Dermatology Coding Alert

Reader Questions: Review Insurer's Modifier 57 Policies

Question: A patient presented with a non-healing spot on his hand. The dermatologist diagnosed a common wart and used cryosurgery to remove the lesion. Aetna denied the claim I submitted with codes 17000, 99212-57. Did I use modifier 57 correctly?

New Jersey Subscriber

Answer: Although you correctly appended the modifier to the E/M code, coding experts usually recommend reserving modifier 57 (Decision for surgery) for E/M services occurring prior to the decision for a major procedure indicated by a 90-day global period.

Medicare's Physician Fee Schedule Database denotes 17000 (Destruction, all benign or premalignant lesions other than skin tags or cutaneous vascular proliferative lesions; first lesion) as a minor procedure, meaning one that contains 10 global days. Therefore, you should attach modifier 25 (Significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service), not modifier 57, to the office visit code. This coding advice is consistent with Medicare guidelines that private payers may adopt.

The dermatologist's documentation should support the E/M service as significant and separately identifiable from the same-day wart destruction. Link both 99212-25 and 17000 to ICD-9 code 078.10 (Other diseases due to viruses and Chlamydiae; viral warts, unspecified).

Tip: Use modifier 57 when a dermatologist performs an E/M service that results in the decision to perform a same-day 90-day global period procedure. For example, if the dermatologist evaluates a patient for a potential skin graft (15260, Full-thickness graft, free, including direct closure of donor site, nose, ears, eyelids and/or lips; 20 sq cm or less) on Monday, and then plans the skin graft for the same day or the following day, you should append modifier 57 to the E/M code.