feature

Wisely Choose Between Modifier 25 and Modifier 57

E/M coding can be difficult enough without throwing a modifier monkey wrench into the mix.

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PROFESSIONAL

A participant in an online coding discussion board to which I belong recently posted a question regarding the appropriate use of modifier 25 *Significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service*, versus that of modifier 57 *Decision for surgery*. After years of taking part in such forums, attending coding conferences, and serving as a coding consultant, I've heard the same question dozens of times, and I always respond the same way.

Determine First: Major or Minor Procedure?

Both modifiers 25 and 57 apply to evaluation and management (E/M) service codes only, and both allow the provider to report an E/M service separately with another procedure or service. For most payers, the distinction between the two modifiers depends on the nature of other, non-E/M service(s) reported.

- Modifier 57 applies when an E/M service results in the initial decision to perform a **major** procedure, which usually is defined as a procedure with a 90-day global surgical period.
- Modifier 25 applies when the provider performs a significant, separately identifiable E/M service on the same date as a **minor** procedure/service. A minor procedure/service has a global period of fewer than 90 days (for instance, 10 days or zero days).

The concept of *major* and *minor* procedures derives not from CPT®, but from the Centers for Medicare & Medicaid Services' (CMS') Physician Fee Schedule Relative Value File, which assigns a global period for all CPT® and HCPCS Level II codes. CPT® (Appendix A – Modifiers) states only that modifier 25 applies when the significant, separately-identifiable E/M service occurs on the day of a procedure or service; whereas modifier 57 applies when an E/M service results in the "initial decision to perform the surgery." CPT® does not, however, precisely define "procedure," "service," or "surgery," or assign global days for any of these categories.

If your payer isn't Medicare, ask for further guidance. The major and minor procedure designations apply definitively only for Medicare and those payers who follow CMS guidelines expressly. Third-party payers often follow CMS in this regard, but may designate their own rules. For example, in defiance of CMS (and CPT®) instruction, Florida Medicaid does not recognize modifier 57 and instead calls for modifier 25 anytime an E/M service and another procedure or service are reported together. The advice I give here assumes a payer follows CMS guidelines; for other payers, inquire specifically as to the rules for applying modifiers 25 and 57 and get those specific payer instructions in writing.

Modifier 57 Parameters

To apply modifier 57, the E/M service must have led to the decision to perform the major procedure that follows.

For example, if surgery was scheduled June 17 and the surgeon sees the patient again the day of the surgery, June 25, do not report a separate E/M with modifier 57 for the encounter on June 25 because the decision for surgery was not made at that visit. Rather, the June 25 visit is bundled into the surgical package.

Accessing the CMS Physician Fee Schedule Relative Value File

The Physician Fee Schedule Relative Value File may be found on the CMS website: www.cms.gov/PhysicianFeeSched/PFSRVF/list.asp?listpage=4. Download the most recent (last posted) file.

In the Relative Value File, the global period for each CPT®/HCPCS Level II code may be found in the column listed "GLOB DAYS." Only those procedures with a 90-day global period are major procedures. Global periods 0, 10, and XXX, designate minor procedures.

In contrast, if a patient presents with a burst appendix and the decision for appendectomy is made immediately, the E/M service (for example, 9928x) with modifier 57 appended may be billed separately with 44970 *Laparoscopy, surgical, appendectomy*.

Note that the global period for all major procedures begins one day prior to the actual procedure; so, if the decision for surgery occurs one day prior to the surgery, you may report that E/M service separately with modifier 57.

For example, a surgeon is following an inpatient with an obstructed colon. On day five, the surgeon decides that if the obstruction does not resolve by the next day, the patient will be brought to surgery for an exploratory laparotomy (and perhaps more extensive surgery). Based on this, the day-five visit (9923x) may need to be reported with modifier 57, if the surgeon decides to perform surgery on the following day. The surgeon should not report the service until day six, when he's certain whether the laparotomy will occur. If the service is reported without modifier 57, and surgery does occur on day six, the day-five E/M service will be bundled inappropriately into the laparotomy (or more extensive surgery).

If the obstruction begins to resolve on day six, and laparotomy is not required, the day-five visit (9923x) may be reported without modifier 57, and the day-six evaluation also may be reported.

Modifier 25 Parameters

Because all minor procedures include an E/M component, you get paid separately for an E/M service with a minor procedure only if the E/M service is "significant and separately identifiable." Here are three conditions when this happens:

1. There is a different diagnosis for the E/M and the procedure. The two diagnoses may be related (i.e., a sign or symptom diagnosis for the E/M and a definitive diagnosis for the procedure). The E/M results in a decision to perform the procedure, either diagnostic or therapeutic.

