

cmi_051721

Title	Modifier 57 – Decision for Surgery		
Number	CP.PP.188.v3.2		
Last Approval Date	03/12/26	Original Effective Date	02/03/03
Cross Reference	<i>Global Surgery</i>		

Coverage of any service is determined by a member's eligibility, benefit limits for the service or services rendered and the application of the Plan's Medical Policy. Final payment is subject to the application of claims adjudication edits common to the industry and the **Plan's professional or facility services claims coding policies**. Reimbursement is restricted to the provider's scope of practice as well as the fee schedule applicable to that provider.

Purpose	To define when the Plan recognizes services appended with Modifier 57 that are submitted on a professional claim.
Scope	Applies to all Premera Blue Cross, Premera Blue Cross Blue Shield of Alaska, LifeWise Health Plan of Washington, LifeWise Assurance Company and Premera Blue Cross HMO lines of business and products.
Policy	<p>The Plan recognizes Modifier 57-<i>Decision for Surgery</i> when appended to an Evaluation and Management (E&M) service to indicate the E&M service resulted in the initial decision for any major procedure (90-day global period), either the day before a major procedure or the day of a major procedure.</p> <p>Modifier 57 should not be appended to an E&M code on the same day as a minor procedure (0- or 10-day global period). E&M visits are considered part of preoperative care and are included/bundled into the global fee for the minor procedure.</p> <p>The determination of whether a procedure code is a major or minor procedure is determined by the current Center for Medicare and Medicaid Services (CMS) National Physician Fee Schedule (LINK) "Global Days flag" indicator. See the "Global Surgery" Payment Policy for a full explanation of the global surgery indicator flags.</p> <p>Modifier 57 should not be appended to an E&M service which was for the sole purpose of rendering a preoperative evaluation or to an E&M service that is associated with a major surgery that was planned in advanced or staged.</p> <p>Modifier 57 should not be appended to an E&M service in the postoperative period when the decision for surgery is made to address complications resulting from the original surgery.</p> <p>The decision for surgery must be documented in the medical records for the E&M service and be available upon request for review.</p> <p>If any allowed amount indicated above exceeds the billed charge for the claim line, that line will allow at the billed charge.</p>

Violations of Policy	Violations of this policy by any party that enters into a written arrangement with the Plan may result in increased auditing and monitoring, performance guarantee contractual penalties, and/or termination of the contract. Disciplinary actions will be appropriate to the seriousness of the violation and shall be determined by the plan.
Exceptions	Exceptions to the policy may be made where a provider or employer group contract dictates otherwise.
Laws, Regulations & Standards	N/A
References	<ul style="list-style-type: none"> American Medical Association’s Current Procedural Terminology (AMA/CPT) codebook Centers for Medicare and Medicaid Services (CMS) National Physician Fee Schedule (NPFS) National Correct Coding Initiative (NCCI) Policy Manual, Chapter 1-General Correct Coding Principles

Policy Owner Review	Payment Integrity Oversight Committee																
Contact	Any questions regarding the contents of this policy or its application should be directed to the Payment Integrity Department.																
Annual Review Dates	03/12/26; 03/07/25; 04/11/24; 05/19/23; 06/06/22; 08/02/21; 08/17/20; 10/11/19; 10/18/18; 11/06/17; 11/08/16; 11/15/15; 11/23/14; 12/15/13; 01/13/13; 01/26/12; 01/27/11; 02/12/10; 03/24/09; 06/16/08; 05/13/07; 04/11/06; 02/28/06; 08/29/05; 04/26/05; 10/08/04; 03/05/04; 03/29/03; 07/17/01																
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