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# Part B Insider (Multispecialty) Coding Alert

## Modifiers: Modifier 57 Still Applies to Some Part B Claims, Despite Consult Pay Elimination

**Don't ignore modifier 57 just because CMS stopped reimbursing for consults.**

Medicare may have stopped paying for consult codes in 2010, but that doesn't mean modifier 57 no longer serves a purpose. Follow these quick tips to find out how this modifier can still serve your practice's needs.

Background: Starting January 1, 2010, CMS eliminated consult codes (99241-99245, 99251-99255) from the Medicare Physician Fee Schedule. Although these codes are still listed in CPT®, Part B MACs will no longer pay you if you report them.

**Non-Consult E/M Codes Keep Modifier 57 Alive**

Modifier 57 (Decision for surgery) was often considered the go-to code for procedures performed on the same date as consults. So when CMS stopped paying for consults, you might have wondered if modifier 57 would remain useful. The answer? You can still use this modifier with a non-consult E/M code that leads to the decision to perform surgery, so long as your documentation supports it.

Remember: Any major procedure includes E/M services performed the day before and the day of the procedure in the global period, says **Barbara J. Cobuzzi, MBA, CPC, CENTC, CPC-H, CPC-P, CPC-I, CHCC,** president of CRN Healthcare Solutions, a consulting firm in Tinton Falls, N.J. "The only way you can be paid properly for an E/M performed the day before the major surgery or the day of the surgery is to indicate that it was a decision for surgery (modifier 57), which also indicates to the payer that the major procedure was not a pre-scheduled service," she explains.

Past: Say the physician carries out a level three inpatient consult in which she figures out the patient requires complex drainage for his parotid abscess the day after the consult. The physician decides to drain the abscess the next day. Appending modifier 57 to the E/M code (99253, Inpatient consultation for a new or established patient, which requires these 3 key components: A detailed history; A detailed examination; and Medical decision making of low complexity.) would show payers why you're billing the consult in addition to the major surgery performed the next day (42305, Drainage of abscess; parotid, complicated).

Present: Using the same scenario for a Medicare patient, the physician would not code a consult but instead would bill an initial hospital visit for the service performed when they initially evaluate the parotid abscess. Based on meeting the requirements for a 99253, the service would convert to a 99221 (Initial hospital care, per day, for the evaluation and management of a patient, which requires these 3 key components: A detailed or comprehensive history; A detailed or comprehensive examination; and Medical decision making that is straightforward or of low complexity.) for a Medicare patient where a consult is not an acceptable code. You would add modifier 57 to 99221 on the day the physician decided to perform 42305. In this case, you shouldn't bill any E/M services on the second day since the decision for surgery was made the day before.

More than one physician can use an initial hospital care code for the same patient. If two physicians from different specialties are both consulting on a patient, both physicians will use the initial code, but the physician of record will use the initial code with modifier AI (Principal physician of record). Suppose your doctor is the principal physician -- the one serving the patient's care and admitting the patient -- don't forget to append modifier AI, in addition to modifier 57.

Consequence: If you don't use modifier 57, the payer will bundle the E/M into the procedure code (42305 in our example), and you'll lose the hospital E/M reimbursement.

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**Differentiate Between Modifiers 25, 57**

You should only report modifier 57 if the physician decides to treat a condition surgically on the day of, or the day before a procedure with a 90-day global period. Take note, too, that the E/M service should result in the initial decision to perform the surgery. You may make the decision to perform surgery for a patient with an emergent condition that requires immediate surgery.

Don't bill an E/M code with modifier 57 if the physician provided the service on the day before, or the day of the procedure with a 0 or 10-day global period. Say the surgeon performs a simple drainage (42300, ... parotid, simple) instead of 42305. In this case, you should use modifier 25 (Significant, separately identifiable E/M service by the same physician on the same day of the procedure or other service) with the E/M.

Do this: Using modifier 25 would call for documentation supporting that the E/M service was above and beyond the reason for the visit.

What about pre-op visits? Modifier 57 would only be used if the E/M is a result of a decision to perform a surgery that is unrelated to the post op global. Any other E/M that your physician performs in the global is inclusive to the post op global. Therefore, modifier 57 is not appropriate in this case. Pre-op visit means the physician has already made the decision for surgery, and you may not use modifier 57 to be paid for a pre-op visit. CPT® includes this service in the global package, so never bill it with modifier 57.

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