	Reimbursement Policy

Subject: Modifier 24: Unrelated Evaluation and Management Service By the Same Physician During the Postoperative Period

Effective Date: **04/01/16**	Committee Approval Obtained: **11/07/16**	Section: **Coding**

*****The most current version of our 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/ia.*****

These policies serve as a guide to assist you in accurate claim submissions and to outline the basis for reimbursement by Amerigroup Iowa, Inc. if the service is covered by a member's Amerigroup 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 These policies may be superseded by mandates in provider, state, federal or CMS contracts and/or requirements.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 claims billed with Modifier 24 unless provider, state, federal or CMS contracts and/or requirements indicate otherwise. Reimbursement is based on 100 percent 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 **11/07/16** • Initial review approved **08/04/15** and effective **04/01/16**
References and Research Materials	This policy has been developed through consideration of the following: • CMS • State Medicaid • State contract
Definitions	• **Modifier 24:** Used to indicate that the same physician needed to perform an Evaluation and Management (E&M) service unrelated to the original procedure during the postoperative period of the original service. 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