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<b>Title</b>	<b>Modifier 24 – Unrelated Evaluation &amp; Management Service by the Same Physician in the Post-Operative Period</b>		
<b>Number</b>	<b>CP.PP.150.v3.1</b>		
<b>Last Approval Date</b>	02/06/26	<b>Original Effective Date</b>	12/01/02
<b>Cross Reference</b>	<ul style="list-style-type: none"> <li>• <i>Global Surgery</i></li> </ul>		

Coverage of any service is determined by a member's eligibility, benefit limits for the service or services rendered and the application of the Plan's Medical Policy. Final payment is subject to the application of claims adjudication edits common to the industry and the Plan's **professional or facility services claims coding policies**. Reimbursement is restricted to the provider's scope of practice as well as the fee schedule applicable to that provider.

<b>Purpose</b>	To define when the Plan recognizes services appended with Modifier 24 that are submitted on a CMS-1500 paper claim form or an 837P electronic claim form.
<b>Scope</b>	Applies to all Premera Blue Cross, Premera Blue Cross Blue Shield of Alaska, LifeWise Health Plan of Washington, LifeWise Assurance Company and Premera Blue Cross HMO lines of business and products.
<b>Policy</b>	<p>The Plan recognizes Modifier 24 - <i>Unrelated Evaluation &amp; Management Service by the Same Physician in the Post-Operative Period</i> when appended to an evaluation and management (E&amp;M) or an eye examination code service to indicate that an <b>unrelated E&amp;M service</b> was provided by the same physician or other qualified healthcare professional (based on provider's Taxonomy/Tax ID number) <b>during the postoperative global surgical period of a major or minor procedure (10- or 90-day postoperative period)</b>.</p> <p>The diagnosis code submitted with the E&amp;M or eye examination service during a postoperative global surgical period of a major or minor procedure should clearly show that the E&amp;M service or eye examination was <b>unrelated</b> to the original surgical procedure.</p> <p>Services submitted with modifier 24 must be sufficiently documented in the members' medical record to establish that the visit was unrelated to the condition that initially required the original surgical procedure.</p> <p>Do not append modifier 24 on an E&amp;M visit or eye exam service related to:</p> <ul style="list-style-type: none"> <li>• A surgical complication or infection which <b>does not require</b> a return trip to the Operating Room</li> <li>• The removal of sutures or other wound treatment which are all considered part of the global surgical package</li> <li>• A service rendered on the same date as the surgical procedure</li> <li>• A routine postoperative exam</li> <li>• A service that is outside of the post-operative global surgical period of a prior major or minor procedure</li> </ul> <p>Review the "Global Surgery" payment policy for additional details.</p>

<b>Violations of Policy</b>	Violations of this policy by any party that enters into a written arrangement with the Plan may result in increased auditing and monitoring, performance guarantee contractual penalties, and/or termination of the contract. Disciplinary actions will be determined by the Plan.
<b>Exceptions</b>	Exceptions to the policy may be made where a provider or employer group contract dictates otherwise.
<b>Laws, Regulations &amp; Standards</b>	
<b>References</b>	<ul style="list-style-type: none"> <li>American Medical Association’s Current Procedural Terminology (AMA/CPT) codebook</li> <li>Centers for Medicare and Medicaid Services (CMS) National Physician Fee Schedule (NPFS)</li> </ul>

<b>Policy Owner Review</b>	Payment Integrity Oversight Committee	
<b>Contact</b>	Any questions regarding the contents of this policy or its application should be directed to the Payment Integrity Department.	
<b>Annual Review Dates</b>	02/06/26; 02/04/25; 03/04/24; 04/06/23; 05/12/22; 05/27/21; 06/15/20; 07/30/19; 10/18/18; 11/06/17; 11/08/16; 11/15/15; 11/23/14; 12/15/13; 01/13/13; 01/26/12; 01/27/11; 02/12/10; 03/24/09; 06/16/08; 05/13/07; 04/11/06; 02/28/06; 08/29/05; 04/12/05; 10/08/04; 03/29/04; 03/29/03; 07/18/00	
<b>Version History</b>	10/18/18	Annual review; no changes
	07/30/19	Annual review; no changes
	06/15/20	Clarified in the Purpose statement that the policy applies to professional services billed on a CMS-1500 or 837P claim form
	05/27/21	Added clarification to second paragraph on how to correctly identify an unrelated E&M visit or eye exam service. Added fourth and fifth paragraphs to the Policy section to identify incorrect use of modifier 24 on E&M and eye exam services related to the surgical procedure or when rendered outside of the postoperative period.
	05/12/22	Additional examples of when not to use modifier 24 added to the fourth paragraph
	04/06/23	Deleted two duplicate sub-bullets of examples where modifier 24 is inappropriate.
	03/04/24	Corrected how the same physician or other qualified healthcare provider is determined based on the provider’s Taxonomy and Tax ID number rather than on provider NPI number.
	02/04/25	Annual review; no changes
	02/06/26	Annual review; no changes