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Part B Insider (Multispecialty) Coding Alert

Recovery Audit Contractors: RACs Zero in on Modifier 57 Usage

Study CPT® guidance for a better understanding of this tricky modifier.

Not only do modifiers help Part B practices explain services and special circumstances to CMS, but they help providers get the reimbursement they deserve. However, choosing the correct modifier can be a daunting and confusing task, and that may be why modifier 57 (Decision for surgery) was recently added to the Recovery Audit Contractors' (RACs) junkets.

Background: RACs review Medicare claims for errors and collect a contingency fee based on the amount they recover. Much like MACs, there are different RAC contractors for the various regions in the country, and each one publishes the open issues that it is in the process of auditing.

Now: On Nov. 1, Cotiviti approved a new audit issue involving modifier 57, and on Nov. 2, another RAC - Performant Recovery - followed suit.

"Carriers may not pay for an evaluation and management [E/M] service billed with the CPT® modifier '-57' if it was provided on the day of or the day before a procedure with a 0 or 10-day global surgical period," Performant says in its "Approved Issues" list. "E/M codes included in the global package billed with modifier 57 will be recovered as overpayments as they are not allowed for surgical procedures with a 0 or 10 global surgical period."

Understand the Issue with 57

Modifier 57 is one of those CPT® options that at first glance appears easy to code. If a patient sees a Medicare provider for an E/M visit that results in a decision for a same day (or the day prior to) surgery, then you should use modifier 57, right? The answer is not always that straightforward.

You must take many variables into account before you appropriately append modifier 57 to an E/M visit. And, that's why this modifier now sits atop the RACs' to-do lists.

Example: If you schedule a 0- or 10-day global period, such as certain lesion excisions, you can't report an E/M with modifier 57 to get paid for both the E/M and the procedure. You'd use modifier 25 (Significant, separately identifiable evaluation and management service by the same physician or other qualified health care professional on the same day of the procedure or other service) instead - assuming the documentation warrants both.

But, if you do a major surgery like a fracture reduction with a 90-day global, you can also bill an E/M service with modifier 57 to get paid for both.

Tip: You should consider only using modifier 57 with an E/M on the day before or the day of a major surgical procedure, never a minor surgical procedure, according to **Catherine Brink, BS, CMM, CPC,** president of Healthcare Resource Management in Spring Lake, New Jersey.

Follow This Expert Advice to Avoid RAC Interest

A great way to home in on modifier 57 claims issues is to review background on proper use of the code. Remember, according to the CPT® manual, you should use modifier 57 when an E/M service results in the physician's initial decision to perform the surgery.

Using modifier 57 lets the provider receive credit for the additional work required to make the decision to do major surgery on the day of or day before that surgery, explains **Melanie Witt, RN, MA,** an independent coding expert based

in Guadalupita, New Mexico.

Warning: You should never report modifier 57 for an E/M service the day of or day before a preplanned or scheduled major (90-day) surgical procedure. "If the decision to do surgery is made before this time period, no modifier 57 is reported for the E/M service as all major procedures include preoperative clearance the day of or the day before surgery," Witt advises.

Brink emphasizes the importance of understanding modifier 57's definition. "You add modifier 57 to the appropriate level of E/M service provided on the day before or day of surgery, in which the initial decision is made to perform major surgery," she explains.

Best bet: Remember to append modifier 57 to the E/M service code to indicate that the E/M service led to the decision to perform a surgery with a 90-day global period on the same day. Always append modifier 57 to the E/M service code, not the surgical procedure code.

Tip: An audit letter may be an unwelcome sight, but it should never be a cause for extreme stress. The letter should spell out exactly 1) which records the payer needs, and 2) the deadline by which you should have those records ready for audit.

It's your responsibility to read all audit letters thoroughly and to respond as soon as possible. This is especially vital because the auditor is looking for reimbursement of over-coded or over-billed money. If you don't respond by the deadline, you're going to be considered to agree with their charge, and the contractor will be notified to recover the money, recommends **Barbara J. Cobuzzi, MBA, CPC, COC, CPC-P, CPC-I, CENTC, CPCO,** AAPC Fellow, of CRN Healthcare in Tinton Falls, New Jersey.