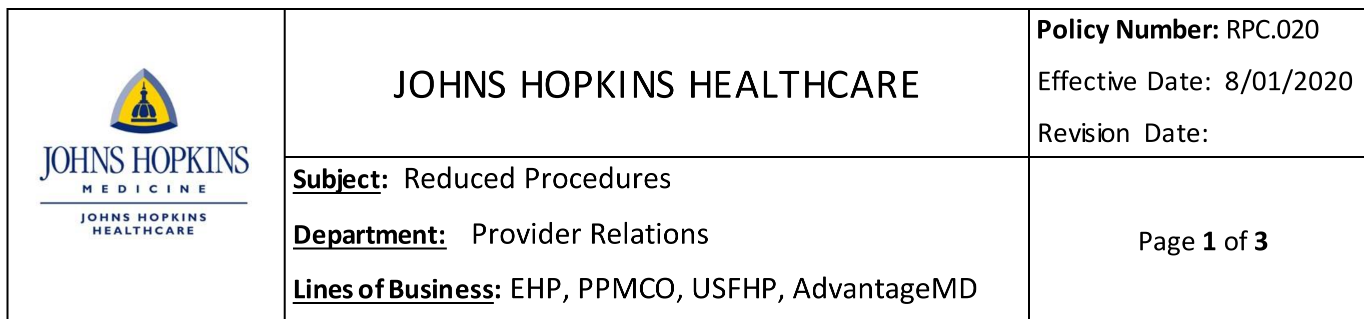

JOHNS HOPKINS MEDICINE JOHNS HOPKINS HEALTHCARE	JOHNS HOPKINS HEALTHCARE	**Policy Number:** RPC.020 Effective Date: 8/01/2020 Revision Date:
	Subject: Reduced Procedures **Department:** Provider Relations **Lines of Business:** EHP, PPMCO, USFHP, AdvantageMD	Page **1** of **3**

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☐ Repealed Policy Date: _______________
☐ Superseded Policy Number: _______________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 These policies may be superseded by mandates in provider, state or commercial client contracts, or state, federal or CMS contracts and/or requirements.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 allows reimbursement for procedure(s) appended with modifier 52 at 50% of the allowable amount. Procedure codes for any other procedure not performed at all should not be additionally reported.

SCOPE:

This payment policy applies to reduced procedures, reported with modifier 52 on CMS-1500 claim forms or its electronic equivalent.

DEFINITIONS:

Modifier 52 – used to indicate partial reduction, cancellation, or discontinuation of services for which anesthesia is not planned. The modifier provides a means for reporting reduced services without disturbing the identification of the basic service.

PROVIDER BILLING GUIDELINES & PAYMENT METHODOLOGY:

When a reduced procedure occurs, it is billed to JHHC by attaching Modifier 52 to the procedure code. If the portion of the procedure that was completed can be represented by another procedure code, JHHC expects the provider to bill for the applicable procedure code instead of billing Modifier 52.

Modifier 52 does not apply to evaluation and management (E/M) codes or the elective cancellation of a procedure prior to the member's anesthesia induction. Elective cancellations include the member not showing, the member's noncompliance, the member deciding not to have the procedure, or rescheduling initiated by either the facility or the member.

JHHC will reimburse appropriately billed reduced services at 50% of the contracted rate (base rate for time based codes).

When another modifier that reduces the fee schedule amount is also applicable, modifier 52 must be reported in the secondary position. Modifier 52's payment reduction will be applied after the payment reduction indicated by the modifier in the primary position. (Ex: Modifier 1 = 80 and Modifier 2 = 52 will result in reimbursement at 20% of the contracted rate then 50% of the reduced rate)

JHHC does not base reimbursement upon medical documentation, but medical documentation must be available upon request to support the use of the modifier.

Documentation should include, but is not limited to, indication if the procedure was discontinued before anesthesia, scope of the procedure code performed, and percent of procedure performed (supported in detail).

EXCLUSIONS

N/A

EXEMPTIONS

N/A

REFERENCES:

CMS, Medicare Claims Processing Manual (Pub. 100-4), Chap. 4, Sect. 20.6.4

CMS, Medicare Claims Processing Manual (Pub. 100-4). Chap.14, Sect. 40.4

Tricare Reimbursement Policy Manual 6010.61-M, April 1, 2015, Chap 13 Sect 3 - Discounting of Surgical and Terminating Procedures, 3.1.5.2.2.1 and 3.1.5.2.2.2

APPROVALS

Reimbursement Policy Committee Date: 7/6/2020

Review/Revision Dates: 6/16/2020