For example, a patient goes to an orthopedist complaining of shoulder pain. The orthopedist works up the patient, performing a complete history, exam, and medi-

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cal decision-making (MDM) relative to the complaint of shoulder pain. After this evaluation (and perhaps an X-ray), the physician determines that the patient has bursitis. He recommends and performs a joint injection. As a minor procedure, the joint injection (20610 *Arthrocentesis, aspiration and/or injection; major joint or bursa (eg, shoulder, hip, knee joint, subacromial bursa)*) includes an E/M component. To be paid separately for the E/M and the minor procedure, the provider must show the payer that the E/M was significant and separately identifiable from the injection. Modifier 25 (supported by documentation) alerts the payer to this fact.

2. A procedure lacks a specific, separate diagnosis. Medicare guidelines state specifically there is no requirement for separate and distinct diagnoses for an E/M with modifier 25 and a same-day procedure. See CMS Transmittal 954, issued May 19, 2006 (*Medlearn Matters* MM5025, Change Request (CR) 5025): "The E/M service may be prompted by the symptom or condition for which the procedure and/or service was provided. As such, different diagnoses are not required for reporting of the E/M services on the same date."

For instance, the E/M service may be linked to a sign or symptom, and a same-day minor diagnostic procedure results in no definitive finding. As such, the sign or symptom also is linked to the procedure. Once again, the E/M service led to the decision to perform the procedure.

As an example, a physician sees a patient who is complaining of recurring hoarseness. During the patient workup (including a history, exam, and MDM for the hoarseness), the physician finds he cannot visualize adequately the larynx via mirror exam, due to gag reflex. He then performs a flexible laryngoscopy (31575 *Laryngoscopy, flexible fiberoptic; diagnostic*), but ultimately finds no reason for the hoarseness. In this case, both the E/M (with modifier 25) and the flexible laryngoscopy should be reported, and may be linked to the same sign and symptom diagnosis (hoarseness).

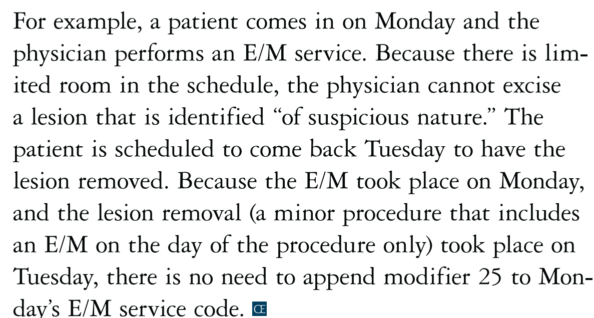
3. An "Oh, by the way" scenario. This is when a patient comes in for one problem for which the E/M is performed and just before leaving the patient states, "Oh, by the way, can you look at my …" This may result in the performance of a minor procedure that is totally unrelated to the original reason for the visit and the diagnosis for the E/M service and the minor procedure is entirely unrelated.

For example, a patient visits her primary care physician to follow up on hypertension and diabetes. The internist performs a history, exam, and MDM for the chronic conditions. After the E/M service has been completed, and the care plan has been reviewed, the patient says to the doctor, "Oh, by the way, can you look at this lump on my back?" The physician examines the mass and decides to perform a biopsy. The encounter for the day will include an E/M with modifier 25 for hypertension and diabetes. The minor procedure, 11100 *Biopsy of skin, subcutaneous tissue and/or mucous membrane (including simple closure), unless otherwise listed; single lesion* also is billed, with the diagnosis of 782.2 *Localized superficial swelling, mass or lump.*

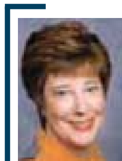
Keep E/M, Procedure Notes Separate

Whenever modifier 25 is used, the documentation must contain a separate history, exam, and MDM, apart from the procedure note. If findings are indicated on the procedure note, you cannot count it towards the exam portion of the E/M. If documentation indicates the physician was unable to ascertain the condition of a "bullet," but findings then are documented via a diagnostic procedure, you can get credit for both the E/M exam section and the procedure. Be able to identify these distinct parts in the chart.

Note, as well, that (unlike modifier 57) modifier 25 applies only if the E/M service and separate procedure occur on the same day.



For example, a patient comes in on Monday and the physician performs an E/M service. Because there is limited room in the schedule, the physician cannot excise a lesion that is identified "of suspicious nature." The patient is scheduled to come back Tuesday to have the lesion removed. Because the E/M took place on Monday, and the lesion removal (a minor procedure that includes an E/M on the day of the procedure only) took place on Tuesday, there is no need to append modifier 25 to Monday's E/M service code.



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