of the significant, separately identifiable E/M service must be clearly separate and distinct in the medical record to fulfill the

requirements of “separately identifiable.” If both services are mixed in a single visit entry without any separation (e.g. under a sub-heading) to identify the separate and distinct nature of the services, then the requirement for a “separately identifiable” service has not been met.

E. Multiple E/M Services

Per CPT and CMS guidelines (AMA⁷, CMS^{9, 10}), only one E&M service code per patient, per physician, per day is eligible for reimbursement, with limited exceptions:

1. If the patient is seen for a single visit or encounter:
 - a. One preventive medicine service (99381 – 99397) may be reported with one problem-oriented E/M Service, if the following criteria is met:
 - i. When, in the process of performing a preventative medicine examination, a pre-existing problem is addressed or an abnormality is encountered and the problem/abnormality *is significant enough to require the additional work of the key components of a problem-oriented E&M service*, the problem-oriented outpatient established patient E/M service code (99211 – 99215) with modifier 25 appended is eligible for separate reimbursement in addition to the preventive visit service. Note the documentation requirements previously mentioned above.
 - ii. When a preventive medicine service is reported in combination with problem-oriented E/M service, the visit documentation must clearly indicate the separate history, exam, and medical decision-making components related to the problem or abnormality being addressed. No portion of the preventive service documentation may be used to support the problem-oriented E/M code selected; the documentation related to the problem must stand on its own to support the level of service and key components of the procedure code.
 - iii. For Medicare Advantage members only:
 - 1) The following procedure codes are also valid preventive medicine service codes:
 - a) G0402 (*Initial preventive physical examination; face-to-face visit, services limited to new beneficiary during the first 12 months of Medicare enrollment*).
All the following terms are used by CMS to describe the visit represented by G0402. All of these are synonymous.
 - i) Welcome to Medicare Exam (WME)
 - ii) Initial Wellness Visit (IWV)
 - iii) Initial Preventative Exam (IPPE)
 - b) Annual Wellness Visit (AWV):
 - i) G0438 [*Annual wellness visit; includes a personalized prevention plan of service (PPS), initial visit*]
 - ii) G0439 [*Annual wellness visit, includes a personalized prevention plan of service (PPS), subsequent visit*]

c) G0468 [*Federally qualified health center (FQHC) visit, initial preventive physical exam (IPPE) or annual wellness visit (AWV)*]. Only one unit of G0468 may be billed per plan benefit year.

d) G0101 (Cervical or vaginal cancer screening; pelvic and clinical breast examination).

2) A Medicare Advantage member may have multiple preventive services per plan benefit year, one from each of the following categories. One of these preventive services needs to be billed with modifier 25 appended.

a) Medicare wellness visit (either G0402, G0438, or G0439).

b) Annual Preventive Physical Exam (99381 – 99397).

c) Gynecological visit exam (G0101)

A problem-oriented visit may also be billed in addition, with modifier 25 appended.

b. If the patient is seen for a problem-oriented visit (for any reason other than a comprehensive preventive medicine visit), then only one E/M service procedure code may be reported. The individual problems may not be coded under separate E/M visit procedure codes using modifier 25. Select an appropriate E/M code and level of service representative of the evaluation and management of all problems and issues addressed during the entire visit. Proper documentation of the exam, history, and medical decision-making for each problem addressed is essential to support the code selection.

c. When a patient presents for a single problem-oriented visit with multiple health concerns, depending upon the remaining patients and procedures scheduled for that day, it may be necessary to prioritize the most pressing needs to address during the current visit, and then schedule a second visit to address the less urgent health concerns. This is solely a provider's workflow and time-management decision, not a coding or financial decision.

2. For two separate visits or encounters:

a. If the patient is seen elsewhere and admitted to the hospital, all services at the original visit and care at the hospital are included in the initial hospital E/M service. (AMA⁷)

b. Two separate visits occurred at different times of day and for unrelated problems that could not be anticipated or addressed during the same encounter. (CMS¹⁰)

i. For example, a scheduled office visit occurs in the morning for upper respiratory infection and 4 hours later an unscheduled visit for a fall with injured knee.

ii. Modifier 25 would be appended to the second visit. Additional information regarding the two separate times should be supplied in box 19 of the claim form, or the equivalent field in the electronic claims submission process.

iii. **Note:** If the patient mentions the second problem at the first visit, and the provider asks the patient to return later in the day for the assessment of the second problem, then all evaluation and management services provided that day would be included in the selection of a single E/M service code.

