Codify
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Pain Management Coding Alert

Modifier Madness: Take this Advice on These '5-' Modifiers for Coding Success

Here's a primer on 51, 54, 57.

Have you ever had a claim come back because of the lack, or misuse, of a modifier? These hassles cause headaches that you can prevent with some basic knowledge about the modifiers you might need to use.

To help, we've got a panel of experts to take you through the basics of three modifiers.

Read on for a Q&A that should help remove doubt about when, and if, to use modifiers 51, 54, and 57.

When should a coder use modifier 51?

Perhaps not at all. Modifier 51 (Multiple procedures) is a modifier that is quickly going to way of the dodo bird.

Many insurers don't require, or flat-out-ignore, modifier 51 due to its redundancy on multiple procedure claims, says **Dawn Rogers**, coding specialist at Caduceus Inc. in Jersey City, N.J.

There might be, however, some payers that still require modifier 51 on multiple procedure claims. For those that do want 51, you'll apply the modifier "to the secondary procedure to inform the insurance company of … multiple procedures by the same provider during the same surgical setting," explains Rogers. "The secondary procedure is determined by RVUs [relative value units] or the less intensive procedure."

You might want to check your payer's policy on modifier 51 to see if you need it all; it might save you time later. "Most insurance companies no longer recognize the 51 modifier as it is redundant to their reimbursement structure. They will automatically reduce reimbursement of the second and following procedures according to the contract agreement," says Rogers.

When should a coder use modifier 54?

Coders use modifier 54 (Surgical care only) "when a physician or other qualified healthcare provider performs a surgical procedure/service, and another provider will be performing the management of postoperative and/or the preoperative component," explains **Yvonne Dillon, CPC, CEDC**, director of emergency department services at Bill Dunbar and Associates, LLC in Indianapolis, Indiana.

Your provider might need to use modifier 54 if he treats a patient for pain management or an injury while she is away from her local area. For example, the patient has a carpal tunnel syndrome (CTS) flareup at an out-of-town business conference and reports to the PM specialist for relief. Another example might be a patient who is on vacation and suffers some sort of injury that requires pain management procedures.

Remember: "Designation of the surgical service is shown by appending modifier 54 to the procedure code," reminds Dillon. "Also, since modifier 54 is not an approved OPPS [Outpatient Prospective Payment System] modifier, it would only be appended to the professional component and not the facility or technical component."

When should a coder use modifier 57?

Unlike modifiers 51 and 54, modifier 57 (Decision for surgery) is for evaluation and management service (E/M) codes, not procedure codes, explains **Sharon Richardson, RN**, consultant for Brault in San Dimas, California.

The basics: You'll employ modifier 57 to separate patient E/M encounters from major procedures - those with 90-day global periods. "It is commonly used during the patient's initial visit, but can be used at any time during a patient's care if that decision for major surgery is made the day of or day before the procedure," Rogers says. "Modifier 57 tells the insurance company that a full review had to be performed in order to accurately assess the decision for surgery."

Without the 57 modifier, the patient's E/M visit would be considered preoperative and the payer would bundle it into the procedure RVUs.

Coders often confuse modifier 57 with 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) - which you typically should use only for significant, separately identifiable E/Ms that lead to minor surgical procedures (global periods of 0 or 10 days).

In a perfect world, the only mistake you could make when choosing between 25 and 57 is miscounting the global days. Payer differences have made the distinction between 25 and 57 more nebulous, Richardson warns.

"Whether a 57 or 25 modifier is used on the E/M service is dependent on the payer," she explains. "Medicare used to always require a 57 modifier when the decision to 'do surgery' was made at the time the patient was initially seen and the procedure had a 90-day global period; but that is no longer the case."

Now, Richardson continues, some Medicare administrative contractors (MACs) still honor this modifier 57 coding convention. However, others now require a 25 modifier instead of 57.

The modifier 25/57 waters are getting muddier with time, so "it really is hit and miss," and can change by payer, or by year, Richardson says. Your best defense against miscoding is to "know your payers and their requirements."