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Outpatient Facility Coding Alert

E/M Coding: Consider These Factors When Billing Modifier 57 With Minor Surgical Procedures

Don't let the plethora of conflicting guidelines overwhelm you.

Most coders working in physician offices or clinics don't think twice about reporting modifier 57 (Decision for surgery) when the situation calls for it. That's because it's one of those modifiers that's seemingly clear on the surface. If a patient sees a provider for an evaluation and management (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?

Problem: Unfortunately, when you are billing for the surgeon's services in outpatient facility or ASC settings, it's not that simple. There are numerous variables you must take into consideration before appropriately adding modifier 57 to an E/M visit on the day of or the day before a minor surgical procedure.

Take a look at this example for a complete breakdown of when (and when not) to consider the use of modifier 57 on minor surgical procedures.

Consider Day of, Day Before E/M Guidelines for Minor Procedures

Scenario: The patient visits a provider for an evaluation and management (E/M) consultation to discuss a biopsy of a suspicious soft tissue growth on the patient's back. The provider has a cancellation and subsequently is able to perform the procedure the following day. Can the provider bill for the E/M service in addition to the procedure?

The answer is a little more complicated than what's presented on the surface. Ultimately, the global period for the surgery will determine whether the E/M visit the day before the procedure is billable. The global period for soft tissue biopsy code 21920 (Biopsy, soft tissue of back or flank; superficial) is 10 days.

Disclaimer: "Keep in mind that modifier 57 and global periods are not applicable in facility outpatient or ASC settings," says **Sarah L. Goodman, MBA, CHCAF, COC, CCP, FCS**, president and CEO of SLG, Inc. Consulting in Raleigh, North Carolina. The following guidelines and scenarios are only applicable when billing for the pro-fee side of outpatient services.

Aggregate CMS Guidelines Into 1 Place

Now, take a look at the guidelines CMS presents in their Global Surgery Booklet. CMS classifies a 10-day global surgery package using the following specifications:

- "No preoperative period,
- "Visit on day of the procedure is generally not payable as a separate service,
- "Total global period is 11 days. Count the day of the surgery and the 10 days immediately following the day of the surgery."

Now consider the following specifications to classify 90-day global period procedures:

- "One day preoperative included,
- "Day of the procedure is generally not payable as a separate service,
- "Total global period is 92 days. Count 1 day before the day of the surgery, the day of surgery, and the 90 days immediately following the day of surgery."

Finally, take note of what services Medicare includes in the global surgery payment:

- "Preoperative visits after the decision is made to operate. For major procedures, this includes preoperative visits the day before the day of surgery. For minor procedures, this includes preoperative visits the day of surgery."

Remember: CMS classifies "major" surgeries with a 90-day global period designation and "minor" surgeries with a 10-day global period designation.

Maneuver Through Contradictory Information

On the surface, it seems you now have enough information at your disposal to determine whether the E/M visit the day prior to the biopsy procedure is billable. Since it's a 10-day global period, the day prior to the procedure is not included in the global surgical package, so you may technically bill out for the E/M visit, right?

Not so fast. There's an important caveat here - and it begins with the application of modifier 57. CMS instructs coders to use modifier 57 when the decision for surgery is made on the day of or the day prior to surgery. "But, keep in mind that modifier 57 was created to override the major surgery global period, which includes the day of and the day before the surgery," warns **Barbara J. Cobuzzi, MBA, CPC, COC, CPC-P, CPC-I, CENTC, CPCO, AAPC Fellow**, of CRN Healthcare in Tinton Falls, New Jersey.

And, while the Global Surgery Booklet guidelines above seem to demonstrate that you may bill for E/M visits the day prior to a minor surgical procedure, CMS offers these additional guidelines, which complicate the matter further:

- "The modifier '57' is not used with minor surgeries because the global period for minor surgeries does not include the day prior to the surgery. When 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. MACs may not pay for an 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 000- or 010-day global surgical period."

Despite the fact that the modifier 57 guidelines do not discriminate between minor and major procedures, CMS incorporates additional rules in the Global Surgery Booklet explaining that modifier 57 should, in fact, not be used with procedures with global periods of 10 days or fewer. However, if that's not complicated enough, CMS goes on to state that Medicare administrative contractors (MACs) "may not" reimburse for an E/M service billed with modifier 57 on the day of, or the day before, a minor surgical procedure.

Break Down Each Respective Policy

First, CMS tells you to use modifier 57 on the day before or the day of a surgery. However, CMS also does not include related E/M services the day prior to a minor surgery as a part of the global surgery package. Next, CMS policy states that modifier 57 is not to be used with any minor surgeries. Finally, CMS states that MACs "may not" pay for a related E/M service the day of or the day before a minor surgical procedure.

As you can see, semantics plays an important role here. It's not necessarily clear if CMS is stating that MACs cannot pay for these services - or if it's up to their own discretion. If you believe the latter is true, then the possibility of reimbursement can be left somewhat open-ended. However, you should contact your MAC to receive further clarity on these guidelines.

Bottom line: Ultimately, you must decide which guidelines take precedence over one another. Since CMS guidelines specifically state that modifier 57 should not be reported alongside minor procedures, you should abide by this rule first and foremost. However, this doesn't mean that you should write off the E/M service. Since CMS specifically excludes E/M services (the day before) resulting in the decision for minor surgeries from the global surgery payment, there's nothing restricting you from submitting the claim without a modifier 57. "Do not, however, report with 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, since the E/M is undoubtedly related to the

minor procedure," warns Goodman.

While most commercial payers follow CMS guidelines, this isn't always the case. You should contact your payers to determine where they stand on specific circumstances such as this. If the guidelines differ between payers, make sure to incorporate each payer-specific guideline into your own practice guidelines for future instances.