New York | Medicaid

Reimbursement Policy
Modifier 24

Policy Number: **G-06011**
Policy Section: **Coding**
Last Approval Date: **06/11/2025**
Effective Date: **06/11/2025**

Visit our provider website for the most current version of the reimbursement policies. If you are using a printed version of this policy, please verify the information by going to https://anthembluecross.com/ny/provider.

Disclaimer

These reimbursement policies serve as a guide to assist you in accurate claims submissions and to outline the basis for reimbursement if the service is covered by a member's benefit plan. The determination that a service, procedure, or item is covered under a member's benefit plan is not a determination that you will be reimbursed. Services must also meet authorization and medical necessity guidelines appropriate to the procedure and diagnosis, as well as to the member's state of residence.

Ensure that you use proper billing and submission guidelines, including industry-standard, compliant codes on all claim submissions. Services should be billed with Current Procedural Terminology (CPT®) codes, Healthcare Common Procedure Coding System (HCPCS) codes, and/or revenue codes. These codes denote the services and/or procedures performed and, when billed, must be fully supported in the medical record and/or office notes. Unless otherwise noted within the policy, our reimbursement policies apply to both participating and non-participating professional providers and facilities.

If appropriate coding/billing guidelines or current reimbursement policies are not followed, we may:

- Reject or deny the claim.
- Recover and/or recoup claim payment.

To learn more about applying for health insurance, including Medicaid, Child Health Plus, Essential Plan, and Qualified Health Plans through the NY State of Health, The Official Health Plan Marketplace, visit nystateofhealth.ny.gov or call 855-355-5777.
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NYBCBS-CD-RP-089952-25-CPN89114 | October 2025

- Adjust the reimbursement to reflect the appropriate services and/or procedures performed.

These reimbursement policies may be superseded by mandates in provider, state, federal, or Centers for Medicare & Medicaid Services (CMS) contracts and/or requirements. We strive to minimize delays in policy implementation. If there is a delay, we reserve the right to recoup and/or recover claims payment to the effective date, in accordance with the policy. We reserve the right to review and revise these policies when necessary. When there is an update, we will publish the most current policy to the website.

Policy

Anthem allows reimbursement for a physician or other qualified healthcare professional for claims billed with modifier 24 unless provider, state, federal, or CMS contracts and/or requirements indicate otherwise.

Reimbursement is based on 100% of the applicable fee schedule or contracted/negotiated rate for the Evaluation and Management (E/M) service performed during the postoperative period of the original procedure if the following criteria are met:

- The appropriate level of E/M service is billed and appended with modifier 24.
- A diagnosis code unrelated to the original procedure is indicated for the E/M service.
- The reason for the E/M service is clearly documented in the member's medical record.

Failure to use modifier 24 correctly may result in denial of the E/M service, and/or claim payments may be recouped and/or recovered.

Related Coding

Standard correct coding applies.

Policy History

- 06/11/2025 Review approved and effective: removed 'limited' from policy statement
- 10/14/2024 - Review approved and effective: updated Definitions section
- 12/27/2022 - Review approved and effective: title updated to remove Unrelated Evaluation and Management Service by the Same Physician or Other Qualified Healthcare Professional during the Postoperative Period; minor language and format changes; updated related policies section
- 09/14/2020 - Review approved and effective: Definition updated
- 10/26/2018 - Review approved and effective: Other qualified healthcare professional language added

- **09/01/2017 -** Policy template updated
- **11/07/2016 -** Review approved: policy template updated
- **09/22/2014 -** Review approved: policy template updated
- **05/20/2013 -** Review approved: policy template updated
- **04/23/2012 -** Review approved: policy template updated
- **06/06/2011 -** Review approved: policy template updated
- **06/21/2010 -** Review approved: policy template updated
- **11/10/2008 -** Review approved: policy template updated
- **05/04/2006 -** Initial approval and effective

References and Research Materials

This policy has been developed through consideration of the following:

- CMS
- Optum Encoder Pro 2025
- State contract
- State Medicaid

Definitions

- **Modifier 24 -** Unrelated Evaluation and Management Service by the Same Physician or Other Qualified Health Care Professional During a Postoperative Period. Used to indicate that the same physician or other qualified healthcare professional needed to perform an Evaluation and Management (E/M) service during the postoperative period for a reason unrelated to the original procedure. This circumstance may be reported by adding modifier 24 to the appropriate level of E/M service. E/M services performed during the postoperative period of the original service usually are considered part of the global surgical package.
- **General Reimbursement Policy Definitions**

Related Policies and Materials

- Modifier Usage
- Modifiers 25 and 57: Evaluation and Management with Global Procedures

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