-

Origination: October 17, 2024
Last Review: October 17, 2024
Next Review: October 17, 2025
Effective Date: February 01, 2025

Description

Provide guidelines for the payment of eligible services appropriately appended with medical billing modifier -57 for professional and outpatient facility claims.

Policy & Guidelines

Policy Statement

Effective with dates of service on or after February 01, 2025, Blue Cross and Blue Shield of Vermont (Blue Cross VT) will allow payment for services associated with the use of modifier -57 as defined below in the payment policy.

Definition(s)

Modifier -57: Is used to report a decision for surgery. Providers should append modifier - 57 to the appropriate level of Evaluation and Management (E/M) service provided on the day before or day of a major surgery, in which the initial decision is made to perform major surgery. The intended use of modifier -57 is to represent that the decision to perform major surgery has occurred on the date of, or one day prior to the surgery and therefore the surgery was not planned in advance of that E/M encounter.

The general rule for appending modifier -57 is the visit needs to actually result in the decision to perform surgery. Members are often referred to a surgeon for a particular procedure and surgeon performs a routine pre-operative clearance exam. Generally, this exam would NOT be separately billable with modifier-57.

Planned Surgery:
Some categories of planned surgery would be inconsistent with a decision for surgery occurring the day of, or day prior to, the procedure, except when performed in the setting of an office or inpatient consultation, or emergency department. Categories of these planned surgeries include

but are not limited to: Spine surgery (excluding fractures and dislocations); Arthroplasty (total, partial, revision); Congenital/deformity procedures (i.e. club foot); Chronic/sub-acute conditions (i.e. tennis elbow, cataract surgery); Transplant procedures.

Major Surgery: Includes all surgical procedures assigned a 90-day global surgery period as defined by CMS. Providers should not append modifier- 57 to E/M encounters performed the day before or the day of any minor procedures with a (0) or (10) day surgical global period.

Services provided to the member preoperatively, intra-operatively and postoperatively are considered part of the global surgical package and are included in the payment of the surgery, whether rendered by the surgeon or by providers of the same medical group within the same specialty.

Reimbursable Services

Blue Cross VT will consider separate reimbursement of an E/M performed one day before or on the same day of a major surgery when modifier -57 is appended to the E/M code submitted. Appending modifier -57 allows the E/M service to be paid outside of the global surgical package. This applies only to major surgical procedures, i.e., those with a 90-day postoperative period.

Blue Cross VT will reimburse E/M services appended with modifier -57 performed the day before or the day of any other major surgery at the applicable fee schedule.

Non-Reimbursable Services

Blue Cross VT will **NOT** allow reimbursement for services billed with Modifier -57 in the following circumstances:

- 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-day 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 a procedure code other than an E/M code.
- E/M codes billed with procedure codes for closed treatment of fracture without manipulation. In the case of closed treatment of fracture without manipulation, no procedure is actually performed therefore, no evaluation with 'decision for surgery' that is separate from the fracture care. The evaluation and the treatment are the same service.
- E/M services with modifier -57 for categories of planned surgery when billed outside the consultative and emergency settings noted below in the definitions section of the

policy.

- E/M services appended with modifier -57 when performed one day prior or the same day as a major surgical procedure when another E/M service has been billed in the previous two (2) months and the primary diagnosis for the services are the same. Exclusions may apply for E/M services with modifier -57 billed in place of service 20 (Urgent Care Facility), 21 (Inpatient Hospital), 23 (Emergency Room-Hospital), or 24 (Ambulatory Surgical Center).
- E/M codes appended with Modifier -57 for surgical procedures that have been planned in advance OR when an E/M was billed by the same provider within two months of a major surgery where the E/M and surgical claims have the same primary diagnosis.
- Blue Cross VT's editing rules for Modifier- 57 shall be applied across providers in the same tax group Identification with the same specialty unless otherwise specified.

Provider Billing Guidelines and Documentation

E/M visits by the same provider on the day before or the same day as a major surgery are included in the payment for the procedure **UNLESS** the visit establishes the decision to operate. Billing for separate E/M visit on the day before or the day of the major surgery would NOT be appropriate if the provider was only discussing the upcoming surgical procedure. Noted below are some guidelines surrounding the use of modifier -57 as well as a Decision Tree for use of the modifier -57.

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

The member's medical record must reflect the medical necessity for the care provided. These medical records may include but are not limited to: Medical records from the professional provider's office, hospital, nursing home, home health agencies, therapies, and test reports.

