# Part B Insider (Multispecialty) Coding Alert

## Modifier 25 Isn't Always the Answer for Same-Day E/M Visit

Keep E/M documentation apart to demonstrate the service's 'separate' status

To report an E/M service that prompts a follow-up procedure, you must append either modifier 25 or modifier 57 to the appropriate E/M service code. Which modifier you select, however, depends not only on the nature of the E/M service but also on the length of the global period associated with the follow-up procedure. Here are the facts you'll need to make the choice easy.

Extra motivation: The Office of Inspector General (OIG) has targeted "services within the global period" -- including E/M services with modifiers 25 or 57 -- for special investigation as part of its 2008 Work Plan.

Call on 57 for 'Major' Follow-up Procedures

You should append modifier 57 (Decision for surgery) to an E/M service that occurs on the same day, or on the day before, a major surgical procedure, and which results in the physician's decision to perform the surgery, instructs **Raemarie Jimenez, CPC,** director of exam content for the **AAPC.**

CMS guidelines identify a major surgical procedure as any procedure with a 90-day global period. Note that the global period for a major surgical procedure begins one day prior to the procedure itself.

**Direct from the source:** Medi-care's Internet Only Manual, section 40.2, tells carriers, "Pay for an E/M service on the day of or on the day before a procedure with a 90-day global surgical period if the physician uses CPT modifier 57 to indicate that the service was for the decision to perform the procedure."

**Example 1:** A surgeon receives a request to evaluate a patient for acute right-upper quadrant pain and tenderness. Following a full evaluation, the surgeon decides to remove the gallbladder and schedules an immediate cholecystectomy (47562, Laparoscopy, surgical; cholecystectomy).

In this case, the surgeon may claim both the surgical procedure (47562) and the examination that led to the decision to perform the surgery (for example, 99243, Office consultation for a new or established patient ...). Because the cholecystectomy is a major procedure, you should append modifier 57 to 99243. The available documentation should specifically note that the E/M service resulted in the decision for surgery.

Use modifier 57 if the claim meets all of the following criteria:

1. The E/M occurs on the same day of or the day before the surg-ical procedure.

2. The E/M service directly prompted the surgeon's decision to perform surgery.

3. The surgical procedure following the E/M has a 90-day global period

4. The same surgeon (or another surgeon with the same tax ID) provided the E/M service and the surgical procedure.

**Example 2:** The surgeon schedules cholecystectomy (47562) for a patient with a diseased gall bladder. On the day prior to surgery, the surgeon meets with the patient for a final evaluation, to answer any questions the patient has and to provide additional instructions for recovery.

In this case, you cannot charge separately for the E/M service. Because the surgeon already decided to perform surgery at a previous encounter -- and because the E/M service occurs within the surgery's global period -- you should bundle this

final presurgery E/M service into the cholecystectomy.

**Don't look for a loophole:** Scheduling pre-op services two or more days before surgery will not necessarily make the services payable, Jimenez warns. Insurers may consider such services to be screening exams unless there is some specific indication, such as hypertension or diabetes. The documentation for these visits must substantiate medical necessity and not just a routine/requirement of the physician or the hospital.

Call on 25 for 'Minor' Procedure

For a separate and significantly identifiable E/M service that occurs on the same day as a minor procedure (any procedure with a zero- or 10-day global period), you should append modifier 25 (Significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service) to the appropriate E/M service code, Jimenez confirms.

**Don't mix your modifiers:** The IOM specifically instructs carriers not to pay for an E/M service "billed with the CPT modifier 57 if it was provided on or the day before a procedure with a zero- or 10-day global surgical period."

**Remember:** All procedures, from simple injections and common diagnostic tests to the most complicated surgeries, include an "inherent" E/M component, according to CMS guidelines. When trying to decide if an E/M service is separate and significantly identifiable, ask yourself, "Can I pick out from the documentation a clear history, exam and medical decision-making apart from any other procedures the physician performs on the same day?" If so, you've probably got a billable service with modifier 25, offers **Joyce Matola,** a billing manager in Cherry Hill, N.J.

Use modifier 25 if the claim meets all of the following criteria:

1. The E/M occurs on the same day as the surgical procedure.

2. The procedure following the E/M does not have a 90-day global period.

3. The E/M service is both significant and separately identifiable from any inherent E/M component included in the procedure.

4. The same physician (or one with the same tax ID number) provided the E/M service and the subsequent procedure.