Amerigroup RealSolutions in healthcare	**Reimbursement Policy**

Subject: Modifier 24: Unrelated Evaluation and Management Service by the Same Physician or Other Qualified Healthcare Professional During the Postoperative Period

Effective Date:	Committee Approval Obtained:	Section:
09/14/20	**09/14/20**	**Coding**

*****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/GA**. Note: State-specific exemptions may apply. Please refer to the Exemptions section below for specific exemptions based on your state.*****

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 Community Care 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 both participating and nonparticipating providers and facilities.

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

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

Amerigroup 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 These policies may be superseded by mandates in provider, state, federal or CMS contracts and/or requirements.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 strives to minimize these variations.

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

	Reimbursement is based on 100% of the applicable fee schedule or contracted/negotiated rate for the Evaluation and Management (E/M) service performed during the postoperative period of the original procedure if the following criteria are met: • The appropriate level of E/M service is billed and appended with Modifier 24. • A diagnosis code **unrelated** to the original procedure is indicated for the E/M service. • The reason for the E/M service is clearly documented in the member's medical record. Failure to use Modifier 24 correctly may result in denial of the E/M service, and/or claim payments may be recouped and/or recovered.
History	• Biennial review approved and effective 09/14/20: • Biennial review approved and effective 10/26/18: Other qualified healthcare professional language added • Biennial review approved 11/07/16: policy template updated • Biennial review approved 09/22/14: Background section/policy template updated • Review approved 05/20/13: Disclaimer updated 04/23/13 • Biennial review approved 04/23/12: Policy template updated • Review approved 06/06/11: Background section/policy template updated • Biennial review approved 06/21/10: Definitions and Background sections updated; policy template updated; accountability language updated • Review approved 11/10/08: Background section/policy template updated • Initial approval and effective: 05/04/06
References and Research Materials	This policy has been developed through consideration of the following: • CMS • State Medicaid • Amerigroup state contracts
Definitions	• **Modifier 24: Unrelated Evaluation and Management Service by the Same Physician or Other Qualified Healthcare Professional During a Postoperative Period** — used to indicate that the same physician or other qualified healthcare professional needed to perform an Evaluation and Management (E/M) service during the postoperative period for a reason unrelated to the original procedure; E/M services performed during the postoperative period of the original service usually are considered part of the global surgical package

	• **General Reimbursement Policy Definitions**
Related Policies	• Modifier Usage
Related Materials	• None