Correct Use of Modifier-57

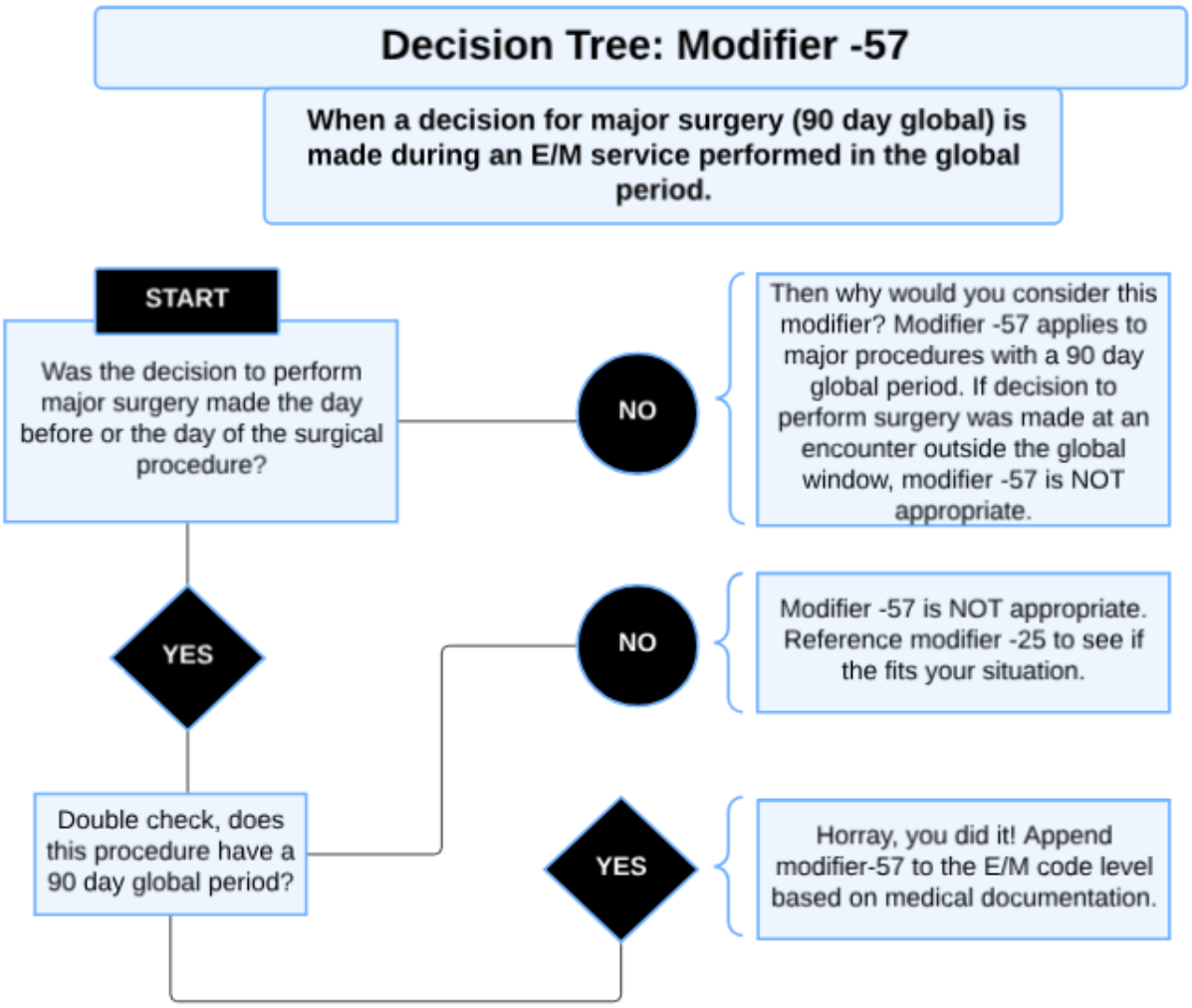
- Append modifier -57 only to E/M visits (office visits, emergency department visits, initial hospital services, critical care services, vision services or any E/M services) involving surgeries with a 90-day post-operative global period. By appending modifier -57 it informs that the provider determined the surgery was medically necessary.
    - For 90-day post-operative period surgeries, global package includes day before surgery, day of surgery and 90 days after surgery.

- It is appropriate to append Modifier -57 to an E/M service when **BOTH** of the following occur:
    - The E/M service resulted in the initial decision to perform a major surgical procedure.
    - The E/M service is performed on the day before or the same day of the major surgical procedure.
- Use modifier -57 when decision for surgery is made on day of or day before surgery.
- Use modifier -57 for the initial consultation or evaluation of problem by surgeon to determine need for major surgery.

Incorrect Use of Modifier -57

- Do **NOT** append modifier -57 to E/M visits with minor procedures (000 or 10-day post-operative period).
- Do **NOT** append modifier -57 to services of other physician's related to surgery, where surgeon and other physician agree on transfer of care of the member.
- Do **NOT** append modifier -57 to E/M service unrelated to diagnosis for which surgical procedure is performed.
- Do **NOT** append modifier -57 to surgical procedure codes.
- Do **NOT** append modifier -57 when the E/M service was for a preoperative evaluation.
- Do **NOT** append modifier-57 on day of surgery for a pre-planned or pre-scheduled surgery.
- Do **NOT** report modifier-57 on the E/M encounter for decision of surgery, but the surgery is scheduled in two or more days.
- Do **NOT** append modifier-57 to an E/M service performed on the day of a major surgical procedure performed in multiple sessions or stages.
- Do **NOT** append modifier-57 to an E/M service that is related to and part of the standard post-operative care of a major surgical procedure.
- The general rule for appending modifier -57 is the visit needs to actually result in the decision to perform surgery. Members are often referred to a surgeon for a particular procedure and surgeon performs a routine pre-operative clearance exam. Generally, this exam would **NOT** be separately billable with modifier-57.
- Modifier -57 is **NOT** accepted with E/M codes billed with procedure codes for closed treatment of fracture without manipulation. In the case of closed treatment of fracture without manipulation, no procedure is actually performed therefore, no evaluation with 'decision for surgery' that is separate from the fracture care. The evaluation and the treatment are the same service.

