JOHNS HOPKINS HEALTH PLANS	Johns Hopkins Health Plans **Provider Relations and Network Innovation Reimbursement Policy**	*Policy Number*	RPC.021
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This document applies to the following Participating Organizations:

EHP | Johns Hopkins Advantage MD | Priority Partners | US Family Health Plan

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I. ABOUT OUR REIMBURSEMENT POLICIES

The most current version of the reimbursement policies can be found on www.hopkinsmedicine.org.

Johns Hopkins Health Plan LLC (JHHP) reimbursement policies serve as a guide to assist in accurate claim submissions and outline the basis for reimbursement of services covered by a member's JHHP benefit plan. The determination that a service, procedure, item, etc. is covered under a member's benefit plan is not a guarantee that you will be reimbursed. Services must meet prior authorization and medical necessity guidelines appropriate to the procedure and diagnosis, as well as to the member's state of residence. Providers are expected to and must follow proper billing and submission guidelines. Providers are required to use industry standard, compliant codes on all claim submissions. Services must be billed with valid ICD-10 diagnosis codes, Healthcare Common Procedure Coding System/Current Procedural Terminology (HCPCS/CPT) codes, place of service (POS) codes, and/or revenue codes as defined by the Centers for Medicare & Medicaid Services (CMS) and in the American Medical Association's (AMA's) "CPT Manual".

The codes billed should denote the services and/or procedures performed. The billed code(s) are required to be fully supported in the patient's medical record and/or office notes and JHHP reserves the right to request the records. Issues related to inconsistent, missing, conflicting, or unclear documentation must be resolved by the provider submitting the claim. If a corrected claim is filed, it must comply with timely filing to be reprocessed through the claims system. Corrected claims are for administrative errors on the claim (i.e., misspelled name, CPT/HCPCS code transposed, wrong DOB, missing modifier, etc.). Intentionally changing the CPT/HCPCS or diagnosis code in order to get the claim paid, after the billed service was denied, is not a correction. The medical records must match the services billed. Unless otherwise noted within the policy, our policies apply to both participating and nonparticipating providers and facilities.

JHHP policies apply to all practitioners, hospitals, providers, or suppliers eligible to bill the relevant HCPCS/CPT codes pursuant to applicable portions of the Social Security Act (SSA) of 1965, the Code of Federal Regulations (CFR), and Medicare rules. JHHP reimbursement policies are developed based on nationally accepted industry standards, coding principles, and follows the CMS guidelines, and the CMS developed National Correct Coding Initiative (NCCI) program to

prevent inappropriate payment of services that should not be reported together. These policies may be superseded by regulatory mandates in provider or state contracts, or state, federal or CMS contracts and/or requirements. If appropriate, when coding/ billing guidelines or current reimbursement policies are not followed, JHHP may:

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

JHHP reserves the right to modify policies at any time and publish new versions when necessary. System logic or setup may prevent the loading of policies into the claims platforms in the same manner as described; however, JHHP strives to minimize these modifications. When there is an update, policies will be published on our website.

II. PURPOSE

The purpose of this policy is to provide basic reimbursement guidance for the appropriate application of Modifier 51 for multiple surgeries/procedures performed on the same day, by the same provider, rendered by network and non-network providers, for claims submitted on a CMS-1500, or its electronic equivalent. When required, prior authorization must be obtained by the supplier/provider, prior to submitting the claim to JHHP for reimbursement. However, authorization does not guarantee payment as providers/suppliers must bill all covered items and/or services within the provider's scope of practice, and in accordance with the members' covered plan benefits, and under state and federal law.

III. POLICY STATMENT

This policy is applicable to multiple surgeries or procedures performed on the same day, by the same provider, regardless of the place of service (POS). JHHP will align with regulatory, state and federal guidance to process claims as applicable to the member's plan. Each line of business possesses its own unique contract and guidelines for benefit and payment purposes. As such, there could be various factors that may impact reimbursement, including but not limited to legislative mandates, provider contracts, and/or the member's benefit coverage, prior authorization, including provisions addressing services rendered by non-participating providers, which may supplement, modify, or supersede this policy.

*Providers are responsible to review the **"EXCEPTIONS & EXCLUSIONS" Sections** below for specific plan guidance, as some guidelines in this policy may not be applicable to all health plans/products.*

