

Reimbursement Policy	
Subject: Modifier 24	
Policy Number: G-06011	Policy Section: Coding
Last Approval Date: 12/27/2022	Effective Date: 12/27/2022

**** Visit our provider website for the most current version of the reimbursement policies. If you are using a printed version of this policy, please verify the information by going to <https://providers.anthem.com/ny>. ****

Disclaimer

These reimbursement policies serve as a guide to assist you in accurate claims submissions and to outline the basis for reimbursement if Anthem Medicare Advantage covered the service for the member's 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 Current Procedure Terminology® (CPT) codes, Healthcare Common Procedure Coding System (HCPCS) codes, and/or revenue codes. These codes denote the services and/or procedures performed and, when billed, must be fully supported in the medical record and/or office notes. Unless otherwise noted within the policy, our reimbursement policies apply to both participating and non-participating professional providers and facilities.

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

- Reject or deny the claim.
- Recover and/or recoup claim payment.
- Adjust the reimbursement to reflect the appropriate services and/or procedures performed.

These reimbursement policies may be superseded by mandates in provider, state, federal, or Centers for Medicare & Medicaid Services (CMS) contracts and/or requirements. Anthem Medicare Advantage strives to minimize delays in policy

implementation. If there is a delay, we reserve the right to recoup and/or recover claims payment to the effective date in accordance with the policy. We reserve the right to review and revise these policies when necessary. When there is an update, we will publish the most current policy to the website.

Policy

Anthem Medicare Advantage allows limited reimbursement for physicians or other qualified healthcare professionals for 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.

Related Coding

Standard correct coding applies

Policy History

12/27/2022	Review approved and effective: title updated to remove Unrelated Evaluation and Management Service by the Same Physician or Other Qualified Healthcare Professional during the Postoperative Period; minor language and format changes; updated related policies section
09/14/2020	Review approved and effective: Definition updated
10/26/2018	Review approved and effective: Other qualified healthcare professional language added
09/01/2017	Policy template updated
11/07/2016	Review approved: Policy template updated
09/22/2014	Review approved: Policy template updated
05/20/2013	Review approved: Policy template updated
04/23/2012	Review approved: Policy template updated
06/06/2011	Review approved: Policy template updated
06/21/2010	Review approved: Policy template updated
11/10/2008	Review approved: Policy template updated

05/04/2006	Initial approval and effective
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References and Research Materials

This policy has been developed through consideration of the following:

- CMS
- State Medicaid
- State contracts
- Optum EncoderPro 2022

Definitions

Modifier 24	<p>Unrelated Evaluation and Management Service by the Same Physician or Other Qualified Healthcare Professional During a Postoperative Period:</p> <ul style="list-style-type: none">• 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 and Materials

Modifier Usage
Modifiers 25 and 57