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Modifier 24 Quick Tip Script

Welcome to the WPS Medicare discussion of Modifier 24.

Our second slide gives you the pathway to find a Fact Sheet on Modifier 24. We list our Website address (<http://www.wpsmedicare.com>) for you. Once on the Website, under Part B on the right side of the screen, choose "Illinois, Michigan, Minnesota, Wisconsin." You will then need to accept the Current Procedural Terminology (CPT) licensure agreement. On the next screen, select "Modifiers" under Education on the lower right side of the screen. Scroll down and select "24 Modifier" to view the fact sheet. The fact sheet provides information on the definition of the modifier and the correct uses.

This modifier is one of three leading causes of telephone calls into our office and requests for Redeterminations. Understanding the accurate use of the modifier allows providers to append the modifier appropriately on the original claim and decreases the number of denied claims necessitating further action by the provider's office.

Slide 3 has a screen print of the Fact Sheet. So let's us talk about this modifier.

The definition of the Modifier is an unrelated Evaluation and Management (E/M) service by the same physician during the post-operative period. This modifier is only valid for use on an E/M service. This modifier, if used on any other type of service, causes Medicare to deny the services as unprocessable.

The second part of the description is "by the same physician." This means the same physician who performed the surgical procedure. Medicare defines the same physician as the same person or a member of the same group with the same specialty.

Then, the third part of the definition is during a post-operative period. Medicare's reimbursement for procedures includes both the procedure itself, and services during a designated post-operative period after the surgery. Medicare designates procedures as 0, 10, or 90 days. Medicare builds all of the services provided during a post-operative period into the calculation of the reimbursement for the procedure. We will have information later to show how to determine the number of post-operative or global days assigned to a procedure.

Any E/M service provided during the post-operative period is part of the global surgery package and is not separately payable.

However, there can be exceptions to this rule and that is when a provider may use the 24 modifier.

The first thing to keep in mind is that documentation must support the use of this modifier. You do not want to have edits built into your billing system that automatically add this modifier. That is inappropriate. You do want to have edits in your system that will cause this type of claim to stop so someone can evaluate the relationship to the surgical procedure. You can then determine whether the service meets an exception indicating you can bill the E/M separately or it does not meet an exception and you cannot bill separately.



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Let's talk about what Medicare considers an exception. The definition tells us that the service is unrelated to the procedure.

For example, you performed surgery on the patient's knee. The patient came back into your office for treatment of a sprained wrist; there is no relationship to the surgery. Therefore, Medicare should pay separately for the treatment of a sprained wrist. Adding Modifier 24 to the E/M service is correct.

Another exception is the treatment of the underlying condition that caused the surgery. An example of this is arthritis. The patient has knee surgery because of the arthritis, but the E/M you provide is treating the arthritis not the knee surgery. This is also true when the E/M is for managing immunosuppressant therapy following a transplant or chemotherapy following a procedure. Documentation is key for these three areas.

Do not use this modifier when the E/M is not in a post-operative period. There is no reason to use it then.

Another improper use is for an E/M on the same day as a procedure. This modifier is only for E/M during the post-operative period that begins the day after the procedure.

What about the treatment for an infection following the surgery, is this separately payable? No. An E/M to treat the infection is part of the surgery and is not a separately payable service. This is an incorrect and improper use of the modifier.

E/M services during a post-operative period are not separately payable by Medicare unless the documentation supports one of the exceptions we have discussed.

Our next slide shows the CMS, or Center for Medicare & Medicaid Services (CMS), Website address and instructions on how to access the Physician Fee Schedule Relative Value file. Once on this file, choose the year and then your procedure code. The column "Global Days" shows the number of post-operative days applicable to the service. There are multiple designations in the "Global Days" column. They are as follows:

- 000 – Service provided on the date of the procedure are included in the reimbursement of the procedure
- 010 – Services provided on the date of the procedure and 10 days after are included in the reimbursement of the procedure
- 090 – Services provided the day before, the day of and 90 days after the procedure are included in the reimbursement of the procedure
- XXX – Global surgery concept does not apply
- YYY – Contractor sets the global period
- ZZZ – This procedure is a component of another code. Look to the other procedure code for global days

Please take some time to ensure your office staff understands the use of this modifier and that your billing software allows you to submit this modifier appropriately. When services meet an exception allowing the use of the modifier, the correct submission of the claim the first time allows your office to receive payment faster and prevents having to look at and evaluate the service again later. Thank you for your time.