



Manual: Reimbursement Policy

Policy Title: **Modifier 57 -- Decision For Surgery**

Section: Modifiers

Subsection: None

Date of Origin: 1/1/2000

Policy Number: RPM029

Last Updated: 9/6/2019

Last Reviewed: 10/14/2020

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### **Scope**

This policy applies to all Commercial medical plans, Medicare Advantage plans, and Oregon Medicaid/EOCCO plans.

### **Reimbursement Guidelines**

An E/M service provided the day before or the day of a surgical procedure which resulted in the initial decision to perform surgery is eligible for separate reimbursement in addition to the global surgery allowance for the procedure code when all of the following criteria are met:

- The surgical procedure code is a major surgery (global period of 090 days).
- Modifier -57 is appended to the E/M code.
- The medical record documentation supports the use of modifier 57.

The submission of modifier -57 appended to a procedure code indicates that documentation is available in the patient's records which will support that the E/M service resulted in the initial decision to perform the surgery, and that these records will be provided in a timely manner for review upon request.

Modifier -57 is not considered valid when the E/M service is associated with a minor surgical procedure (defined as having a 0 or 10 day global period). (CMS<sup>2</sup>) If an evaluation and management (E/M, E&M) service is billed with modifier 57 appended and is identified as related to a minor surgery procedure, the service will be denied as included in the global surgery package despite the use of the modifier.

Modifier -57 should not be used when the E/M service was for the preoperative evaluation.

## Codes, Terms, and Definitions

Modifier	Modifier Definition
Modifier 57	<b>Decision for Surgery:</b> An evaluation and management service that resulted in the initial decision to perform the surgery, may be identified by adding modifier 57 to the appropriate level of E/M service.

### Coding Guidelines

“CPT Surgical Package Definition – By their very nature, the services to any patient are variable. The CPT codes that represent a readily identifiable surgical procedure thereby include, on a procedure-by-procedure basis, a variety of services. In defining the specific services “included” in a given CPT surgical code, the following services are always included in addition to the operation per se:...Subsequent to the decision for surgery, one related Evaluation and Management (E/M) encounter on the date immediately prior to or on the date of procedure (including history and physical)...” (AMA<sup>1</sup>)

“If a procedure has a global period of 090 days, it is defined as a major surgical procedure. If an E&M is performed on the same date of service as a major surgical procedure for the purpose of deciding whether to perform this surgical procedure, the E&M service is separately reportable with modifier 57. Other *preoperative* E&M services on the same date of service as a major surgical procedure are included in the global payment for the procedure and are not separately reportable.” (CMS<sup>2</sup>)

“If a procedure has a global period of 000 or 010 days, it is defined as a minor surgical procedure. *E&M services on the same date of service as the minor surgical procedure are included in the payment for the procedure.* The decision to perform a minor surgical procedure is included in the payment for the minor surgical procedure and should not be reported separately as an E&M service....The fact that the patient is “new” to the provider is not sufficient alone to justify reporting an E&M service on the same date of service as a minor surgical procedure.” (CMS<sup>2</sup>)

“Procedures with a global surgery indicator of “XXX” are not covered by these rules. Many of these “XXX” procedures are performed by physicians and have inherent pre-procedure, intra-procedure, and post-procedure work usually performed each time the procedure is completed. This work should never be reported as a separate E&M code. Other “XXX” procedures are not usually performed by a physician and have no physician work relative value units associated with them. A physician should never report a separate E&M code with these procedures for the supervision of others performing the procedure or for the interpretation of the procedure.” (CMS<sup>2</sup>)

### Cross References

- A. “Clinical Editing.” Moda Health Reimbursement Policy Manual, RPM002.

- B. "Global Surgery Package for Professional Claims." Moda Health Reimbursement Policy Manual, RPM011.
- C. "Valid Modifier to Procedure Code Combinations." Moda Health Reimbursement Policy Manual, RPM019.
- D. "Modifier 25 – Significant, Separately Identifiable E/M Service." Moda Health Reimbursement Policy Manual, RPM028.

## References & Resources

1. American Medical Association. "Surgery Guidelines." *Current Procedural Terminology (CPT)*. Chicago: AMA Press.
2. CMS. *National Correct Coding Initiative Policy Manual*. Chapter 1 General Correct Coding Policies, § D, "Evaluation and Management (E&M) Services".

## Background Information

Modifiers are two-character suffixes (alpha and/or numeric) that are attached to a procedure code. CPT modifiers are defined by the American Medical Association (AMA). HCPCS Level II modifiers are defined by the Centers for Medicare and Medicaid Services (CMS). Like CPT codes, the use of modifiers requires explicit understanding of the purpose of each modifier.

Modifiers provide a way to indicate that the service or procedure has been altered by some specific circumstance, but has not been changed in definition or code. Modifiers are intended to communicate specific information about a certain service or procedure that is not already contained in the code definition itself. Some examples are:

- To differentiate between the surgeon, assistant surgeon, and facility fee claims for the same surgery
- To indicate that a procedure was performed bilaterally
- To report multiple procedures performed at the same session by the same provider
- To report only the professional component or only the technical component of a procedure or service
- To designate the specific part of the body that the procedure is performed on (e.g. T3 = Left foot, fourth digit)
- To indicate special ambulance circumstances

More than one modifier can be attached to a procedure code when applicable. Not all modifiers can be used with all procedure codes.

Modifiers do not ensure reimbursement. Some modifiers increase or decrease reimbursement; others are only informational.

Modifiers are not intended to be used to report services that are "similar" or "closely related" to a procedure code. If there is no code or combination of codes or modifier(s) to accurately report the service that was performed, provide written documentation and use the unlisted code closest to the section which resembles the type of service provided to report the service.

### **IMPORTANT STATEMENT**

The purpose of Moda Health Reimbursement Policy is to document payment policy for covered medical and surgical services and supplies. Health care providers (facilities, physicians and other professionals) are expected to exercise independent medical judgment in providing care to members. Reimbursement policy is not intended to impact care decisions or medical practice.

Providers are responsible for accurately, completely, and legibly documenting the services performed. The billing office is expected to submit claims for services rendered using valid codes from HIPAA-approved code sets. Claims should be coded appropriately according to industry standard coding guidelines (including but not limited to UB Editor, AMA, CPT, CPT Assistant, HCPCS, DRG guidelines, CMS' National Correct Coding Initiative (CCI/NCCI) Policy Manual, CCI table edits and other CMS guidelines).

Benefit determinations will be based on the applicable member contract language. To the extent there are any conflicts between the Moda Health Reimbursement Policy and the member contract language, the member contract language will prevail, to the extent of any inconsistency. Fee determinations will be based on the applicable provider contract language and Moda Health reimbursement policy. To the extent there are any conflicts between Reimbursement Policy and the provider contract language, the provider contract language will prevail.