Understanding the -25 and -57 Modifiers

It's important to know when to use each of these.

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The American Medical Association Current Procedural Terminology (CPT) Panel realized many years ago that a shorthand of explanatory terms was needed so that professional services could be reported more efficiently. To that end, the Panel developed a code set of two-digit modifiers. They assigned two types of modifiers. Reimbursement modifiers explain special circumstances that should allow services to be reimbursed. In addition, there are informational modifiers that do not determine reimbursement but add value to the data collection performed by insurance companies.

The correct use of modifiers assures carrier consideration to special circumstances while improper use of modifiers may result in payment denials. This article will deal with two specific modifiers that are appended to Evaluation and Management [E/M] codes. It will explain the differences and similitudes between the -25 and -57 modifiers.

Modifier -57 is defined as an "evaluation and management service that resulted in the decision to perform a major surgery."

Modifier -25

Modifier -25 is defined as "Significant, Separately Identifiable Evaluation and Management Service by the Same Physician on the Day of a Procedure or other Service." On Medicare claims this should be used when the procedure is defined as a minor surgical procedure and has either a 0 or 10 day global period.

Most insurance companies will acknowledge that an initial patient visit on the same day as a surgical procedure does not need a modifier appended on the evaluation and management code and that a different diagnosis is not needed. No supporting documentation is needed to accompany the claim but documentation

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-25 & -57 Modifiers

-25 and -57 similitude
E/M done with procedure done or planned within 24 hrs.

-25 and -57 differences
-25 for 0 or 10 day global procedure
-57 for 90 day global procedure

Modifiers *(from page 57)*

supporting the services must be contained in the patient's chart. When using -25, the history, examination, and complexity of decision-making need to be above and beyond what the provider would normally do for that level of E/M code.

Providers should create a policy on how modifier -25 should be used in their clinical practice when the patient's presenting problems require work-up above and beyond the normal pre-service and post-service of the procedure.

Examples:

- Established patient presents for a planned matricectomy. No E/M is separately reported.
- Same scenario but the patient describes new neuropathy symptoms, has diabetes and the physician performs a medically reasonable and necessary neurological examination. E/M may be separately reportable.
- Physician examines the patient for both heel pain and a neuroma and decides to inject the heel. E/M for the neuroma is separately reported.
- Established patient with a new diagnosis—examination is performed and decision to do a procedure is made. E/M is separately reportable with the same diagnosis.

Modifier -57

Modifier -57 is defined as an "evaluation and management service that resulted in the decision to perform a major surgery. In this situation, "major surgery" is defined as a procedure which encompasses a 90 day global period. The -57 is used on the day before or the day of the surgery.

Examples:

- Initial hospital visit with 5th metatarsal fracture ORIF performed that day or the next day. -57 modifier is needed.
- Same scenario except surgery is scheduled for 2 days later. No -57 is needed.
- Established patient seen in the office with continued complaint of bunion pain. Evaluation is performed, and surgery is scheduled in 2 weeks. No -57 modifier is needed.
- Established patient seen in office with osteomyelitis that has developed since last visit. Patient is admitted to the hospital for metatarsal head resection later that night. -57 modifier is needed. **PM**

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