Modifier Coding Alert

Mythbuster: Dispel 5 Modifier 24 Myths

A new diagnosis may make increasing your revenue easier.

When your physician sees a patient during the global period of a procedure, you could be costing your practices hundreds of dollars each time, if you assume the office visit is bundled with the procedure. 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).

Our experts will bust five common modifier 24 myths to help you become an unrelated E/M service coding expert.

Myth #1: Modifier 24 Applies To Any Service Done In the Post-Op Period

You should only attach modifier 24 to an appropriate E/M code when an E/M service occurs during a postoperative global period for reasons unrelated to the original procedure. Modifier 24 tells the payer that the surgeon is seeing the patient for a problem unrelated to surgery. Therefore, the plan should not include the E/M service in the previous procedure's global surgical package.

Modifier 24 is only for use on E/M codes, and only for use during the post-operative period (10 days or 90 days), experts say. The very definition of the modifier states it plainly: "unrelated evaluation and management service."

Rule: You cannot bill separately for E/M-related services relating to the original surgery during the global period. The global surgical package includes routine postoperative care during the global period.

Additionally: Modifier 24 only applies to services your physician performs after the surgical procedure. If your physician performs an E/M service before a procedure, on the day of that procedure, you would need a 25 (Significant, separately identifiable evaluation and management service by the same physician or other qualified health care professional on the same day of the procedure or other service) modifier (for minor procedures) or the 57 (Decision for surgery) modifier (for major procedures). Modifier 57 also applies to E/M codes done the day before the major procedure. This is true provided that the E/M code is significant and separately identifiable.

Myth #2: Scheduled Office Visit Rules Out Modifier 24

Just because a patient was scheduled to come into your office for a follow-up visit related to the surgery, you shouldn't automatically assume you're unable to bill separate services using modifier 24.

"The way the visit was scheduled could certainly suggest how the service should be billed," **Suzan Berman (Hauptman), MPM, CPC, CEMC, CEDC**, manager of physician compliance auditing at Allegheny Health Network in Pittsburgh, Penn. "However, it should not necessarily dictate how the visit should be billed. If a patient was scheduled for a post-op visit, but during the visit a new diagnosis is discovered/confirmed, the visit can be billed as an E/M service instead of a post-op visit that wouldn't carry reimbursement with it."

Example: The surgeon removes a lump near the knee and later confirms the outgrowth to be a sarcoma of the bone. When the patient comes back in to the office for review, the surgeon does an extensive E/M service/office visit with the patient to discuss.

"Modifier 24 should only be used when the visit is unrelated to the procedure, when they are seen during the post-operative period," **Becky Boone, CPC, CUC**, senior urology surgical coder for The Coding Network, LLC in Columbia, Mo. CPT® would always allow this but even Medicare states that care directed at the underlying disease process is separately billable in the global period.

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Key: In the above example, the return office visit would have to be performed outside of the global period to be billable, Boone says.

Myth #3: You Can Never Use Modifier 24 for Complication-Related Services

When you report postoperative services to payers that follow CPT® guidelines, you'll need to attach modifier 24 to the E/M code to indicate that the service took place during the surgery's global period.

Example: If a patient has abdominal surgery and returns to your office with a postoperative wound infection along the suture line, you may be able to collect from private payers for an established patient visit and for the physician's treatment of the infection.

If the physician treats the infection in his office, you may be able to file a claim using modifier 24 to those payers following CPT® guidelines.

Pointer: Complications of surgery can be separate and billable in some cases, unless the payer is following Medicare rules, experts say. Medicare does not allow post-operative complications (hematoma, seroma, infection, etc.) to be reimbursed unless there is a need to return to the operating room. At that point, a different modifier comes into play.

CMS and CPT® agree: If the physician must return to the OR to treat a post-op complication, both Medicare and private payers will pay at a reduced rate when you attach the appropriate modifier to the surgical CPT® code describing the surgeon's treatment of the postsurgical complication. If the surgeon returns to the operating room to surgically correct a post-operative complication during the global period of a previous surgery, the correct modifier is 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).

Bottom line: Determining whether complications of the surgery/procedure count as unrelated, and therefore mean you'll use 24, means you must know what the guidelines are for the insurance company being billed. Medicare considers all complications part of global unless the patient is taken back to the OR. Most commercial insurances however will allow complications to be billed during global with the modifier 24.

Myth #4: There Must Be a New Diagnosis If You Use Modifier 24

While a different ICD-9 diagnostic code might indicate that the E/M service performed in a global period was unrelated to the surgery, you do not have to have different diagnoses to attach modifier 24 and to receive payment for those services.

In a modifier 24 fact sheet on its website, WPS Medicare instructs providers to "Use modifier 24 on the E/M if documentation indicates the service was exclusively for treatment of the underlying condition and not for post-operative care." See http://wpsmedicare.com/j5macpartb/resources/modifiers/modifier-24.shtml for more details.

Caveat: It is not mandatory to have a different diagnosis. However, that said, for some insurance companies it is easier to get them to pay for the E/M completed during post op if the diagnosis is different.

"For this reason there can be cases in which the diagnosis for the surgery and the diagnosis for the follow up E/M will be the same," says **Sarah Reed, BSE, CPC**, senior managing consultant at Medical Revenue Solutions, LLC in Kansas City, Mo. "The coder should follow these encounters through the revenue cycle to ensure that they are recognized for payment. Be prepared to send records to support your position."

Pitfall: Do not code the E/M if the documentation is short! This would be considered fraud and certainly not an area where any coder [or biller] should go. The proper use of modifier 24 can legally increase revenue and should be applied if applicable.

Myth #5: You Should Never Use Modifiers 24 and 25 Together

You may find yourself in situations where you need to combine the forces of modifiers 24 and 25 to avoid a denial of a

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claim.

You can use 24 and 25 on the same claim, if you are seeing a patient for a completely new issue within the post-op period, a procedure was done that same day, and the E/M code is significant and separately identifiable from the procedure.

Example: A patient undergoes major surgery. During the postoperative period, the patient comes for an office visit that is absolutely unrelated to the first surgery. At the unrelated E/M visit, the physician also performs a minor surgical procedure (such as a biopsy or cystoscopic examination) unrelated to the initial surgical procedure. In this case, you will attach both modifiers 24 and 25 to the E/M code; modifier 24 to allow payment of the E/M service in the global period of the initial surgery and modifier 25 to allow payment of the E/M service along with another procedure performed on the same day.

Tip: Always use the postoperative modifier 24 first, before you use other modifiers. Most computers sequence their edits, putting the postoperative period edits as the primary edit.

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