Table 1: -57 Modifier Decision Tree



Benefit Determination Guidance

Payment for services is determined by the member's benefits. It is important to verify the member's benefits **prior** to providing the service to determine if benefits are available or if there is a specific exclusion in the member's benefit.

Eligible services are subject to applicable member cost sharing such as co-payments, co-insurance, and deductible.

Federal Employee Program (FEP): Members may have different benefits that apply. For further information, please contact FEP customer service or refer to the FEP Service Benefit Plan Brochure. It is important to verify the member's benefits **prior** to providing the service to determine if benefits are available or if there is a specific exclusion in the member's benefit.

Inter Plan Programs (IPP): In accordance with the Blue Cross and Blue Shield Association's Inter-Plan Programs Policies and Provisions, this payment policy governs billing procedures for goods or services rendered by a Vermont-based provider (Blue Cross VT is the local Plan), including services rendered to out-of-state Blue members. Provider billing practices, payment policy and pricing are a local Plan responsibility that a member's Blue Plan must honor. A member's Blue Plan cannot dictate the type of claim form upon which services must be billed, codes and/or modifiers, place of service or provider type, unless it has its own direct contract with the provider (permitted only in limited situations). A member's Blue Plan cannot apply its local billing practices on claims rendered in another Plan's service area. A member's Blue Plan can only determine whether services rendered to their members are eligible for benefits. To understand if a service is eligible for payment, it is important to verify the member's benefits **prior** to providing services. In certain circumstances, the member may be financially responsible for services beyond the benefit provided for eligible services.

Claims are subject to payment edits that are updated at regular intervals and generally based on Current Procedural Terminology (CPT®), Health Care Procedural Coding System (HCPCS), Internal Classification of Diseases, CMS National Correct Coding Initiative Edits, Specialty Society guidelines, etc.

Eligible Providers

This policy applies to all providers/facilities contracted with the Plan's Network (participating/in-network) and any non-participating/out-of-network providers/facilities.

Audit Information

Blue Cross VT reserves the right to conduct audits on any provider and/or facility to ensure adherence with the guidelines stated in the payment policy. If an audit identifies instances of non-adherence with this payment policy, Blue Cross VT reserves the right to recover all non-adherence payments.

Legislative and Regulatory Guidelines

N/A

Related Policies

N/A

Document Precedence

The Blue Cross VT Payment Policy Manual was developed to provide guidance for providers regarding Blue Cross VT payment practices and facilitates the systematic application of Blue Cross VT member contracts and employer benefit documents, provider contracts, Blue Cross VT corporate medical policies, and Plan's claim editing logic. Document precedence is as follows:

1) To the extent that there may be any conflict between the Blue Cross VT Payment Policy Manual and the member contracts or employer benefit documents, the member contract or employer benefit document language takes precedence.
2) To the extent that there may be any conflict between the Blue Cross VT Payment Policy Manual and provider contract language, the provider contract language takes precedence.
3) To the extent that there may be any conflict between the Blue Cross VT Payment Policy Manual and corporate medical policy, the corporate medical policy takes precedence.
4) To the extent that there may be any conflict between the Blue Cross VT Payment Policy Manual and the Plan's claim editing solutions, the Plan's claim editing solution takes precedence.

References

American Me*dical Association. (2024). Current Procedural Terminology (CPT)*. Appendix A – Modifiers. Chicago: AMA Press.

American Medical Association. (2024). *Current Procedural Terminology (CPT).* Surgery Guidelines. *Chicago*: AMA Press.

Centers for Medicare and Medicaid Services (CMS). MLN Booklet: Global Surgery Booklet. [CMS Web site.] September 2018. Available at: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network MLN/MLNProducts/downloads/GloballSurgery-ICN907166.pdf. Accessed September 26, 2024.

Centers for Medicare and Medicaid Services (CMS). National Correct Coding Initiative Policy Manual. Chapter 1 General Correct Coding Policies, § D, "Evaluation and Management (E/M) Services".

Centers for Medicare and Medicaid Services (CMS). Pub 100 Medicare Claims Processing, Retrieved from: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c23.pdf. Accessed September 26, 2024.

Centers for Medicare and Medicaid Services (CMS). Pub 100 Medicare Claims Processing, Retrieved from: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c12.pdf. Accessed September 24, 2024.

Policy Implementation/Update Information

This policy was originally implemented on February 01, 2025.

Date of Change	Effective Date	Overview of Change
October 17, 2024	February 01, 2025	New policy. Payment policy statement established for -57 modifier.

Approved by **Update Approved: 10/17/2024**

Tom Weigel, MD, Chief Medical Officer