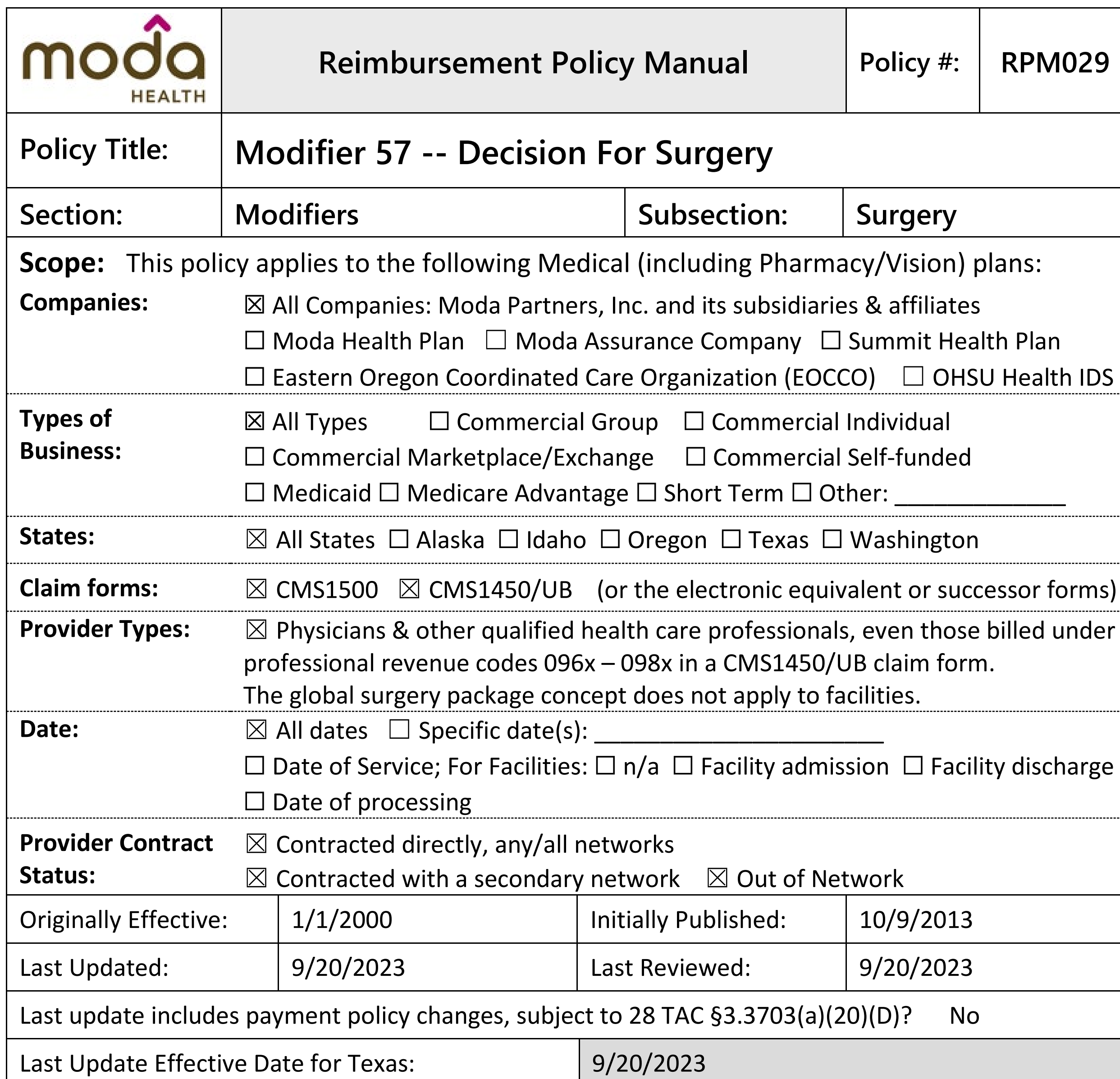

moda HEALTH	Reimbursement Policy Manual	Policy #:	RPM029
Policy Title:	**Modifier 57 -- Decision For Surgery**		
Section:	**Modifiers**	**Subsection:**	**Surgery**

Scope: This policy applies to the following Medical (including Pharmacy/Vision) plans:

