ACTION

☒ New Policy
☐ Repealed Policy Date: _____
☐ Superseded Policy Number: _____

The most current version of the reimbursement policies can be found on www.jhhc.com.

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 Johns Hopkins HealthCare (JHHC) 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 must be billed with ICD-10 codes, 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, Johns Hopkins HealthCare (JHHC) may:

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

JHHC reimbursement policies are developed based on nationally accepted industry standards and coding principles. These policies may be superseded by mandates in provider, state or commercial client contracts, or state, federal or CMS contracts and/or requirements.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, JHHC strives to minimize these variations.

JHHC reserves the right to review and revise our policies periodically when necessary. When there is an update, we will publish the most current policy on www.jhhc.com.

POLICY:

Johns Hopkins HealthCare LLC recognizes, and allows reimbursement for modifiers 58, 78 and 79, when billed with global surgery codes appropriately and correctly. Inappropriate, or incorrect use of the modifiers will result in denial of the surgery.

SCOPE:

This payment policy applies to procedure within the global surgical period, reported with modifiers 58, 78, or 79 on CMS-1500 claim forms or its electronic equivalent.

DEFINITIONS:

Modifier 58 - applies to a procedure performed during the postoperative period that was planned or anticipated (**staged**), more extensive than the original procedure (**related**), or therapeutic following a diagnostic procedure (related). The procedure must be performed by the same physician as in the operating session that initiated the global period. Appending modifier 58 breaks the global period of the initial procedure and resets the global period based on the procedure modifier 58 has been appended to.

Modifier 78 - applies to a procedure in the postoperative period that requires a return to the operating room to treat a problem or complication of a procedure performed during the operating session that initiated the global period. This procedure must be unplanned. The term operating room includes a cardiac catheterization suite, a laser suite, and an endoscopy suite.

Modifier 79 - applies to a procedure in the postoperative period that requires a return to the operating room to treat a problem or complication **unrelated** to the procedures performed during the operating session that initiated the global period. This procedure must be unplanned. The term operating room includes a cardiac catheterization suite, a laser suite, and an endoscopy suite.

PROVIDER BILLING GUIDELINES & PAYMENT METHODOLOGY:

Modifiers 58, 78, and 79 are only applicable for procedure codes with a global days indicator of 010 or 090. The modifiers are mutually exclusive to one another; only one of these modifiers may be applied to a procedure performed within a postoperative global period.

Appropriately billed procedures with Modifier 78 will be paid at 85% of the contracted rate. Modifiers 58 and 79 will be paid at 100% of the contracted rate.

When another modifier that reduces the fee schedule amount is also applicable, Modifiers 58, 78, and 79 must be reported in the secondary position. Their respective payment adjustment will be applied after the payment reduction indicated by the modifier in the primary position. (Ex: Modifier 1 = 51 and Modifier 2 = 78 will result in reimbursement at 50% of the contracted rate then 85% of the reduced rate)

JHHC does not base reimbursement upon medical documentation review, but medical documentation must be available upon request to support the use of the modifier. Documentation should include, but is not limited to, the operative reports for the original surgery and the reason for the subsequent procedure.

EXCLUSIONS

This policy does not apply to AdvantageMD.

EXEMPTIONS

N/A

REFERENCES:

CMS, Medicare Claims Processing Manual, Chap. 12, Sect. 40.2, A. 5, 6, and 7

CMS, MLN, Global Surgery Booklet, ICN 907166 September 2018

APPROVALS

Reimbursement Policy Committee Date: 7/6/2020

Review/Revision Dates: 6/16/2020