IV. GENERAL BILLING GUIDELINES AND PAYMENT METHODOLOGY

1. Multiple procedures not considered to be integral to the primary procedure should be reported with modifier 51 appended to the second and subsequent procedure codes.
2. Covered procedures (including endoscopic and colonoscopy procedures) performed during the same operative session, through only one route of access and/or on the same body system and that are clinically integral to the primary procedure, are usually considered incidental, integral to/included in, or mutually exclusive to the primary procedure.
3. To account for overlap of the pre-procedure and post-procedure work, secondary and subsequent procedures may be subject to the multiple procedure payment reduction (MPPR) rule, in alignment with CMS guidance.
4. Billing expectations and reimbursement for modifier 51 are based on the procedure code's multiple procedure indicator (MPI) found in the CMS Physician Fee Schedule (PFS).
5. MPPR rules apply to assistants at surgery services.
6. When modifier 51 is billed with modifiers 62, 66, 80, 81, 82, or AS, the MPPR rule will be applied to each modifier grouping (all claims lines with Modifier 80 will be ranked for the multiple procedure payment adjustment).
7. Multiple surgery pricing applies to bilateral services (modifier 50) performed on the same day with other procedures.
8. JHHP will utilize NCCI and MUE edits to process professional claims for supplies billed by providers/suppliers. When applicable, supplies and services reported for the same encounter will be bundled in alignment with CPT and CMS

guidelines. If JHHP receives a claim that is solely for a service or supply that must be mandatorily bundled, the claim will be processed accordingly.
- Refer to the JHHP NCCI and MUE Edits Reimbursement Policy for additional guidance.

9. The appropriate modifier must be appended to the applicable CPT/HCPCS code and assigned in the correct modifier position, in order for the claim to be processed. Modifiers that are reported incorrectly and/or are missing, may cause a delay in processing or a denial of payment.
10. The billing provider is responsible to obtain the applicable referral and/or authorization prior to submitting the claim to JHHP for reimbursement, or the claim may be denied.
11. The appropriate diagnosis code(s) is required to be used and reported at the highest number of characters available and to the highest level of specificity documented in the medical record, to support the item/service billed.
    - When ICD-10 codes are submitted incorrectly or when an inappropriate diagnosis is pointed to or linked as primary on the claim form, JHHP will deny the associated claim line.
12. JHHP may conduct medical record documentation reviews on a randomly selected sample of suppliers or providers who bill for items or services outside their regular scope of practice or assigned specialty.
    - Refer to the JHHP resources and guidelines for all of our health plans for additional information for Medical Record Standards Documentation.

V. MULTIPLE PROCEDURE INDICATOR (MPI)

1. The Multiple Procedure Indicator (MPI) indicates which payment adjustment rule for multiple procedures applies to the service(s) reported.
2. If the procedure is reported with other procedures that have an MPI of 2, the procedure is subject to the MPPR adjustment.
    a. Bill the procedure with the highest CMS PFS rate with modifier 51.
    b. Reimbursement for the procedure with modifier 51 will be 100% of the contracted rate; reimbursement for all subsequent procedures subject to the MPPR adjustment will be at 50% of the contracted rate.
3. If multiple procedures are assigned an MPI of 2 or 3, billed on the same claim, JHHP will apply the multiple endoscopic payment adjustment first, then the MPPR adjustment if applicable.
4. Billing expectations and reimbursement for modifier 51 are based on the procedure code's MPI found in the Medicare Physician Fee Schedule (MPFS).

Multiple Procedure Indicator	Definition
0	No payment adjustment rules for multiple procedures apply. If the procedure is reported on the same day as another procedure, base payment on the lower of: (a) the actual charge or (b) the fee schedule amount for the procedure.
1	Position another procedure with an indicator of 1,2, or 3, rank the procedures by fee schedule amount and apply the appropriate reduction to this code (100 percent, 50 percent, 25 percent, 25 percent, 25 percent, and by report). Base payment on the lower of: (a) the actual charge or (b) the fee schedule amount reduced by the appropriate percentage.

2	Standard payment adjustment rules for multiple procedures apply. If the procedure is reported on the same day as another procedure with an indicator of 1, 2, or 3, rank the procedures by fee schedule amount and apply the appropriate reduction to this code (100 percent, 50 percent, 50 percent, 50 percent, 50 percent, and by report). Base payment on the lower of: (a) the actual charge or (b) the fee schedule amount reduced by the appropriate percentage.
3	Special rules for multiple endoscopic procedures apply if procedure is billed with another endoscopy in the same family (i.e., another endoscopy that has the same base procedure). The base procedure for each code with this indicator is identified in the endoscopic base code field. • For endoscopy procedures in the same endoscopic family as defined by CMS, bill the endoscopic procedure with the highest CMS PFS rate with modifier 51. • The endoscopy procedure billed with modifier 51 will be paid at 100% of the contracted rate. • The subsequent endoscopy procedures will be paid the difference between their contracted rate and the contracted rate for the base endoscopy procedure (no payment will be made if a subsequent procedure is the base endoscopy procedure). • If the endoscopy procedures are not in the same endoscopic family, the multiple procedure payment adjustment applies. • Use the total payment for related endoscopies as one endoscopic procedure when ranking for the multiple procedure payment adjustment.

