



## Reimbursement Policy

**Subject: Modifier 24: Unrelated Evaluation and Management Service by the Same Physician or Other Qualified Health Care Professional during the Postoperative Period**

Effective Date: <b>10/26/18</b>	Committee Approval Obtained: <b>10/26/18</b>	Section: <b>Coding</b>
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\*\*\*\*\*The most current version of the reimbursement policies can be found on our provider website. If you are using a printed version of this policy, please verify the information by going to <https://providers.amerigroup.com>. Under Quick Tools, select Reimbursement Policies > Medicare. \*\*\*\*\*

These policies serve as a guide to assist you in accurate claim submissions and to outline the basis for reimbursement if the service is covered by a member's Amerigroup Medicare Advantage benefit plan. The determination that a service, procedure, item, etc. is covered under a member's benefit plan is not a determination that you will be reimbursed. Services must meet authorization and medical necessity guidelines appropriate to the procedure and diagnosis as well as to the member's state of residence. You must follow proper billing and submission guidelines. You are required to use industry standard, compliant codes on all claim submissions. Services should be billed with CPT® codes, HCPCS codes and/or revenue codes. The codes denote the services and/or procedures performed. The billed code(s) are required to be fully supported in the medical record and/or office notes. Unless otherwise noted within the policy, our policies apply to participating providers and facilities; a non-contracting provider who accepts Medicare assignment will be reimbursed for services according to the original Medicare reimbursement rates.

If appropriate coding/billing guidelines or current reimbursement policies are not followed, Amerigroup Medicare Advantage may:

- Reject or deny the claim.
- Recover and/or recoup claim payment.

Amerigroup Medicare Advantage reimbursement policies are developed based on nationally accepted industry standards and coding principles. These policies may be superseded by mandates in provider, state, federal or CMS contracts and/or requirements. System logic or setup may prevent the loading of policies into the claims platforms in the same manner as described; however, Amerigroup Medicare Advantage strives to minimize these variations.

Amerigroup Medicare Advantage reserves the right to review and revise our policies periodically when necessary. When there is an update, we will publish the most current policy to this site.

**Policy**

Amerigroup Medicare Advantage allows limited reimbursement for physician or other qualified health care professional claims billed with Modifier 24 unless provider, state, federal or CMS contracts and/or requirements indicate otherwise.

	<p>Reimbursement is based on 100 percent of the applicable fee schedule or contracted/negotiated rate for the evaluation and management (E&amp;M) service performed during the postoperative period of the original procedure if the following criteria are met:</p> <ul style="list-style-type: none"> <li>• The appropriate level of E&amp;M service is billed and appended with Modifier 24.</li> <li>• A diagnosis code unrelated to the original procedure is indicated for the E&amp;M service.</li> <li>• The reason for the E&amp;M service is clearly documented in the member’s medical record.</li> </ul> <p>Failure to use Modifier 24 correctly may result in denial of the E&amp;M service and/or claim payments may be recouped and/or recovered.</p>
<b>History</b>	<ul style="list-style-type: none"> <li>• Biennial review approved and effective 10/26/18: Policy template updated</li> <li>• Biennial review approved 11/07/16: Policy template update</li> <li>• Initial review approved and effective 01/01/15</li> </ul>
<b>References and Research Materials</b>	<p>This policy has been developed through consideration of the following:</p> <ul style="list-style-type: none"> <li>• CMS</li> <li>• State contract</li> </ul>
<b>Definitions</b>	<ul style="list-style-type: none"> <li>• <b>Modifier 24:</b> used to indicate that the same physician or other qualified health care professional needed to perform E&amp;M service during the postoperative period for a reason unrelated to the original procedure; E&amp;M services performed during the postoperative period of the original service usually are considered part of the global surgical package</li> <li>• <b>General Reimbursement Policy Definitions</b></li> </ul>
<b>Related Policies</b>	<ul style="list-style-type: none"> <li>• Modifier Usage</li> </ul>
<b>Related Materials</b>	<ul style="list-style-type: none"> <li>• None</li> </ul>