Codify
BY AAPC

Modifier Coding Alert

Reader Questions: Make Sure the Surgery is Major with 57

Question: My physician admitted a patient with parotitis to the hospital for IV antibiotics. Three days later, the patient developed a parotid abscess that required complex drainage. During the inpatient visit, my physician made the decision to drain the abscess (42305). How do I code the inpatient visit?

Wyoming Subscriber

Answer: You should attach modifier 57 (Decision for surgery) to the appropriate subsequent hospital care code from the 99231-99233 (Subsequent hospital care, per day, ...) range, based on your provider's documentation. The modifier communicates to the payer that your physician made the decision for surgery during the E/M service. Then you will also report the surgical procedure with 42305 (Drainage of abscess; parotid, complicated).

Explanation: Modifier 57 is appropriate because the 42305 is major surgery with a 90-day global period. If your surgeon performed a simple drainage (42300, ... parotid, simple), you would instead 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).

Warning: If you don't attach modifier 57 to the E/M code, the payer will bundle the E/M with the 42305 procedure and you will forfeit anywhere from $39.33 for 99231 (1.10 relative value units times the 2015 quarter one national unadjusted conversion factor of 35.7547) to $105.12 for 99233 (2.94 relative value units times the 2015 quarter one national unadjusted conversion factor of 35.7547) for the hospital care E/M reimbursement.

Depending the payer, they may choose to pay for the visit and not the procedure; so make certain the you append the modifier when applicable.

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