Codify
BY AAPC

Dermatology Coding Alert

Modifiers: The 3 Questions You Need to Answer for Modifier 24, 25, and 27 Mastery

Warning: Pick the wrong modifier and leave $100 on the table.

Does your dermatologist ever provide E/M services on the same day as (or during the global period of) a procedure? Of course he does. Do you know how to choose the right modifier when billing the E/M? If not, you're at risk of losing payment for his service.

Answers to these three key questions will rescue you from making a blunder and help you recoup the max out of modifiers 24, 25, and 57 reporting.

Question 1: Does the E/M Follow Another Service?

Answer: No.

Example: A doctor saw a patient for an E/M service in the office and decided to perform a [related, major] surgery that evening or the next day. What is the best modifier that you can attach to the E/M service?

In this situation, the E/M service happens prior to the surgery. Therefore, you would not choose modifier 24 (Unrelated evaluation and management service by the same physician or other qualified health care professional during a postoperative period).

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

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

Question 2: Was It a "Major" or "Minor" Procedure?

Answer: Major.

Because the surgery was a major service, then you should strike off modifier 25 (Significant, separately identifiable E/M service by the same physician or other qualified health care professional on the same day of the procedure or other service) as an option.

Rationale: If the surgeon provides a significant, separately identifiable E/M service on the same date as a minor procedure, including those with zero-day, 10-day, or "XXX" global periods, you should append modifier 25 to the E/M code.

Question 3: Was E/M Related to the Major Surgery?

Answer: Yes.

In the scenario, the surgery is "major" and "related" to the E/M service the physician performs the day of or the day prior to the surgery. Therefore, you should append modifier 57 (Decision for surgery) to your E/M service (such as 99214, Office or other outpatient visit...) to indicate that this E/M service led to the decision for surgery.

Caution: Failure to append modifier 57 to the E/M code will result in the payer bundling the E/M service into the global surgical package, leading to a loss in reimbursement. Without the modifier, the visit will appear to be the preoperative visit that the global surgical package includes.

For instance, suppose your dermatologist removes a lesion with Mohs surgery and repairs the site with a skin graft, which has a 90-day global period. If you failed to apply modifier 57 to the E/M code (such as 99214), you would only receive payment for the surgical procedures, not 99214, costing you more than $100.

When you correct your claim by appending modifier 57, however, you should be paid for the visit. Medicare's 2015 Physician Fee Schedule, which can be used as a benchmark for private payers' rates, assigns 3.03 relative value units (RVUs) to 99214 and pays the code nationally at $108.88.

Tip: Relax; if you haven't been using the correct E/M appendage, all is not lost. Many Medicare carriers have a dedicated review line that you can call to add the missing modifier, and payment is usually processed between 10 and 14 days.

Caution: Global periods or their absence thereof has a large bearing on the usage of all the modifiers discussed here. However, in the final 2015 Medicare Physician Fee Schedule rule, CMS announced its intention to eliminate all 10- and 90-day global payment periods for surgical services.

The change will be implemented beginning January 1, 2017, when 10-day global payments will be eliminated. The 90-day payments may then be phased out on January 1, 2018, although CMS has withheld the plan due to pressure.

For more information, visit www.bit.ly/Federal-Register-2015-Rule.