

		<b>Reimbursement Policy</b>
<b>Subject: Modifier 57: Decision for Surgery</b>		
Effective Date: <b>01/01/14</b>	Committee Approval Obtained: <b>07/03/19</b>	Section: <b>Coding</b>
<p>*****The most current version of our 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 <a href="https://mediproviders.anthem.com/ky/pages/reimbursementpolicies.aspx">https://mediproviders.anthem.com/ky/pages/reimbursementpolicies.aspx</a>.*****</p> <p>These policies serve as a guide to assist you in accurate claims submissions and to outline the basis for reimbursement by Anthem Blue Cross and Blue Shield Medicaid (Anthem) if the service is covered by a member’s 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.</p> <p>If appropriate coding/billing guidelines or current reimbursement policies are not followed, Anthem may:</p> <ul style="list-style-type: none"> <li>• Reject or deny the claim.</li> <li>• Recover and/or recoup claim payment.</li> </ul> <p>Anthem 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 These policies may be superseded by mandates in provider, state, federal or CMS contracts and/or requirements.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, Anthem strives to minimize these variations.</p> <p>Anthem 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.</p>		
<b>Policy</b>	<p>Anthem allows separate reimbursement for an Evaluation and Management (E&amp;M) visit provided on the day prior to or the day of a major surgery when it is billed with Modifier 57, which indicates the E&amp;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.</p>	



	<p>Reimbursement for the E&amp;M visit is based on 100% of the applicable fee schedule or contracted/negotiated rate. Anthem reserves the right to request medical records for review to support payment for the E&amp;M visit. Failure to use this modifier when appropriate may result in denial of the claim for the visit.</p> <p><b>Nonreimbursable</b>          Anthem 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:</p> <ul style="list-style-type: none"> <li>• An E&amp;M visit the day before or day of the surgery when the decision to perform the surgery was made prior to the E&amp;M visit</li> <li>• An E&amp;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</li> <li>• A service billed with CPT code other than an E&amp;M code</li> </ul>
<b>History</b>	<ul style="list-style-type: none"> <li>• Biennial review approved <b>07/03/19</b>: Policy template updated</li> <li>• Biennial review approved <b>08/14/17</b></li> <li>• Biennial Anthem review approved <b>05/14/15</b>: Policy template updated</li> <li>• Initial approval and effective date <b>01/01/14</b></li> </ul>
<b>References and Research Materials</b>	<p>This policy has been developed through consideration of the following:</p> <ul style="list-style-type: none"> <li>• CMS</li> <li>• State Medicaid</li> <li>• Kentucky Medicaid Managed Care Contract</li> <li>• American Medical Association: Coding with Modifiers, Fifth Edition</li> <li>• Optum 360 EncoderPro 2019</li> <li>• American Association of Professional Coders 2017 Procedural Coding Expert</li> </ul>
<b>Definitions</b>	<ul style="list-style-type: none"> <li>• <b>General Reimbursement Policy Definitions</b></li> </ul>
<b>Related Policies</b>	<ul style="list-style-type: none"> <li>• Global Surgical Package</li> <li>• Modifier 25: Significant, Separately Identifiable Evaluation and Management Service by the Same Physician on the Same Day of the Procedure or Other Service</li> <li>• Modifier Usage</li> </ul>
<b>Related Materials</b>	<ul style="list-style-type: none"> <li>• None</li> </ul>