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Modifier Coding Alert

E/M Modifiers: Let Payer Policy Guide Your Pre-Fracture Care E/M Decision

Both 25, 57 are in play with E/M-fracture code combo.

When your physician provides intraoperative fracture care for a patient, he will very likely perform a separate E/M prior to the fracture care.

How you'll report this separate E/M depends entirely on the payer, however. Check out what the pros had to say about how to separately code an E/M service and fracture care on your claims.

Observe Payer Specificities On Fracture Care E/Ms

For most E/M services that result in fracture care with a 90-day global period, you should use modifier 57 (Decision for surgery) on the E/M code, says **Dawn Rogers**, orthopedic coding specialist at Caduceus Inc. in Jersey City, N.J. Coders employ modifier 57 commonly for the patient's initial visit, but it can be used "at any time during a patient's care, if that decision for major surgery is made the day of or day before the procedure," she explains.

Benefit: Most insurers accept modifier 57 for these encounters because it tells them that a full review was necessary to assess the decision for surgery. Without the 57 modifier, the patient's visit would be normal preoperative care, and payers would bundle it into the procedure code, Rogers explains.

Example: In California, non-health maintenance organization (HMO) Medi-Cal now requires a 57 modifier for any 90-day global service, "which is new since they implemented use of the [Correct Coding Initiative] CCI edits about a year and a half ago," explains **Sharon Richardson, RN**, compliance officer for E /M services at Emergency Groups' Office in San Dimas, Calif. So when it comes to which modifier to use on pre-E/M fracture care claims "it really is hit and miss and can change," she says.

Payers Muddy Modifier Waters With 25 Decision

While you'll be using modifier 57 on most pre-fracture care E/Ms, there's not a cut-and-dried answer to the modifier question when you're talking about fracture care coding and separate E/Ms. The modifier you use now depends on the payer, says Richardson.

"Medicare used to always require a 57 modifier when the decision to 'do surgery' was made at the time the patient was initially seen and the procedure had a 90-day global period attached to it," she explains. But this is not necessarily true anymore.

Some Medicare administrative contractors (MACs) still require modifier 57 in these situations, but others want 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), Richardson says.

For example, **Catherine Brink BS, CMM, CPC, CMSCS, CPOM**, president of Healthcare Resource Management Inc. in Spring Lake, N.J. says the 25 or 57 decision would depend on the number of days in the surgical package for her payers

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modifier 25 for E/Ms prior to a fracture care treatment with a 10-day global, and modifier 57 for an E/M before surgery with a 90-day global.

Do this: Check all of your contracts before filing another preoperative E/M service along with a fracture care code.

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