TITLE: **Use of Modifier 24**

POLICY/PURPOSE: To establish a procedure under which the Modifier 24 may be appended to an Evaluation and Management (E/M) code.

DEFINITIONS:
Modifier 24 Definition: Unrelated Evaluation and Management Service by the Same Physician or Other Qualified Health Care Professional During the Postoperative Period.

When the Modifier 24 is used appropriately, visits rendered during the postoperative period of a surgery will be reimbursed (assuming no other payment policy restrictions apply). Inappropriate application of Modifier 24 may lead to the postoperative E/M services being overpaid or, if the modifier is not appended when it should be, the charge may be underpaid.

PROCEDURE:
The physician or other qualified health care professional may need to indicate than an E/M service was performed during a postoperative period for a reason(s) unrelated to the global procedure. This circumstance may be reported by adding Modifier 24 to the appropriate level of E/M service. The documentation must support that the reason for the E/M service is unrelated to the surgical procedure. Treat established patient eye exam codes 92012 and 92014 as E/M services when determining whether to report Modifier 24.

1. Postoperative Care During the Global Surgery Period In General

Medicare policy allows payment for an E/M service other than inpatient hospital care before discharge from the hospital following surgery (CPT codes 99221-99238) if it was provided during the postoperative period of a surgical procedure, furnished by the same physician who performed the procedure, billed with Modifier 24, and is accompanied by documentation that supports that the service is not related to the postoperative care of the procedure. Medicare does not pay for inpatient hospital care that is furnished during the hospital stay in which the surgery occurred unless the surgeon is also treating another medical condition that is unrelated to the surgery. All care provided during the inpatient stay in which the surgery occurred is compensated through the global surgical payment.

For unrelated postoperative care, Modifier 24 must be used with the procedure code. Services submitted with Modifier 24 must be sufficiently documented to establish that the visit was unrelated to the surgery. Documentation which clearly indicates that the diagnosis being managed was unrelated to the surgery is acceptable.

Modifier 24 is intended for use with services that are absolutely unrelated to the surgery. It is not to be used for the medical management of a patient by the surgeon following surgery. Recognize Modifier 24 only for care following the discharge from the hospital during which the surgery was performed unless:

- the care is for immunotherapy management furnished by the transplant surgeon;
- the care is for critical care for a burn or trauma patient; or
- the documentation demonstrates that the visit occurred during a subsequent hospitalization and the diagnosis supports the fact that it is unrelated to the original surgery.

2. Immunosuppressive Therapy
   Physicians may bill for management of immunosuppressive therapy using the office or subsequent hospital visit codes that describe the services furnished. If the physician who is managing the immunotherapy is also the transplant surgeon, he or she bills these visits with Modifier 24 indicating that the visit during the global period is not related to the original procedure if the physician also performed the transplant surgery and submits documentation that shows that the visit is for immunosuppressive therapy.

3. Nursing Facility Admissions

Medicare policy is to pay for an E/M service, other than inpatient hospital care before discharge from the hospital following surgery (CPT codes 99221-99238), if the E/M service was provided during the postoperative period of a surgical procedure, furnished by the same physician who performed the procedure, billed with Modifier 24, and accompanied by documentation that supports that the service is not related to the postoperative care of the procedure. Medicare does not pay for inpatient hospital care that is furnished during the hospital stay in which the surgery occurred unless the physician is also treating another medical condition that is unrelated to the surgery. All care related to recovery from the surgery that is provided during the inpatient stay in which the surgery occurred is compensated through the global surgical payment.

Medicare policy is to pay the hospital discharge code (codes 99238 or 99239) in addition to a nursing facility admission code when they are billed by the same physician with the same date of service.
If a surgeon is admitting the patient to the nursing facility during the postoperative period of a service with the global surgical period, and the admission is for a condition that is not a result of the surgery, the physician bills for the nursing facility admission and care with Modifier 24 and provides documentation that the service is unrelated to the surgery (e.g., return of an elderly patient to the nursing facility in which he/she has resided for five years following discharge from the hospital for cholecystectomy).

Medicare policy restricts payment for a nursing facility admission by a surgeon in the postoperative period of a procedure with a global surgical period if the patient's admission to the nursing facility is to receive postoperative care related to the surgery (e.g., admission to a nursing facility to receive physical therapy following a hip replacement). Payment for the nursing facility admission and subsequent nursing facility services are included in the global fee and cannot be paid separately.

4. Observation Care During the Postoperative Period of a Global Surgery

The global surgical fee includes payment for hospital observation (codes 99217, 99218, 99219, 99220, 99224, 99225, 99226, 99234, 99235, and 99236) services unless the observation care is unrelated to the surgery.

The surgeon would bill the observation code with Modifier 24 and the documentation must support that the observation services were unrelated to the surgery.

