

## **Modifiers 25 and 59 Exceptions for Claim Management Services, Inc.**

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Inclusion of a procedure code or edit in the list below does not imply or guarantee coverage. Furthermore, Reimbursement Policies/Edits evolve over time, and we reserve the right to review and update these Reimbursement Policies/Edits periodically.

**Modifier 25:** Claim Management Services, Inc. generally will recognize modifier 25, for payment purposes, when modifier 25 is appropriately reported from both a clinical and coding perspective.

**Modifier 59:** Claim Management Services, Inc. generally will recognize modifier 59, for payment purposes, when modifier 59 is appropriately reported from both a clinical and coding perspective. However, in certain situations, described below, Claim Management Services, Inc. will not recognize modifier 59, for payment purposes, under any circumstance.

**“Duplicate” Procedures:** Claim Management Services, Inc. will not pay for “duplicate” procedures performed on the same patient on the same date of service, even if a provider reports modifier 59 with these procedures. “Duplicate” procedures, as used in this paragraph, fall into the following categories:

(a) If the description of a procedure code contains either the word “bilateral” or the phrase “unilateral/bilateral,” the procedure code can be reported only once for a covered procedure performed on a single date of service (and the reporting of any additional such procedures performed on the same date will be considered non-payable “duplicates”);

(b) If the description of a procedure code states that the procedure may be performed a specified number of times on a single date of service, a provider should not report the performance of any such procedure beyond the specified number of times (and the reporting of any additional such procedures performed on the same date will be considered non-payable “duplicates”).

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