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Part B Insider (Multispecialty) Coding Alert

Modifiers: Get the Facts on Modifier 24

A comprehensive understanding of global surgical packages is imperative.

Now and again, a physician performs surgery on a patient, and during the global period, the patient returns to the practice for an evaluation of a different problem. If you assume the visit is bundled into the surgery, you will likely choose not to report the E/M. But you may be costing your practice hundreds of dollars and not even know it.

You can - and should - bill for some E/M services during the post-op period using modifier 24 (Unrelated evaluation and management service by the same physician or other qualified health care professional during a postoperative period). Check out the following three truths about modifier 24, along with one key myth, to get on the road to appropriately reporting it.

Fact 1: Global Days Are Essential

The first step to understanding modifier 24 is to get a firm grasp on how global surgical packages work. For example, "with a surgical code such as cataract extraction, insurers assign postoperative days, which are zero, 10 day or 90 days," said **Ian Mattis, CPC, CEMC,** during the Sept. 27 Eye Care Leaders webinar "Understanding and Correctly Using the Modifier 24."

Medicare defines what it's going to pay you for a procedure using information that goes beyond the intraoperative services you're performing. "Also included in that global package are any preoperative visits that occur following the decision for surgery, any complications that are addressed postoperatively, any postop visits within the global surgical period, any postsurgical pain management, supplies, and miscellaneous services," Mattis said.

There are, however, certain services that aren't included in the surgical package, and those can be reported during the postsurgical period. Some of these require a modifier; some do not. The services not included in the global package include the following, Mattis said:

- Initial consultation or evaluation when the patient's condition is discussed.
- Services by other physician groups.
- Visits unrelated to the diagnosis for the surgical procedure. "This is very, very important, because if a patient comes back for treatment of a condition that has nothing to do with the surgery - say you performed a cataract excision but the patient is coming in for diabetic retinopathy - that can be billed even if it's within the surgical period because it's unrelated to the cataract excision," Mattis said.
- Treatment for underlying conditions.
- Diagnostic tests or procedures.
- Distinct procedures that are not reoperations or treatments for complications.
- Postoperative complications that require a return trip to the operating room or ASC.

Fact 2: It Only Applies to E/M Codes

If you report an E/M service that's unrelated to the surgery, you'll append modifier 24 to the E/M code - but you should never append modifier 24 to a procedure code. "It only applies to E/M codes and general services codes," Mattis said. "For any other services or procedures, you would not append modifier 24 because, by definition, it's only for E/M services."

Therefore, if the physician performs a surgical procedure that has a 10- or 90-day global period and then sees the patient for an unrelated E/M service during that global period, you can append modifier 24 to the E/M code.

Fact 3: Auditors Examine Whether Visit Was Related to Surgery

If your documentation shows that somehow the visit is related to the surgery, do not use the 24 modifier, Mattis said. "This is very important. Documentation drives a lot of modifier use, so you want to be sure you're documenting exactly what's going on with that patient." In fact, if auditors review your records and find that you only documented a postoperative visit and nothing else, you're likely to have the claim denied, he said.

"As an auditor, I've seen certain things such as the chief complaint or HPI saying that the patient is presenting for a postop visit, and that immediately throws up red flags when a 24 modifier is on a postop visit claim with that in the documentation," he said.

"Also, if I see in the HPI, 'the patient presents for complications post surgery,' well, complications are included in the surgical package. An auditor would question this and throw a red flag."

In addition, if the documented diagnosis for the E/M visit is the same as the surgical diagnosis, auditors would take a closer look. You aren't required to have separate diagnoses, but thanks to the specificity of ICD-10, using the same diagnosis will make auditors double-check the diagnosis.

Of course, if the patient suffers from a condition that has a nonspecific diagnosis code, using the same diagnosis might be appropriate - this is just an area that you should look out for.

Avoid documentation using non-descript phrases like "patient presents for postop visit" because that doesn't support use of modifier 24, Mattis said. "Always support the diagnosis codes you're using."

Myth: Returning Patients to the OR Warrants Modifier 24

Complications of surgery can be billable during the global period if the patient must be returned to the operating room - but 24 isn't the right modifier in this situation.

If the physician must return to the OR to treat a postop complication, both Medicare and private payers will pay at a reduced rate when you attach modifier 78 (Unplanned return to the operating/procedure room by the same physician or other qualified health care professional following initial procedure for a related procedure during the postoperative period) to the code.