Part B Insider (Multispecialty) Coding Alert

Part B Mythbuster: Using Modifier 57? Then Ditch Modifier 25 on That Claim

Medicare carriers don't require you to append both modifiers.

Tips passed around from coder to coder at classes and conventions can be incredibly helpful when filling out your billing forms—but they can also hurt you if you take the wrong advice. Such has been the case for several practices who contacted the Insider recently noting that they were told to stop using modifier 57 because "payers don't like it" and to use modifier 25 instead when filing decision for surgery claims. Although this may be true of some specific payers, it isn't a blanket truth, and you shouldn't heed this advice unless you have advice from your payer instructing you to follow it.

Myth: Payers hate modifier 57 (Decision for surgery), so it's okay to use modifier 25 (Significant, separately identifiable evaluation and management service by the same physician or other qualified healthcare professional on the same day of the procedure or other service) instead when you want to collect for both an E/M service and a procedure on the same date of service.

Reality: You should append modifier 57 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.

Scenario: Suppose your physician performs an E/M service followed by three major procedures. You erroneously append modifiers 25 and 57 to the E/M code.

Correct coding: Medicare payers should accept the claim with modifier 57 appended to the E/M code if the documentation supports it. You shouldn't have to append both modifiers.

Direct from the source: CMS says in its Global Surgery Fact Sheet, "E/M services on the day before major surgery or on the day of major surgery that result in the initial decision to perform the surgery are not included in the global surgery payment for the major surgery and therefore may be billed and paid separately. In addition to the E/M code, modifier 57 is used to identify a visit that results in the initial decision to perform surgery."

Since the physician is billing just one E/M service, only one modifier — 25 or 57 — is necessary. You'll use modifier 25 if the procedure being done is a minor procedure, meaning it has zero to 10 global days. When you use this modifier, you're telling the payer that the E/M performed entails more than the small E/M included in the minor procedure.

Modifier 57, however, tells the payer that the physician made the decision to perform a major surgery (with a global procedure of 90 days) at that particular E/M service.

Because procedures with 90-day global periods include E/M services performed the day of the procedure and the day before the procedure, you must append a modifier if the physician performs an E/M service and decides to do a procedure that he had not already scheduled and planned.

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 to the appropriate E/M service code.

Don't mix your modifiers: The Global Surgery Fact Sheet specifically instructs carriers not to pay for an E/M service

"billed with the modifier 57 if it was provided on the day of or the day before a procedure with a 0 or 10 day global surgery period."

Important: Be certain that the E/M service was significant, separately identifiable, and medically necessary before you append either modifier to it.