Modifier 57-Decision for Surgery

Reimbursement Policy ID: RPC.0002.72AC

Recent review date: 11/2025

Next review date: 02/2027

AmeriHealth Caritas Pennsylvania Community HealthChoices reimbursement policies and their resulting edits are based on guidelines from established industry sources, such as the Centers for Medicare and Medicaid Services (CMS), the American Medical Association (AMA), state and federal regulatory agencies, and medical specialty professional societies. Reimbursement policies are intended as a general reference and do not constitute a contract or other guarantee of payment. AmeriHealth Caritas Pennsylvania Community HealthChoices may use reasonable discretion in interpreting and applying its policies to services provided in a particular case and may modify its policies at any time.

In making claim payment determinations, the health plan also uses coding terminology and methodologies based on accepted industry standards, including Current Procedural Terminology (CPT®); the Healthcare Common Procedure Coding System (HCPCS); and the International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM), and other relevant sources. Other factors that may affect payment include medical record documentation, legislative or regulatory mandates, a provider's contract, a member's eligibility in receiving covered services, submission of clean claims, other health plan policies, and other relevant factors. These factors may supplement, modify, or in some cases supersede reimbursement policies.

This reimbursement policy applies to all health care services billed on a CMS-1500 form or its electronic equivalent, or when billed on a UB-04 form or its electronic equivalent.

To the extent that any procedure and/or diagnosis codes are specified in this policy, such inclusion is provided for reference purposes only, may not be all inclusive, and is not intended to serve as billing instructions. Listing of a code in this policy does not imply that the service described by the code is a covered or non-covered health service. Benefit coverage for health services is determined by federal, state, or contractual requirements and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other Policies and Guidelines may apply.

Policy Overview

Provides guidelines for the application of modifier 57 when appropriately billed by providers. Modifier 57 (Decision for Surgery) is used to indicate that the decision to perform major surgery has occurred on the date of, or the date prior to, the surgery.

Exceptions

N/A

Reimbursement Guidelines

An evaluation & management (E/M) service that results in a decision to perform a major surgical service performed within the immediate pre-operative period of that major surgical procedure will be considered for reimbursement at the applicable AmeriHealth Caritas Pennsylvania Community HealthChoices fee schedule when appropriately appended with modifier 57. The “immediate pre-operative period” is considered to be the day of, or the day prior to, the surgery.

E/M services billed with modifier 57 are not reimbursable by AmeriHealth Caritas Pennsylvania Community HealthChoices if billed in addition to a procedure with a “0” to “10” day global surgical procedure (minor procedure).

AmeriHealth Caritas Pennsylvania Community HealthChoices will not reimburse E/M services with modifier 57 when billed with planned major surgical services with a “90” day global surgical procedure.

Examples of planned surgeries:

- 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

AmeriHealth Caritas Pennsylvania Community HealthChoices will not allow payment for modifier 57 when appended to a

- E/M services that resulted in a minor surgical procedure.
- When applied to an E/M service for post-operative evaluation.
- When applied to an E/M service that resulted in an ineligible surgical service.

Definitions

Modifier 57- Decision for Surgery
An evaluation and management (E/M) service that resulted in the initial decision to perform the surgery may be identified by adding this modifier to the appropriate level of E/M service.

Edit Sources

I. Current Procedural Terminology (CPT) and associated publications and services.
II. International Classification of Diseases,10th Revision, Clinical Modification (ICD-10).
III. Healthcare Common Procedure Coding System (HCPCS).
IV. Centers for Medicare and Medicaid Services (CMS) /https://www.cms.gov/files/document/mln907166-global-surgery-booklet.pdf
V. The National Correct Coding Initiative (NCCI).
VI. PA Medicaid Fee Schedule(s).

Attachments

N/A

Associated Policies

RPC.0012.72AC Global Surgical Package and Split Surgery

Policy History

11/2025	Reimbursement Policy Committee Approval
06/2025	Minor updates to formatting and syntax
04/2025	Revised preamble
04/2024	Revised preamble
08/2023	Removal of policy implemented by AmeriHealth Caritas Pennsylvania Community HealthChoices from Policy History section
01/2023	Template Revised • Revised preamble • Removal of Applicable Claim Types table • Coding section renamed to Reimbursement Guidelines • Added Associated Policies section