- iv. Modifier XE (separate encounter) would appear to be a more specific modifier to use in this instance, but modifiers -X{EPSU} were created by CMS as specific subsets of modifier 59. Since modifier 59 is not appropriate to use with E/M services, modifier XE should not be used for a separate encounter E/M service either.

F. Appropriate Use of Modifier 25

#	Appropriate Use of Modifier 25 Example Scenario	Correct Code(s)	Coding Rationale
1	An established patient is seen for periodic follow-up for hypertension and diabetes. During the visit, the patient asked the physician to address right knee pain which developed after recent yard work. The physician performed a problem-focused history and exam of the patient’s hypertension and diabetes, and adjusted medications. Then the physician evaluated the knee and performs an arthrocentesis.	99212-25 20610	The evaluation of the knee problem is included in the arthrocentesis reimbursement. The presenting problem for the visit was other than the knee problem. A separate evaluation of the hypertension and diabetes was performed (<i>Grider^A</i>) (and would have been performed if the knee problem did not exist), making the use of modifier 25 appropriate.
2	An established patient is seen for a 2.0 finger laceration, which is closed with a simple repair. The patient also asks the physician to evaluate sinus problems, which is addressed with an expanded problem-focused history and exam and low medical decision making.	12001 99213-25	The patient presented to the provider with two problems. A surgical procedure was performed, and a separate E/M service was performed to address the second problem. The visit notes clearly document the assessment and treatment of the two problems separately. (<i>Grider^A</i>)
3	A new patient presents with head trauma, loss of consciousness at the scene, and a 4.2 cm scalp laceration. The physician determines the laceration requires sutures, confirms the allergy and immunization status, obtains informed consent, and performs a simple repair. Due to the loss of consciousness, the physician also performs a full neurological examination with an expanded problem-focused history, expanded problem-focused examination, and medical decision making of low complexity.	12002 99202-25	The possible neurological damage from the head trauma extended beyond the laceration which was repaired. The full neuro exam, history, and medical decision making outside of the laceration issues are separate and distinct, significantly separate, and well documented to support the use of modifier 25. (CMS ⁸)

G. Improper Use of Modifier 25

#	Improper Use of Modifier 25 Example Scenario	Correct Code(s)	Coding Rationale
4	An established patient returns to the orthopedic physician with escalating right knee pain 6 months post a series of Hyaluronan injections. After evaluating the knee and the patient's medical suitability for the procedure (meds, vitals, etc.), the physician determines a second series of hyaluronan injections is needed and performs the first of three intra-articular injections.	20610	It would not be appropriate to bill the E/M visit with modifier 25, because the focus of the visit is related to the knee pain, which precipitated the injection procedure. The evaluation of the knee problem and the patient's medical suitability for the procedure is included in the injection procedure reimbursement/RVU, per CMS NCCI Policy Manual. (CMS ⁸)
5	A 63-year-old woman presents with complaint of multiple skin lesions on her arms. The physician determines these are actinic keratosis and recommends removal. Informed consent was obtained. A total of 12 lesions were removed with cryosurgery.	17110	The office visit is considered part of the surgery service and therefore not separately reimbursable. The use of modifier 25 is not appropriate because the E/M service did not go above and beyond the usual preoperative service. (<i>Grider^A</i>) Also, since 17110 has a global period of 010 days, the decision for surgery E/M services on the same date of service as the minor surgical procedure are not eligible to be reported with modifier 57 either, but are included in the payment for the surgery procedure. (CMS ²)
6	A new patient was hit by a falling icicle and presents with a 2.2 cm laceration of the forehead. The physician determines the laceration requires sutures, confirms the allergy and immunization status, obtains informed consent, and performs a layered, intermediate repair. No loss of consciousness was reported by those at the scene and the patient reports no dizziness or blurred vision, so the physician does not perform a full neurological examination.	12051	The physician is not concerned about possible neurological damage based on the information supplied, so no full neurological exam was performed. The additional exam questions to determine this are not significant and separately identifiable as key components of an E/M service extending beyond the laceration which was repaired. The documentation does not support the use of modifier 25 with an E/M code. (CMS ⁸)

