Codify
BY AAPC

Modifier Coding Alert

Reader Question: Remember 57 On E/Ms After Physician Makes Surgery Decision

Question: A patient had an office visit (99213) with a 185 diagnosis on Aug. 17. The next day, Aug. 18, my doctor did an inpatient procedure (55866), which has a 90-day global period, with the same diagnosis. Medicare denied the office visit as being part of the global period. Can we resubmit with modifier 57?

California Subscriber

Answer: If your physician did indeed make the decision for surgery on Aug. 17, the day before a laparoscopic retropubic robotic assisted radical prostatectomy (55866, Laparoscopy, surgical prostatectomy, retropubic radical, including nerve sparing, includes robotic assistance, when performed), then using modifier 57 (Decision for surgery) would be correct.

Watch out: Modifier 57 is usually necessary for payment of an E/M service when a decision for major emergency surgery occurs on the day of or on the day before surgery. However, 55866 is usually an elective procedure, and is rarely considered as an emergency procedure.

The procedure is scheduled to be performed in hospital often weeks after the initial E/M office service when the urologist makes the decision for surgery. During this preoperative period, your urologist will seek medical clearance, order laboratory and radiological services, and establish a firm date for surgery.

The clinical scenario you present, although possible, would be quite unusual. To help code this E/M visit correctly you must carefully study the documentation and reason for the office visit 24 hours before surgery. Unless this visit is unrelated to the upcoming surgery or diagnosis, the E/M visit would be in the global period of the surgery (24 hours before major surgery and 90 days after) and would not be a billable service.