Codify
BY AAPC

Internal Medicine Coding Alert

Reader Questions: Review Insurer's Modifier Policies

Question: A mother brings her son in for a non-healing spot on his hand. The physician diagnoses a common wart and uses 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 that occur prior to the decision for a major procedure--a code indicated by a 90-day global period.

Medicare's Physician Fee Schedule Database denotes 17000 (Destruction [e.g., laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement], all benign or premalignant lesions [e.g., actinic keratoses] 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 internist'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 physician performs an E/M service that results in the decision to perform a same-day procedure with a 90-day global period. For instance, a patient presents with acute shoulder pain. The physician performs a history, examination and medical decision-making, diagnoses the patient with a fractured clavicle, and decides to treat the closed fracture.

In this case, because the E/M service involves a decision for a procedure that contains 90 global days, you should assign 9921x-57 and 23500 (Closed treatment of clavicular fracture; without manipulation) with 810.0x (Fracture of clavicle; closed).

But Aetna would deny the service appended with modifier 57 even for the correctly coded claim in the example above. **Good news:** As of February 2006, Aetna has changed its policy and allowed payment for E/M services that involve a decision for major surgery. Act fast and appeal any timely submitted claims that were denied for this within the previous 180 days.

The same terms apply to claims for modifier 25- appended 99201-99215 services (Office or other outpatient visit ...) with 99381-99397 (Preventive medicine services). Aetna also reversed its policy that disallowed separate payment for a problem-focused E/M using modifier 25 on the same day as a preventive medicine service.