As payors become more prone to denying payment for Current Procedural Terminology (CPT)* evaluation and management (E/M) codes billed as “incidental to another service,” surgical practices are seeking appeal assistance with increasing frequency. Practice staff members who handle appeals need to know when the denials are appropriate and whether they should appeal. If the service was coded appropriately, then the practice should appeal. If the case was not reported appropriately, however, it should be used as an educational opportunity with the surgeons and any staff member involved in the coding and billing process. (If incorrect, adjust the charge and document the reason as coding error for compliance monitoring.)

Global billing

CPT and Medicare reimbursement rules allow the reporting of an E/M service when the service is either a significant, separate service or leads to the decision to operate or perform a procedure. Medicare assigns global days to the surgical procedure codes. Some key points to keep in mind for global billing include the following:

• A minor procedure, for the purpose of global days, is a surgical procedure that has a zero- or 10-day global period.

A major procedure, for the purpose of global days, is a surgical procedure that has a 90-day global period. The number of days may vary by payors, but 90-day global periods are the most common and follow Medicare rules.

• Surgical procedures with no global days are typically indicated on the Medicare fee schedule as 000, meaning that the global period concept does not apply. Of course, add-on surgical codes do not have global days either. Since add-on codes are not reported independently, the concept of applying Modifier 25 or Modifier 57 does not apply to them.

The definition of the two modifiers, the rules, and a scenario for each follow.

Modifier 25

Modifier 25, Significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service, is appended to an E/M service most common on the same day as a minor surgical procedure if the E/M is for a significant separate service. This situation typically occurs when a patient presents for evaluation of a condition and the surgeon decides to perform a minor surgical procedure. In these instances, append Modifier 25 to the E/M code and report in addition to the minor procedure.

• Scenario 1: E/M as significant service. A non-Medicare patient is seen in consultation for evaluation of a breast mass that was identified via a mammogram. The surgeon performs and documents an E/M service, as well as diagnoses a breast cyst, which the surgeon decides to aspirate. The surgeon aspirates three cc’s of fluid from the cyst during the same visit. In this case, the reason for the encounter was the E/M service; thus, the E/M is the significant service and is reported in addition to the aspiration of the breast cyst. A written report is sent to the physician who requested the consultation.

Because the patient is non-Medicare, the surgeon reports 9924x–25, Significant E&M service, consult, non-Medicare patient, and 19000, puncture aspiration of cyst of breast. Both services are reportable assuming the documentation supports the services. If denied, appeal on the basis that the E/M was the reason for the visit and the decision to perform the aspiration of the cyst occurred as a result of the E&M service.

• Scenario 2: E/M as separate service. The

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same patient who had the breast cyst aspirated three weeks ago presents to the surgeon because the cyst has reappeared. At the same visit, the patient asks the surgeon to evaluate a skin lesion that has become increasingly bothersome and has started bleeding. The surgeon evaluates both the cyst and the new lesion. The surgeon re-aspirates the breast cyst and evaluates the new lesion.

The surgeon reports 9921x–25, Established patient visit linked to the new lesion diagnosis, and 19000, Puncture aspiration of the cyst linked to the breast cyst diagnosis. Both services are reportable, as the E/M service was for a separate condition than the aspiration of the breast cyst. If the claim is denied based on the E/M service that was not inclusive to the surgical procedure, the surgeon should appeal because the E/M is reported for a separate condition.

**Modifier 57**

Modifier 57, Decision for surgery, is appended to the E/M code when the surgeon evaluates a patient and determines that the patient requires a major operation that will be performed the same day or next day. The key here is that the decision-making E/M takes place and results in the decision for a major surgical procedure either the same day or the next day. Most typically, this E/M represents the urgent decision for surgery.

- **Scenario 1.** A 10-year-old female presents to the emergency room (ER) with complaints of lower right, lower quadrant pain, fever, nausea, and vomiting. The ER physician evaluates her and consults the general surgeon, as he or she suspects the condition might be acute appendicitis. The general surgeon evaluates the patient in the ER and, after reviewing all scans and labs, diagnoses acute appendicitis, confirms the concern of rupture, and makes immediate plans to take the child to the operating room for an open appendectomy. The surgeon reports the consultation service and appendectomy, appending Modifier 57 to the E/M to indicate that it was a decision-making service. Specifically, the surgeon reports 9924x–57, Outpatient consultation (decision for surgery), and 44960, Appendectomy; for ruptured appendix with abscess or generalized peritonitis.

To receive payment, ensure all services are accurately reported and supported by documentation, and append Modifier 25 or 57 as appropriate, based on the CPT rules and the payor’s definition of major and minor procedures, if they are different than Medicare. Construct the appeal to indicate the E/M was the significant, separate, or decision-making visit, and thus should not be bundled into the surgical services. Also, link diagnosis or diagnoses codes appropriately to support the medical necessity of each service. Do not automatically write off any payor denials as incidental or inclusive without appeal. If the case was accurately documented and reported on the first claim submission, an appeal is warranted.

In addition, review payor contracts to ensure there is no hidden language indicating the bundling of an E/M with a surgical procedure. If this language is found, reconsider the contract with this payor. Also trend payor behavior, and if denials consistently track to one or two payors and there is no contract restriction, meet with the medical director and outline the concerns and increasing health care costs for the payor and the surgeon to construct appeals and overturn inappropriate denials. It may be necessary to request the payor to turn off an automatic edit that may be causing the inappropriate and automatic denial. Review insurance rules for your state, and if the payor continues to violate a contract or deny services without any sound coding foundation, consider reporting the insurer to the state insurance commissioner, the American Medical Association, the state medical society, and the American College of Surgeons, as appropriate.

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1Under this non-Medicare scenario, the guidance suggests using a consultation code. This would not be appropriate in the Medicare context given that Medicare has eliminated the use of consultation codes, and similar visits should now use new or established patient visit codes. Note, however, that several private payors have followed Medicare’s lead and have also eliminated consultation codes. To avoid delays in payment, ensure that you are aware of your payor’s policy regarding consultation codes.

**Ms. LeGrand** is a consultant and speaker with Karen-Zupko & Associates, Inc. and teaches the Power Case Coding for Surgeons workshop sponsored by the ACS. Visit [http://www.karenzupko.com](http://www.karenzupko.com) for more information on the ACS 2010 coding workshop series.