# Part B Insider (Multispecialty) Coding Alert

## Modifiers: Bill Separately for Decision to Operate

**Understand the difference between modifiers -57 and -25**

Before she picks up a scalpel, the surgeon needs to decide to operate on the patient. And this decision deserves its own reimbursement, even if it happens during the day before a surgery preceded by a one-day global period.

But what confuses many coders is which modifier to use for that service:  modifier -25 (Significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service) or modifier -57 (Decision for surgery)? It depends on the circumstances, coding experts say.

When **Stacey Elliott** started coding years ago, she used modifier -57 for a number of E/M claims that led up to surgery, only to be told by the carriers that she should be using -25 instead. "It's really a gray area," says Elliott, now a coding consultant with JR Associates in Grants Pass, Ore.

You can use modifier -25 for the decision to initiate minor procedures that have a global period of 10 days or fewer, says **Quin Buechner** with ProActive Consultants in Cumber-land, Wis. But you should always use modifier -57 for major procedures. Non-Medicare payers in particular will expect to see modifier -25 for minor and modifier -57 for major procedures.

But consultant **Robyn Lee** in Lee-Brooks Consulting in Chicago disagrees, saying that you should only use -25 for services with no global period at all.

"The -25 is not only for surgery. It has a broader application," Buechner says. You can use -25 if you perform a preventive exam on a patient and discover problems that then require surgery.

If the patient has a separate diagnosis that requires E/M services before surgery, you should definitely use modifier -25, Lee says.

Just because the physician has seen the patient previously and discussed surgery as an option doesn't mean that the decision to operate doesn't require a lot of work, Buechner says. When the patient shows up with aggravated symptoms, such as rectal bleeding that indicates a polyp is getting worse, the physician still has to make the final decision for surgery, he adds.

The surgeon must go through the diagnostic decision tree and discuss the implications of surgery with the patient, who may still decide not to go through with it, Buechner says.

But Elliott says you shouldn't bill for an E/M service before surgery unless it's a separately identifiable service involving a different diagnosis. For example, if a patient comes in for unrelated problems and the doctor notices a lot of cerumen during the exam, the E/M visit can be billed separately from the cerumen removal. But if the only reason the patient comes in is to bring up a problem that requires a surgery that the physician performs, Elliott would bill for the surgery alone.