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 These policies may be superseded by mandates in provider, state or commercial client contracts, or state, federal or CMS contracts and/or requirements.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:

It is the policy of Johns Hopkins HealthCare (JHHC) to allow reimbursement of bilateral procedures reported with modifier 50 by the Same Individual Physician or other Qualified Health Care Professional during the same session, and surgical codes appended with split care modifiers 54, 55, or 56; unless provider, State, Federal or CMS contracts and/or requirements indicate otherwise.
SCOPE:

This policy applies to all products and all network and non-network physicians and other qualified health care professionals, including, but not limited to, non-network authorized and percent of charge contract physicians and other qualified health care professionals.

DEFINITIONS:

Accredited Practitioner/Physician - for the purpose of this policy, refers to providers who are not an excluded, nor opt-out physician or practitioner, and who meet the criteria for participation outlined in the credentialing policy (see References; PCR.002)

Bilateral Procedure (Modifier 50) – A procedure which can be performed on both sides of the body during the same session.

Same Individual Physician or Other Qualified Health Care Professional – The same individual rendering health care services reporting the same Federal Tax Identification number.

Split Care – Occurs when a component of the surgical package is rendered by a physician other than the physician performing the surgical service:

- **Modifier 54** – Used to indicate that a surgeon performed only the surgical component of a global surgical package (i.e., another physician provides postoperative care).
- **Modifier 55** – Used to indicate that a physician other than the surgeon performed only the postoperative management component of a global surgical package.
- **Modifier 56** – Used to indicate that a physician other than the surgeon performed only the preoperative evaluation component of a global surgical package.

Surgical Package – A Surgical Package includes the following services in addition to the procedure:

- Visits after the decision for a procedure is made beginning with the day before the procedure for a major procedure and the day of the procedure for all others;
- Services that are normally a usual and necessary part of a procedure;
- Complications Following the Procedure - All additional medical or surgical services required during the postoperative period because of complications which do not require additional trips to the operating room;
- Postoperative Visits - Follow-up visits during the postoperative period that are related to recovery;
- Post-procedure Pain Management;
- Supplies - Except for those identified as exclusions; and
- Miscellaneous Services - Items such as dressing changes; local incisional care; removal of operative pack; removal of cutaneous sutures and staples, lines, wires, tubes, drains, casts, and splints; insertion, irrigation and removal of urinary catheters, routine peripheral intravenous lines, nasogastric and rectal tubes; and changes and removal of tracheostomy tubes.
PAYMENT METHODOLOGY

Bilateral Procedures - Modifier 50

JHHC will reimburse 150% of the fee schedule, contracted, or negotiated rate (allowed amount) of the procedure when the procedure is submitted as directed below. Any other variation may result in denial or underpayment of the claim.

- Submit the procedure on two claim lines. The modifier must be included, and on the second line only. Surgical and non-surgical codes should be listed with one unit, on each line. The first claim line will process at 100% of the allowed amount, and the second line at 50% of the allowed amount; for a total of 150% on the procedure.
- CPT and HCPCS procedure codes defined as “bilateral” or “unilateral or bilateral” in their intent or written description will not be reimbursed when submitted with the modifier 50, as the code is inclusive of the bilateral procedure (see References for CMS, MLN for further information).
- Modifier 50 should not be used with HCPCS modifiers RT and LT. If the CPT code descriptor indicates a bilateral procedure (and there is not CPT code for unilateral procedure), and the procedure was only performed on one side, it is appropriate to use HCPCS modifiers RT or LT with modifier 52 (Reduced Services). RT and LT may be used without modifier 50 but not in addition to modifier 50.

Split-Care Modifiers – 54, 55, and 56

Reimbursement is based on a percentage of the fee schedule, contracted, or negotiated rate (allowed amount) for the surgical procedure. The percentage will not exceed 100% of the total global surgical allowed amount and is determined by which modifier is appended to the procedure code:

<table>
<thead>
<tr>
<th>Modifier</th>
<th>Description</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>54</td>
<td>Surgical Care Only</td>
<td>70%</td>
</tr>
<tr>
<td>55</td>
<td>Postoperative Management Only</td>
<td>20%</td>
</tr>
<tr>
<td>56</td>
<td>Preoperative Management Only</td>
<td>10%</td>
</tr>
<tr>
<td></td>
<td>TOTAL:</td>
<td>100%</td>
</tr>
</tbody>
</table>

The global surgical package consists of preoperative services, surgical procedures, and postoperative services. Total reimbursement for a global surgical package is the same regardless of how the billing is split between the different physicians involved in the member's care. When more than one physician performs services that are included in the global surgical package, the
total amount reimbursed for all physicians may not be higher than what would have been paid if a single physician provided all services.

Correct coding guidelines require that the same surgical procedure code (with the appropriate modifier) be used by each physician to identify the services provided when the components of a global surgical package are performed by different physicians.

Claims received with split-care modifiers after a global surgical claim have been paid will be denied.

When an assistant surgeon is used and/or multiple procedures are performed, assistant surgeon and/or multiple procedure rules and fee reductions apply.

EXCLUSIONS
N/A

EXEMPTIONS

The following lines of business do not allow separate reimbursement for Modifier 56:

- Priority Partners
- Hopkins Health Advantage

REFERENCES: This policy has been developed through consideration of the following:

JHHC Credentialing Policy PCR.002 - Criteria for Practitioner Participation

TRICARE Reimbursement Manual 6010.61-M, April 1, 2015, Chapt.1, Sect.16 - Surgery

CMS, MLN Matters Article SE1422 Revised, January 17, 2018: Medically Unlikely Edits (MUE) and Bilateral Surgical Procedures

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

Pub.100-04, Medicare Claims Processing Manual, Chapt.12, Sect.40, Surgeons and Global Surgery

Maryland Medical Assistance Program, 2019 Professional Services Provider Manual
Subject: Bilateral and Split-Care Procedures
Department: Provider Relations
Lines of Business: EHP, USFHP, PPMCO, and AdvantageMD