

Part B Insider (Multispecialty) Coding Alert

Modifiers: Refresh Your Modifier 57 Knowledge to Keep Reimbursement Flowing

Hint: Avoid using 57 for minor procedures.

In these tough economic times, every dollar counts--and if you're not applying modifier 57 (Decision for surgery) when your physician performs an E/M visit prior to the decision for surgery, you could be leaving ethical reimbursement on the table.

Reserve 57 for Major Surgeries

You should only report modifier 57 when the doctor decides to treat a condition surgically on the day before or the day of a 90-day global period procedure per Medicare guidelines. The documentation must support that the decision for surgery was made on that date and it was not a scheduled surgery.

Example: A physician admits a patient with parotitis to the hospital for IV antibiotics. Three days later, the patient develops a parotid abscess that requires complex drainage. At that inpatient visit, the physician makes the decision to drain the abscess.

You should append modifier 57 to the hospital care code (99231-99233, Subsequent hospital care, per day, for the evaluation and management of a patient ...).

Modifier 57 tells the insurer that during this E/M the physician decided the patient required surgery. If you don't use modifier 57, the insurer will bundle the E/M into the procedure code (42305, Drainage of abscess; parotid, complicated). You'll lose the hospital E/M reimbursement.

Be careful: In the parotid example, modifier 57 appropriately describes the scenario because 42305 is a major surgery -- one that has a 90-day global period. If the physician instead performs a simple drainage (42300, ... parotid, simple), 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).

Check Payer Policies

Like many modifier rules, modifier 57 guidelines depend on the insurer. Some payers may direct you to use modifier 25 instead of 57. Insurers usually make this policy because their claims software programs cannot check for an E/M prior to the surgery date. If a payer has different policies, try to get them writing.

Tactic: If the payer does not have them in writing, you can request the email address of the person who gave you the information and then send a confirming email with the content of your call. That way, you have it on the record what you have been told to do in terms of coding, particularly when it goes against AMA coding rules. In this email, you can indicate you understand the instructions from the payer. At the end of the email, ask the person to get back to you if anything has been misunderstood, so that you can correct what you thought you were told in your call.

Rule: If a payer directs you to use modifier 25 for procedures with a 90-day global period, you must follow the insurer's guidelines. If your payer accepts both modifier 25 and/or modifier 57, follow these guidelines to differentiate the two:

Do this for 25: Your modifier 25 claims should meet all of the following criteria:

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

- The procedure following the E/M is minor (has a zero- or 10-day global period)
- The E/M service is both significant and separately identifiable from any inherent E/M component that the procedure involves
- The same physician (or one with the same tax ID, same specialty) provides the E/M service and the subsequent procedure.

Note that the diagnosis associated with the E/M service can be the same as the diagnosis associated with the same day procedure, which means that the E/M prompted the follow-up procedure. Or, the diagnosis associated with the E/M service can be different than the diagnosis associated with the same-day procedure, meaning that the E/M was for a significant problem unrelated to the procedure.

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

The E/M occurs on the same day of or the day before the surgical procedure. Note: Technically, this is an informative modifier and should be used whenever the decision is made. As a rule of thumb, to be safe many experts instruct providers to use 57 if surgery is planned in the next 7 days.

- The E/M service directly prompted the surgeon's decision to perform surgery
- The surgical procedure following the E/M has a 90- day global period
- The same surgeon (or another surgeon of the same specialty with the same tax ID) provided the E/M service and the surgical procedure.

Because modifier 57 claims involve an E/M service that results in a decision for surgery, you would expect to see the same diagnosis code for both the E/M and the surgical procedure. The surgeon would not make a decision for surgery based on a significant problem unrelated to the procedure.