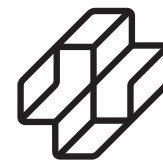


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Coding Modifiers 24, 25, and 57: The Good, the Bad, and the Necessary

By Jennifer Swindle

Modifiers used with evaluation and management services can create a financial Pandora's box if they are not used correctly.

Modifiers are necessary to clarify, interpret, and provide more detail when a CPT code alone does not provide enough information to accurately identify the entire service provided. The modifiers allow for payers to reimburse appropriately. Modifiers for evaluation and management (E/M) services are among the most commonly called for and among the most commonly misused.

Failure to use E/M modifiers when appropriate and supported can cause unnecessary and costly denials. These denials may affect not only the E/M service for which the modifier was missed or incorrectly applied, but also associated charges for hospital, emergency department, or outpatient facility services.

Misuse of modifiers or inappropriate use of modifiers that results in increased payment can also cause tremendous risk. Medicare and many private insurers regularly audit modifier use. A pattern of misuse not only will result in retroactive claim denials and charge recoveries, but could also lead to civil penalties or even criminal charges of fraud.

Modifiers 24, 25, and 57 should be used in some instances with an E/M service code.

Modifier 24

Modifier 24 is used to identify a separate and unrelated E/M service that is provided during the global period of a major surgery during which E/M services related to the surgery are included in the

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surgical global package. Note that the modifier should not be attached to any code used to bill the global surgical package, which includes all pre-op, operative, and post-op services related to the surgery within a specified timeframe, but should be attached to a separately filed E/M bill for the unrelated service.

Appropriate use. A patient has hip replacement surgery, which has a 90-day global period of coverage. During the first 90 days following surgery, the patient slips and sprains her ankle. The physician who performed the hip replacement surgery provides an E/M service for the sprain.

Because the patient is still in the global period for the hip surgery, modifier 24 should be affixed to the office visit code for the ankle sprain. This modifier alerts payers that this visit was not part of the

global package and is unrelated to the hip replacement surgery. Use of modifier 24 allows the E/M service for the sprained ankle to be paid separately.

Inappropriate use. A patient has gallbladder removal surgery due to acute and chronic cholecystitis. This surgery has a 90-day global period. Ten days following surgery, the patient returns to have sutures removed, evaluation of the abdomen for pain and tenderness, and follow-up care.

Although this service is provided in the office and is documented, it should be reported as a routine postoperative service (CPT 99024), because there is no separate billable or reimbursable service. The relative value units (RVUs) of the procedure include routine normal follow-up in the global period. Reporting this E/M service with a modifier 24 to obtain additional payment would be an inappropriate use of the modifier and fraudulent.

Modifier 25

Modifier 25 captures an E/M service that is separate and significant from another service performed on the same day for the same patient by the same provider.

Appropriate use. An established patient presents to the pediatrician with fever, cough, and stuffy nose and is diagnosed with maxillary sinusitis. During the course of the exam, an impacted cerumen is identified in the ear canal and is removed by the physician. Both the E/M service for the sinusitis and the procedure for the manual removal of the impacted cerumen are documented.

Misuse of modifiers or inappropriate use of modifiers that results in increased payment can also cause tremendous risk.

In this instance, the office visit is a separate and significant service from the procedure reported. However, without a modifier 25, the office visit will not be covered by most payers.

Inappropriate use. A patient is receiving a series of three injections into the knee for osteoarthritis pain. During the patient's visit for the second of three injections, the physician asks about the results from the first injection, inspects the knee for swelling and redness, and then gives the injection.

This "mini-exam" of the affected area is not considered a separate and significant service that warrants separate billing or payment for an E/M visit. A "mini-E/M" is included in every procedure code, and the RVU values for the procedure include assessing the area involved and asking the relevant questions. Modifier 25 should be used only when an accompanying E/M service is separate and significant.

Modifier 57

Modifier 57 identifies situations when the initial decision to perform a major surgery is made within 24 hours of the actual surgery. When used appropriately, this modifier clarifies that an E/M service—which would normally be considered part of the global surgical package—is separately reimbursable.

Appropriate use. A patient suffers acute abdominal pain and presents at an immediate care clinic. The physician calls in a general surgeon and transfers care to the surgeon. After performing a complete history and exam, including the necessary diagnostic tests, the surgeon determines that the patient needs an appendectomy. The surgeon then admits the patient to the hospital, completes the history and physical documentation, and performs the surgery later the same day.