5. Critical Care Services Provided During Postoperative Period for Trauma and Burn Cases

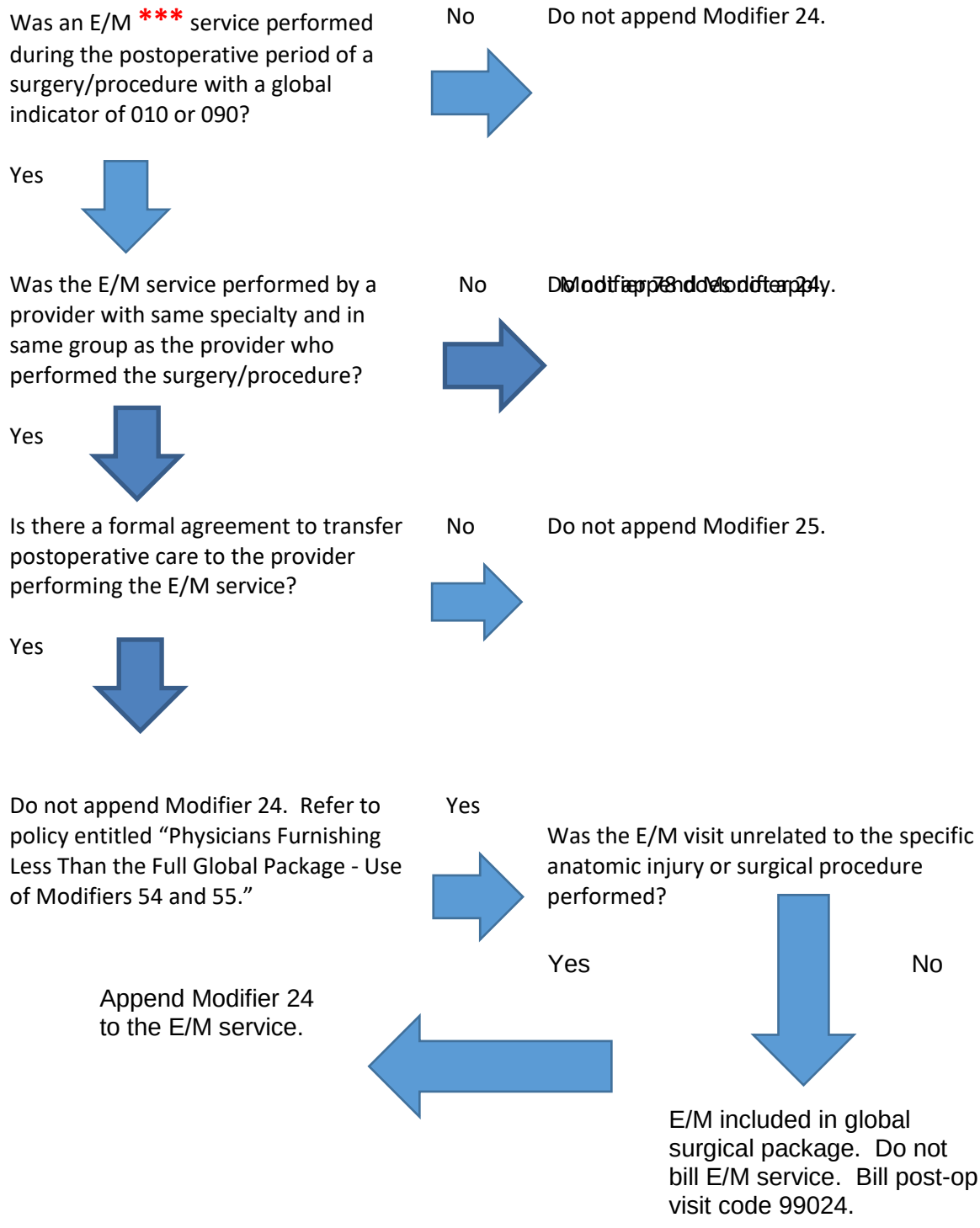
Postoperative critical care services provided during the global surgical period for a seriously injured or burned patient are not considered related to a surgical procedure and may be paid separately under the following circumstances:

- the patient is critically ill and requires the constant attendance of the physician; and
- the critical care is above and beyond, and, in most instances, unrelated to the specific anatomic injury or general surgical procedure performed.

Modifier 24 is used to indicate that the critical care service is unrelated to the procedure. Services submitted with Modifier 24 must be sufficiently documented to establish that the critical care was unrelated to the specific anatomic injury or general surgical procedure performed.

When postoperative critical care services (for procedures with a global surgical period) are provided by a physician other than the surgeon, no modifier is required unless all surgical postoperative care has been officially transferred from the surgeon to the physician performing the critical care services. In this situation, follow the policy entitled "Physicians Furnishing Less Than the Full Global Package - Use of Modifiers 54 and 55."

Modifier 24 Decision Chart



***** Treat established patient eye exam codes 92012**

& 92014 as an E/M service in determining whether to report Modifier 24.

REFERENCES:

APPROVED BY:
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