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Proper Billing for Modifier 24 and Documentation Requirements

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There have been many provider submissions recently of modifier 24 without proper indication of the E/M service being unrelated to prior surgical procedure. NGS has seen this through the appeals and/or reopening process as well. As a reminder, review the CMS regulation for usage of this modifier.

The CMS Internet-Only Manual (IOM) Publication 100-04, *Medicare Claims Processing Manual*, Chapter 12, Section 40 is the main point of reference which refers to the global surgery policy. Specifically, Section 40.2 (A)(7) covers the usage of modifier 24. Within the regulation, CMS has stated modifier 24 reports an unrelated evaluation and management service by the same physician during a postoperative period. This is for those situations where a physician performed surgery on a patient then needs to see them for some reason unrelated to the surgery they performed.

An example of this would be a situation where a patient had a fractured leg that the physician performs surgery to correct. This procedure has a 90-day global period in which that operating physician follows the progress of the patient and their healing. Any service within that 90 day period related to that fracture is part of the global surgery payment the physician received when he billed for the surgical procedure. There are some exceptions. One of those exceptions would be if the patient develops another condition in this global period unrelated to the leg fracture and is being treated by that same physician.

Example: Patient was seen for evaluation and management of an arm injury. Since the injury is unrelated to the fractured leg, this would be an unrelated E/M service that could be billed to Medicare for coverage. To do so, the provider would bill with modifier 24 appended to the CPT code for the E/M.

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In order to bill the modifier 24 to the MAC for consideration the IOM guidelines state:

Services submitted with the "-24" modifier must be sufficiently documented to establish that the visit was unrelated to the surgery. A diagnosis code that clearly indicates that the reason for the encounter was unrelated to the surgery is acceptable documentation.

Also, in Section 40.4 of the same chapter of the IOM, providers are required to submit documentation that the visit is unrelated to the surgery. The IOM further states that A/B MACs do not allow separate payment for visits during the postoperative period billed with the modifier 24 but without sufficient documentation.

Please note if you are billing an initial claim and appending a 24 modifier to the E/M visit, your diagnosis for the visit must clearly be unrelated to the surgical procedure(s) diagnosis. The same holds true if you fail to provide the modifier on the initial submission and choose to do a reopening or redetermination. You must provide some type of documentation to indicate how the E/M is unrelated or your request will not be able to be adjudicated to your benefit.