#	Improper Use of Modifier 25 Example Scenario	Correct Code(s)	Coding Rationale
7	The patient returns to the office to review the results of the MRI of the left elbow. The results of the MRI were reviewed, and treatment options were discussed. PARQ was then held regarding further diagnostic as well as potentially therapeutic options including corticosteroid injection. The patient elected to proceed with the injection which was then performed.	20605	It would not be appropriate to bill the E/M visit with modifier 25, because the focus of the visit is related to the elbow pain, which precipitated the injection procedure. The evaluation of the elbow MRI results and the patient's medical suitability for the injection procedure, discussion of treatment options, risks, benefits, PARQ is ALL included in the injection procedure reimbursement/RVU, per CMS NCCI Policy Manual. (CMS ⁸)

Codes, Terms, and Definitions

Acronyms Defined

Acronym		Definition
AMA	=	American Medical Association
ASC	=	Ambulatory Surgery Center
AWV	=	Annual Wellness Visit
CCI	=	Correct Coding Initiative (see "NCCI")
CMS	=	Centers for Medicare and Medicaid Services
CMT	=	Chiropractic Manipulative Treatment
CPT	=	Current Procedural Terminology
DRG	=	Diagnosis Related Group (also known as/see also MS DRG)
E/M		Evaluation and Management
E&M E & M	=	(Abbreviated as "E/M" in CPT book guidelines, sometimes also abbreviated as "E&M" or "E & M" in some CPT Assistant articles and by other sources.)
HCPCS	=	Healthcare Common Procedure Coding System (acronym often pronounced as "hick picks")
HIPAA	=	Health Insurance Portability and Accountability Act
IPPE	=	Initial Preventive Physical Examination
IWV	=	Initial Wellness Visit

Acronym		Definition
MRI	=	Magnetic Resonance Imaging
MS DRG	=	Medicare Severity Diagnosis Related Groups (also known as/see also DRG)
NCCI	=	National Correct Coding Initiative (aka "CCI")
OMT	=	Osteopathic Manipulative Treatment
OPPS	=	Outpatient Prospective Payment System
PARQ	=	Procedures, Alternatives, Risks, Questions (This acronym is used for documenting informed consent prior to a procedure, especially a surgical procedure)
PPS	=	Personalized Prevention Plan of Service
RPM	=	Reimbursement Policy Manual (e.g. in context of "RPM052" policy number, etc.)
RVU	=	Relative Value Unit
UB	=	Uniform Bill
WME	=	Welcome to Medicare Exam

Modifier Definitions:

Modifier	Modifier Definition
Modifier 25	<p>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: It may be necessary to indicate that on the day a procedure or service identified by a CPT code was performed, the patient’s condition required a significant, separately identifiable E/M service above and beyond the other service provided or beyond the usual preoperative and postoperative care associated with the procedure that was performed. 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 (see Evaluation and Management Services Guidelines for instructions on determining the level of E/M service.) The E/M service may be prompted by the symptoms or condition for which the procedure and/or service was provided. As such, different diagnoses are not required for reporting of the E/M services on the same day. The circumstances may be reported by adding modifier 25 to the appropriate level of E/M service.</p> <p>Note: This modifier is not used to report an E/M service that resulted in a decision to perform surgery. See modifier 57. For significant, separately identifiable non-E/M services, see modifier 59.</p>

Coding Guidelines

“Modifiers may be appended to HCPCS/CPT codes only if the clinical circumstances justify the use of the modifier. A modifier should not be appended to a HCPCS/CPT code solely to bypass an NCCI edit if the clinical circumstances do not justify its use. If the Medicare program imposes restrictions on the use of a modifier, the modifier may only be used to bypass an NCCI edit if the Medicare restrictions are fulfilled.” (CMS²)

“Modifier 59 and other NCCI-associated modifiers should NOT be used to bypass an NCCI edit unless the proper criteria for use of the modifier are met. Documentation in the medical record must satisfy the criteria required by any NCCI-associated modifier used.” (CMS²)

“Modifier 25 may be appended to E&M services reported with minor surgical procedures (global period of 000 or 010 days) or procedures not covered by global surgery rules (global indicator of XXX). Since minor surgical procedures and XXX procedures include pre-procedure, intra-procedure, and post-procedure work inherent in the procedure, the provider should not report an E&M service for this work. Furthermore, Medicare Global Surgery rules prevent the reporting of a separate E&M service for the work associated with the decision to perform a minor surgical procedure whether the patient is a new or established patient.” (CMS²)

