Part B Insider (Multispecialty) Coding Alert

Part B Mythbuster: Same-Day E/M Visit? Modifier 25 May Not Always Be Your Best Bet

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

When you report an E/M service that prompts a follow-up procedure, you may be accustomed to always reaching for modifier 25. That, however, may be incorrect coding.

In reality, to report an E/M service that prompts a follow-up procedure, you'll typically choose from either modifier 25 or modifier 57. 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.

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.

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: Medicare's Claims Processing Manual, section 40.2, tells carriers, "If evaluation and management services occur on the day of surgery, the physician bills using modifier 57, not 25. The 57 modifier is not used with minor surgeries because the global period for minor surgeries does not include the day prior to the surgery. Moreover, where the decision to perform the minor procedure is typically done immediately before the service, it is considered a routine preoperative service and a visit or consultation is not billed in addition to 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, 99213, Office or other outpatient visit for the evaluation and management of an established patient...). Because the cholecystectomy is a major procedure, you should append modifier 57 to 99213. 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 surgical 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 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. 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 be 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 identifiables 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.

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.

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 provided the E/M service and the subsequent procedure.