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Staff working denials should be well-versed in correct and accurate modifier use.

In this instance, modifier 57 must be appended to the initial inpatient admission E/M code. The modifier identifies the clinic visit as one where the decision to perform surgery was made. Normally, the E/M services provided at admission would be part of the global package; however, this surgery was not a planned service. In this case, a full E/M service was completed to make the determination for surgery. If the service had been planned more than 24 hours before surgery, the surgeon could have billed for a separate and reimbursable E/M office visit. Modifier 57 makes it clear that the comprehensive initial evaluation took place rather than a scheduled admission service.

Inappropriate use. A patient has degenerative arthritis of the knee and is being followed by the orthopedic surgeon. The

orthopedic surgeon determines that the patient is a good candidate for knee replacement surgery and schedules the procedure. The day before the surgery, the surgeon has the patient come in for preoperative lab work and also performs a cursory examination to make sure the patient is ready for surgery.

This visit should not be reported with a separate E/M service with a modifier 57. The decision to perform surgery was not made during this cursory exam. This mini-service is included in the global surgical package.

Risks of Modifier Misuse

Modifiers often allow for additional payment when used appropriately. However, they should be used appropriately, following the necessary rules for modifier use. Inappropriate use can create significant compliance exposure and risk. Therefore, billing staff should have a detailed knowledge of when modifiers are appropriate.

Staff working denials also should be well-versed in correct and accurate modifier use, as many denials may include terminology such as “modifier needed.” This terminology can be interpreted to mean that, if a modifier is attached, the claim will be covered. But this denial is actually stating, “Take a look and see if a modifier is appropriate.”

The physician and staff still have complete responsibility for knowing if a modifier can and should be used. If the need for a modifier cannot be documented, do not use one.

Hospital revenue cycle staff want to use modifiers and get all services reimbursed that should be. But never use modifiers to gain payment that should not be separately captured. ☞

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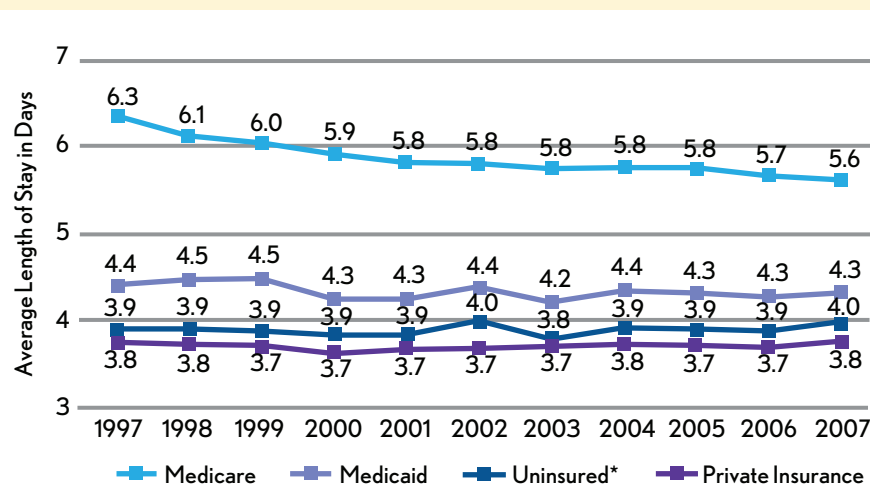
Facts and Figures

Average Length of Stay, by Payer, 1997-2007

From 1997 to 2007, the average length of stay (ALOS) for hospitalizations declined from 4.8 days to 4.6 days. However, the ALOS varied by payer, and most of the reduction in ALOS over the decade came from Medicare alone.

The ALOS for stays billed to Medicare decreased substantially from 6.3 days in 1997 to 5.6 days in 2007. However, the ALOS for stays covered by Medicaid, uninsured, and private insurance remained relatively stable over time.

In 2007, hospital stays billed to Medicare had the greatest ALOS (5.6 days), followed by those billed to Medicaid (4.3 days), uninsured (4.0 days), and private insurance (3.8 days). This pattern was consistent throughout all years from 1997 through 2007.



* Includes discharges classified as self-pay or no charge.

Source: AHRQ, Center for Delivery, Organization, and Markets, Healthcare Cost and Utilization Project, Nationwide Inpatient Sample, 1997-2007.

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