

Modifier Coding Alert

Mind Your Modifiers: Replace Confusion with Expertise When Using Modifier 57

Crack down on denials by knowing how global periods factor in.

You're always under the watchful eye of Medicare and other payers, especially when you add a modifier to your claim. You can eliminate one reason for denials or owing money back to your payers at audit time by being an expert with modifier 57.

Read on to learn about two culprits that you'll want to avoid when your physician makes the decision to perform a major surgery procedure during an E/M service.

End the Confusion Between Modifier 57 and Modifier 25

Even senior coders, with years of experience, sometimes confuse modifier 25 (Significant, separately identifiable evaluation and management service ...) and modifier 57 (Decision for surgery). Making the mistake of attaching the wrong modifier, may lead to denials, or worse, audits.

The primary difference between modifiers 57 and 25 is that you'll use modifier 57 when the E/M service resulted in the decision for the major surgery. You'll use modifier 25 when there's a separate identifiable E/M service on the same day of a minor surgery or procedure.

"Medicare will not allow payment for an E/M visit billed with modifier 57 on the day of, or the day before, a minor surgical procedure (one with a 0- or 10-day global surgical period)," says **Marvel J. Hammer, RN, CPC, CCS-P, ACS-PM, CPCO**, owner of MJH Consulting based in Denver, Co.

According to CMS, "Use of a modifier 57 is limited to operations with 90-day global periods. Modifier 57 allows separate payment for the visit at which the decision to perform the surgery was made, if adequate documentation is submitted demonstrating that the decision for surgery was made during a specific visit."

What to do: Work with your physician to make sure the documentation is thorough, to help you code correctly and take less time doing it.

Terminology indicates that the decision for surgery has occurred. "If the physician says, 'The risks and benefits of the procedure were explained to the patient and she agrees to proceed' that would make it clear that the decision for surgery had been made," says **Marcella Bucknam, CPC, CCS-P, CPC-H, CCS, CPC-P, CCC, COBC, CPC-I**, audit manager at CHAN Healthcare in Vancouver, Wash. "Another thing that you often see is in the assessment and plan. The assessment will list the problem (e.g., cholelithiasis with possible cholecystitis) and the plan will show how it will be treated (e.g., we will schedule for surgery next week). If you see something like that, clearly the decision was made to perform surgery."

Don't miss: If the decision for surgery was made more than 24 hours before the surgery took place, then there's no need for a modifier, Bucknam adds.

Know Your Payer's Definition of a Global Period

Because some payers have a different definition of a global period than CMS, they may deny a claim with modifier 57. Typically, these payers don't think the E/M service should be billed separately.

CMS defines a global surgical package as "...all necessary services normally furnished by a surgeon before, during, and after a procedure. Medicare payment for the surgical procedure includes the pre-operative, intra-operative and post-operative services routinely performed by the surgeon or by members of the same group with the same specialty. Physicians in the same group practice who are in the same specialty must bill and be paid as though they were a single physician."

CMS, along with most other payers, assigns a procedure or service to one of the following types of global surgical packages:

- 0-day ☐ only the day of the surgery is a part of the package.
- 10-day ☐ the day of surgery and 10 days following the surgery, totaling an 11-day package.
- 90-day ☐ one day before the surgery, the day of the surgery and 90 days following the surgery, totaling a 92-day package.

Both Medicare and CPT® include, for their procedures with a 90-day global, the day of or day before surgery. But many other payers, including many of the Medicaid programs, don't include a day before surgery so the only thing they're concerned about is E/M on the same day as the surgery," Bucknam explains.

What to do: Once you sign a contract with a payer, you're obligated to know their rules, including their definition of a global period. If you don't follow their billing rules, you're most likely losing money by not billing for payable services or spending money on appeals.

Good practice: AMA suggests keeping a health insurer reference log where you can include the payer's global period definition, so that it's at your fingertips when you are coding.