“The CPT codes for procedures do include the evaluation services necessary prior to the performance of the procedure (eg, assessing the site/condition of the problem area, explaining the procedure, obtaining informed consent), however, when significant and identifiable (ie, key components/counseling) E/M services are performed, these services are not included in the descriptor for the procedure or service performed. It is important to note that the diagnosis reported with both the procedure/service and E/M service need not be different, if the same diagnosis accurately describes the reasons for the encounter and the procedure.” (AMA³)

“Osteopathic manipulative treatment (OMT) is a form of manual treatment applied by a physician or other qualified health care professional to eliminate or alleviate somatic dysfunction and related disorders. This treatment may be accomplished by a variety of techniques. Evaluation and management services including new or established patient office or other outpatient services (99201- 99215)... may be reported separately using modifier 25 if the patient’s condition requires a significant, separately identifiable E/M service above and beyond the usual preservice and postservice work associated with the procedure.” (AMA⁶)

“The chiropractic manipulative treatment codes [98940 – 98943] include a pre-manipulation patient assessment. Additional evaluation and management services including office or other outpatient services (99201 – 99215)...may be reported separately using modifier 25 if the patient’s condition requires a significant, separately identifiable E/M service above and beyond the usual preservice and postservice work associated with the procedure.” (AMA⁶)

“When the patient is admitted to the hospital as an inpatient in the course of an encounter in another site of service (eg, hospital emergency department, observation status in the hospital, office, nursing facility) all evaluation and management services provided by that physician in conjunction with that admission are considered part of the initial hospital care when performed on the same date as the

admission. The inpatient care level of service reported by the admitting physician should include the services related to the admission he/she provided in the other sites of service as well as in the inpatient setting.

Evaluation and management services including new or established patient office or other outpatient services (99201-99215), emergency department services (99281-99285), nursing facility services (99304-99318), domiciliary, rest home, or custodial care services (99324-99337), home services (99341-99350), and preventive medicine services (99381-99397) on the same date related to the admission to “observation status” should **not** be reported separately.” (AMA⁷)

“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.” (CMS⁹)

“As for all other E/M services except where specifically noted, the Medicare Administrative Contractors (MACs) may not pay two E/M office visits billed by a physician (or physician of the same specialty from the same group practice) for the same beneficiary on the same day unless the physician documents that the visits were for unrelated problems in the office, off campus-outpatient hospital, or on campus-outpatient hospital setting which could not be provided during the same encounter (e.g., office visit for blood pressure medication evaluation, followed five hours later by a visit for evaluation of leg pain following an accident).” (CMS¹⁰)

“An E&M service is separately reportable on the same date of service as a procedure with a global period of 000, 010, or 090 under limited circumstances...If an E&M is performed on the same date of service as a major surgical procedure for the purpose of deciding whether to perform this surgical procedure, the E&M service is separately reportable with modifier 57. Other preoperative E&M services on the same date of service as a major surgical procedure are included in the global payment for the procedure and are not separately reportable.

If a procedure has a global period of 000 or 010 days, it is defined as a minor surgical procedure. In general E&M services on the same date of service as the minor surgical procedure are included in the payment for the procedure. The decision to perform a minor surgical procedure is included in the payment for the minor surgical procedure and should not be reported separately as an E&M service. However, a significant and separately identifiable E&M service unrelated to the decision to perform the minor surgical procedure is separately reportable with modifier 25. The E&M service and minor surgical procedure do not require different diagnoses. If a minor surgical procedure is performed on a new patient, the same rules for reporting E&M services apply. The fact that the patient is “new” to the provider is not sufficient alone to justify reporting an E&M service on the same date of service as a minor surgical procedure.

Example: If a physician determines that a new patient with head trauma requires sutures, confirms the allergy and immunization status, obtains informed consent, and performs the repair, an E&M service is not separately reportable. However, if the physician also performs a medically reasonable and necessary full neurological examination, an E&M service may be separately reportable.” (CMS⁸)

Cross References

- A. "Clinical Editing." Moda Health Reimbursement Policy Manual, RPM002.
- B. "Valid Modifier to Procedure Code Combinations." Moda Health Reimbursement Policy Manual, RPM019.
- C. "Modifiers XE, XS, XP, XU, and 59 - Distinct Procedural Service." Moda Health Reimbursement Policy Manual, RPM027.
- D. RPM044, "Gynecologic or Annual Women's Exam Visit & Use of Q0091 (Pap, Pelvic, & Breast Visit)."

