Amerigroup RealSolutions in healthcare	**Reimbursement Policy**

Subject: Modifier 57: Decision for Surgery

Effective Date: **04/09/09**	Committee Approval Obtained: **08/14/17**	Section: **Coding**

*****The most current version of the Reimbursement Policies can be found on our provider website. If you are using a printed version of this policy, please verify the information by going to https://providers.amerigroup.com. Under Quick Tools, select Reimbursement Policies > Medicaid/Medicare. Note: State-specific exemptions may apply. Please refer to the Exemptions section below for specific exemptions based on your state.*****

These policies serve as a guide to assist you in accurate claim submissions and to outline the basis for reimbursement if the service is covered by a member's Amerigroup benefit plan. The determination that a service, procedure, item, etc. is covered under a member's benefit plan is not a determination that you will be reimbursed. Services must meet authorization and medical necessity guidelines appropriate to the procedure and diagnosis as well as to the member's state of residence. You must follow proper billing and submission guidelines. You are required to use industry standard, compliant codes on all claim submissions. Services should be billed with CPT codes, HCPCS codes and/or revenue codes. The codes denote the services and/or procedures performed. The billed code(s) are required to be fully supported in the medical record and/or office notes. Unless otherwise noted within the policy, our policies apply to both participating and nonparticipating providers and facilities.

If appropriate coding/billing guidelines or current Reimbursement Policies are not followed, Amerigroup may:

- Reject or deny the claim.
- Recover and/or recoup claim payment.

Amerigroup reimbursement policies are developed based on nationally accepted industry standards and coding principles. These policies may be superseded by mandates in provider, state, federal or CMS contracts and/or requirements. System logic or setup may prevent the loading of policies into the claims platforms in the same manner as described; however, Amerigroup strives to minimize these variations.

Amerigroup reserves the right to review and revise our policies periodically when necessary. When there is an update, we will publish the most current policy to this site.

Policy	Amerigroup allows separate reimbursement for an Evaluation and Management (E&M) visit provided on the day prior to or the day of a major surgery when it is billed with Modifier 57 to indicate the E&M visit resulted in the initial decision to perform the major surgical procedure unless provider, state, federal or CMS contracts and/or requirements indicate otherwise. A major surgery has a 90-day global period. Reimbursement for the E&M visit is based on 100 percent of the applicable fee schedule or contracted/negotiated rate. Amerigroup reserves the right to request medical records for review to support payment for the E&M visit. Failure to use this modifier when appropriate may result in denial of the

	claim for the visit. **Nonreimbursable** Amerigroup does not allow reimbursement for services billed with Modifier 57 in the following circumstances unless state, federal or CMS contracts and/or requirements indicate otherwise: • An E&M visit the day before or day of the surgery when the decision to perform the surgery was made prior to the E&M visit • An E&M visit for minor surgeries (0- or 10-day global period) — Since the decision to perform a minor surgery is usually reached the same day or day before the procedure, it is considered a routine preoperative service • A service billed with CPT code other than an E&M code
Exemptions	• There are no exemptions to this policy.
History	• Biennial review approved 08/14/17: Florida exemption language removed; Updated language: Policy template updated • Effective 12/31/15: Exited Florida Medicare • Biennial review approved 05/14/15: Florida exemption language updated • Effective 12/31/14: Exited Maryland Medicare • Effective 12/31/13: Exited New Mexico • Effective 07/01/13: Exited Ohio • Biennial review approved 05/20/13 and effective 04/09/09: Policy template updated • Review approved 04/23/12: Policy template updated • Biennial review approved 04/25/11 and effective 04/09/09: Language updated for clarity; Background section and policy template updated • Review approved 07/12/10 and effective 04/09/09: Background section/policy template updated • Review approved 02/09/09 and effective 04/09/09: Florida exemption added; Background section/policy template updated • Review approved 07/25/06 and effective 05/22/06: Florida exemption to deny Modifier 57 removed • Initial committee approval and effective date: 05/22/06
References and Research Materials	This policy has been developed through consideration of medical necessity, generally accepted standards of medical practice, and review of medical literature and government approval status, in addition to the following: • CMS • State Medicaid • Amerigroup state contracts • American Medical Association: Coding with Modifiers, fifth edition • Optum Learning: Understanding Modifiers, 2015 edition • American Association of Professional Coders 2017 Procedural Coding Expert
Definitions	• **General Reimbursement Policy Definitions**
Related Policies	• Global Surgical Package • Modifier 25: Significant, Separately Identifiable Evaluation and Management Service by the Same Physician on the Same Day of the Procedure or Other Service

	• Modifier Usage
Related Materials	• None