The Transplant Global Period

How is the modifier 24 used?

One of the first concepts a new coder has to learn is the basics of global surgical packages. It’s relatively easy to understand that a minor procedure has a 0 or 10 day period for routine follow-up and major procedures and surgeries have 90 days. But there are a few exceptions to this rule, beyond the standard “unrelated” services that would warrant a 24 modifier. CMS Chapter 12 Processing Manual has a specific policy section, “Payment for Immunosuppressive Therapy Management,” that details the need to separate certain services for organ transplant patients. It states that any office visit or subsequent hospital visit performed for immunosuppressive therapy management within the 90 day global after an organ transplant can be billed with a 24 modifier. It stipulates that documentation may be provided that shows the visit was for immunotherapy management.

So how exactly does one document appropriately for this situation? Medicare provides no further details on what specific information is needed. Best bet is to document as thoroughly as possible, but at a minimum that record should state “immunosuppressive management” in the plan and give details on any changes in the current medications related to the patient’s organ transplant.

Simply listing the patient’s current immunosuppressive drug, such as Tacrolimus, is not enough to substantiate billing a service with a 24 modifier during the 90 day global following an organ transplant. The record must clearly indicate that there was management done, either remarking on continuation of the current medication as previously given or to increase or decrease dosage. The service must also complete all requirement for the level of the evaluation and management that is being billed.

Although Section 30.6.3 Payment for Immunosuppressive Therapy Management states that the 24 modifier can be used on certain E/Ms in the global period for these therapy services, not all carriers may follow Medicare’s guidelines. Please consult with each individual payer policy regarding transplant management and review the documentation for completion before attempting to seek reimbursement for these visits.

The primary ICD-9 code billed with this service is V07.2 Need for prophylactic immunotherapy, and the status code for the organ transplant should be used secondary. Though the patient may be in for various complications and/or co-morbid conditions, it’s best to use the V07.2 to drive the medical necessity for payment of the E/M service.