References & Resources

1. American Medical Association. "Appendix A – Modifiers." *Current Procedural Terminology (CPT)*. Chicago: AMA Press.
2. CMS. *National Correct Coding Initiative Policy Manual*. Chapter 1 General Correct Coding Policies, § E, "Modifiers and Modifier Indicators."
3. American Medical Association. "Appropriate Use of Modifier -25." *CPT Assistant*, September 1998: 4.
4. Grider, Deborah J. *Coding with Modifiers: A Guide to Correct CPT and HCPCS Level II Modifier Usage*. Chicago: AMA Press, 2004, pp. 59-71.
5. American Medical Association. "Modifiers, 25 (Q&A)". *CPT Assistant*. Chicago: AMA Press, January 2008, p. 9.
6. American Medical Association. "Osteopathic Manipulative Treatment guidelines and Chiropractic Manipulative Treatment guidelines." *Current Procedural Terminology (CPT)*. Chicago: AMA Press.
7. American Medical Association. "Initial Hospital Care." *Current Procedural Terminology (CPT)*. Chicago: AMA Press.
8. CMS. *National Correct Coding Initiative Policy Manual*. Chapter 1 General Correct Coding Policies, § D, "Evaluation and Management (E&M) Services."
9. CMS. *Medicare Claims Processing Manual* (Pub. 100-4). Chapter 12 – Physician Practitioner Billing, § 30.6.5.
10. CMS. *Medicare Claims Processing Manual* (Pub. 100-4). Chapter 12 – Physician Practitioner Billing, § 30.6.7.B.

Background Information

Modifiers are two-character suffixes (alpha and/or numeric) that are attached to a procedure code. CPT modifiers are defined by the American Medical Association (AMA). HCPCS Level II modifiers are defined by the Centers for Medicare and Medicaid Services (CMS). Like CPT codes, the use of modifiers requires explicit understanding of the purpose of each modifier.

Modifiers provide a way to indicate that the service or procedure has been altered by some specific circumstance but has not been changed in definition or code. Modifiers are intended to communicate specific information about a certain service or procedure that is not already contained in the code definition itself. Some examples are:

- To differentiate between the surgeon, assistant surgeon, and facility fee claims for the same surgery
- To indicate that a procedure was performed bilaterally
- To report multiple procedures performed at the same session by the same provider
- To report only the professional component or only the technical component of a procedure or service
- To designate the specific part of the body that the procedure is performed on (e.g. T3 = Left foot, fourth digit)
- To indicate special ambulance circumstances

More than one modifier can be attached to a procedure code when applicable. Not all modifiers can be used with all procedure codes.

Modifiers do not ensure reimbursement. Some modifiers increase or decrease reimbursement; others are only informational.

Modifiers are not intended to be used to report services that are "similar" or "closely related" to a procedure code. If there is no code or combination of codes or modifier(s) to accurately report the service that was performed, provide written documentation and use the unlisted code closest to the section which resembles the type of service provided to report the service.

IMPORTANT STATEMENT

The purpose of this Reimbursement Policy is to document Moda Health's payment guidelines for those services covered by a member's medical benefit plan. Healthcare providers (facilities, physicians and other professionals) are expected to exercise independent medical judgment in providing care to members. Moda Health Reimbursement Policy is not intended to impact care decisions or medical practice.

Providers are responsible for accurately, completely, and legibly documenting the services performed. Billed codes shall be fully supported in the medical record and/or office notes. Providers are expected to submit claims for services rendered using valid codes from HIPAA-approved code sets. Claims are to be coded appropriately according to industry standard coding guidelines (including but not limited to UB Editor, AMA, CPT, CPT Assistant, HCPCS, DRG guidelines, CMS' National Correct Coding Initiative [CCI] Policy Manual, CCI table edits and other CMS guidelines).

Benefit determinations will be based on the member's medical benefit plan. Should there be any conflicts between the Moda Health Reimbursement Policy and the member's medical benefit plan, the member's medical benefit plan will prevail. Fee determinations will be based on the applicable provider fee schedule, whether out of network or participating provider's agreement, and Moda Health Reimbursement Policy.

Policies may not be implemented identically on every claim due to variations in routing requirements, dates of processing, or other constraints; Moda Health strives to minimize these variations.

***** The most current version of our reimbursement policies can be found on our provider website. If you are using a printed or saved electronic version of this policy, please verify the information by going to https://www.modahealth.com/medical/policies_reimburse.shtml *****