VI. INAPPROPRIATE BILLING OF MODIFIER 51

1. A procedure or surgical code with an MPI of 0, 1, or 9 should not be reported with modifier 51; if reported with this modifier, the claim line will be denied for incorrect coding.
2. Modifier 51 cannot be billed with Modifier 78.
3. Do not append modifier 51 when two or more physicians each perform distinctly, different, unrelated surgeries on the same day to the same patient.
4. Multiple approaches to the same procedure are mutually exclusive of one another and shall not be reported separately.
    - *For example, both a vaginal hysterectomy and abdominal hysterectomy shall not be reported separately.*
5. A HCPCS/CPT code describing the services performed shall be reported. A physician shall not report multiple codes corresponding to component services if a single comprehensive code describes the services performed. There are limited exceptions to this rule which are specifically identified in the NCCI manual maintained by CMS.

VII. EXCEPTIONS and EXCLUSIONS

1. **PPMCO:** Multiple surgical services or procedures are reimbursed in accordance to the Maryland Medicaid Administration Professional Services Provider Manual. Please consult the authoritative guidance found in the MDH and COMAR guiance to obtain additional specific information on policy, benefits, and coverage not addressed in this reimbursement policy.
   - JHHP requires all providers (i.e., ordering, referring, rendering, servicing, billing) delivering services to Maryland Medicaid members to have an active enrollment status in the electronic Provider Revalidation and Enrollment Portal (ePREP) on the date of service.
   - Claims submitted by individual providers, provider groups and facilities who are inactive or unregistered in ePREP will not be reimbursed.
   - Providers are solely responsible for ensuring their information in the ePREP portal is valid and active.
2. **USFHP:** JHHP will process and reimburse claims for multiple surgical services or procedures in accordance with TRICARE guidance. Please consult the authoritative guidance found in the TRICARE Manuals to obtain additional specific information on policy, benefits, and coverage not addressed in this reimbursement policy.

VIII. CODES, TERMS and DEFINITIONS

Term	Definition
Medically Unlikely Edit	An MUE is the maximum units of service (UOS) reported for a HCPCS/CPT code on the vast majority of appropriately reported claims by the same provider/ supplier for the same member on the same date of service.
Multiple Procedure Payment Reductions (MPPR)	The multiple procedure payment reduction (MPPR) methodology may apply to certain services (i.e., diagnostic imaging, endoscopic, cardiovascular, ophthalmology, select therapy, etc.) when multiple services are furnished by the same physician to the same patient in the same session on the same day.

National Correct Coding Initiative (NCCI) Program	CMS developed the National Correct Coding Initiative (NCCI) program to promote national correct coding methodologies and to control improper coding that leads to inappropriate payment of claims. The coding policies are based on coding conventions defined in the American Medical Association's Current Procedural Terminology (CPT) Professional, national and local Medicare policies and edits, coding guidelines developed by national societies, standard medical and surgical practice, and/or current coding practice. The NCCI program includes 3 types of edits: • NCCI Procedure-to-Procedure (PTP) edits • Medically Unlikely Edits (MUEs) • Add-on Code (AOC) Edits • Physician or Other Qualified Health Care Professional
Physician or Other Qualified Health Care Professional	A Physician or Other Qualified Health Care Professional is an individual who is qualified by education, training, licensure/regulation (when applicable), and facility privileging (when applicable) who performs a professional service within his/her scope of practice and independently reports that professional service.
Same Individual Physician or Qualified Health Care Professional	The same individual rendering health care services reporting the same Federal Tax Identification number.
Separate Procedure	If a CPT code descriptor includes the term “separate procedure,” the CPT code may not be reported separately with a related procedure. CMS interprets this designation to prohibit the separate reporting of a “separate procedure” when performed with another procedure in an anatomically related region often through the same skin incision, orifice, or surgical approach. A CPT code with the “separate procedure” designation may be reported with another procedure if it is performed at a separate patient encounter on the same date of service or at the same patient encounter in an anatomically unrelated area often through a separate skin incision, orifice, or surgical approach.

IX. REFERENCES

This policy has been developed through consideration of the following:

- COMAR- Maryland Department of Health- Maryland Medicaid Administration

- CPT Copyright American Medical Association. All rights reserved. CPT® is a registered trademark of the American Medical Association
- Johns Hopkins Health Plans Reimbursement Policies
- Medicare Claims Processing Manual Chapter 12 - Physicians/Nonphysician Practitioners
- Medicare Claims Processing Manual CH. 26- Completing and Processing Form CMS-1500 Data Set
- NCCI Policy Manual for Medicaid
- NCCI Policy Manual for Medicare
- TRICARE Manuals

X. APPROVALS

Date	Review/Revision	Reason for Modification	Approved By
10/15/2024	Revision	Policy formatting, language updated, and references updated	Reimbursement Policy Committee (RPC)
6/20/2022	Review	Policy language and guidance updated	Reimbursement Policy Committee (RPC)
8/01/2020	Review	Policy language and guidance updated	Reimbursement Policy Committee (RPC)