Companies:	☒ All Companies: Moda Partners, Inc. and its subsidiaries & affiliates ☐ Moda Health Plan ☐ Moda Assurance Company ☐ Summit Health Plan ☐ Eastern Oregon Coordinated Care Organization (EOCCO) ☐ OHSU Health IDS
Types of Business:	☒ All Types ☐ Commercial Group ☐ Commercial Individual ☐ Commercial Marketplace/Exchange ☐ Commercial Self-funded ☐ Medicaid ☐ Medicare Advantage ☐ Short Term ☐ Other: _____________
States:	☒ All States ☐ Alaska ☐ Idaho ☐ Oregon ☐ Texas ☐ Washington
Claim forms:	☒ CMS1500 ☒ CMS1450/UB (or the electronic equivalent or successor forms)
Provider Types:	☒ Physicians & other qualified health care professionals, even those billed under professional revenue codes 096x – 098x in a CMS1450/UB claim form. The global surgery package concept does not apply to facilities.
Date:	☒ All dates ☐ Specific date(s): ______________________ ☐ Date of Service; For Facilities: ☐ n/a ☐ Facility admission ☐ Facility discharge ☐ Date of processing
Provider Contract Status:	☒ Contracted directly, any/all networks ☒ Contracted with a secondary network ☒ Out of Network

Originally Effective:	1/1/2000	Initially Published:	10/9/2013
Last Updated:	9/20/2023	Last Reviewed:	9/20/2023
Last update includes payment policy changes, subject to 28 TAC §3.3703(a)(20)(D)? No			
Last Update Effective Date for Texas:	9/20/2023		

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*[2]) 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 may not be used when the E/M service was for the preoperative evaluation.

Codes, Terms, and Definitions

Acronyms & Abbreviations Defined

Acronym or Abbreviation		Definition
AMA	=	American Medical Association
CCI	=	Correct Coding Initiative (see “NCCI”)
CMS	=	Centers for Medicare and Medicaid Services
CPT	=	Current Procedural Terminology
DRG	=	Diagnosis Related Group (also known as/see also MS DRG)
E/M E&M E & M	=	Evaluation and Management (services, visit) (Abbreviated as “E/M” in CPT book guidelines, sometimes also abbreviated as “E&M” or “E & M” in some CPT Assistant articles and by other sources.)
HCPCS	=	Healthcare Common Procedure Coding System (acronym often pronounced as "hick picks")
HIPAA	=	Health Insurance Portability and Accountability Act
MS DRG	=	Medicare Severity Diagnosis Related Group (also known as/see also DRG)
NCCI	=	National Correct Coding Initiative (aka “CCI”)
RPM	=	Reimbursement Policy Manual (e.g., in context of “RPM052” policy number, etc.)
UB	=	Uniform Bill

Definition of Terms

Term	Definition
Decision for Surgery Visit	An evaluation and management service that results in the initial decision to perform the surgery. (*AMA*[3])
Major Surgical Procedure	A procedure code which has a global period of 090 days on the CMS Physician Fee Schedule. (*CMS*[2])
Minor Surgical Procedure	A procedure code which has a global period of 000 or 010 days on the CMS Physician Fee Schedule. (*CMS*[2])

Modifier Definitions:

Modifier	Modifier Description & Definition
Modifier 57	**Decision for Surgery:** 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. (*AMA*[3])

Coding Guidelines & Sources - (Key quotes, not all-inclusive)

"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*[1])

"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*[2])

"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*[2])

"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*[2])

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".

3. American Medical Association. "Appendix A – Modifiers." *Current Procedural Terminology (CPT)*. Chicago: AMA Press.

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 this Reimbursement Policy is to document our payment guidelines for those services covered by a member's medical benefit plan. Healthcare providers (facilities, physicians, and other professionals) are expected to exercise independent medical judgment in providing care to members. Our Reimbursement Policy is not intended to impact care decisions or medical practice.

Providers are responsible for submission of accurate claims using valid codes from HIPAA-approved code sets and for accurately, completely, and legibly documenting the services performed. Billed codes shall be fully supported in the medical record and/or office notes. Claims are to 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] Policy Manual, CCI table edits and other CMS guidelines).

Benefit determinations will be based on the member's medical benefit plan. Should there be any conflicts between our Reimbursement Policy and the member's medical benefit plan, the member's medical benefit plan will prevail. Fee determinations will be based on the applicable provider fee schedule, whether out of network or participating provider's agreement, and our Reimbursement Policy.

Policies may not be implemented identically on every claim due to variations in routing requirements, dates of processing, or other constraints; we strive to minimize these variations.

***** The most current version of our reimbursement policies can be found on our provider website. If you are using a printed or saved electronic version of this policy, please verify the information by going to https://www.modahealth.com/medical/policies_reimburse.shtml *****

Policy History

Date	Summary of Update
9/20/2023	Formatting/Update: Cross References: Hyperlinks added.
9/14/2022	Formatting/Update: Change to new header. Policy History section: Added. Entries prior to 2022 omitted (in archive storage).
10/9/2013	Policy initially approved by the Reimbursement Administrative Policy Review Committee & initial publication.
1/1/2000	Original Effective Date (with or without formal documentation). Policy based on CMS global surgery package/modifier 57 policy.