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☐ Repealed Policy Date: _____
☐ Superseded Policy Number: _____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 These policies may be superseded by mandates in provider, state or commercial client contracts, or state, federal or CMS contracts and/or requirements.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 modifier 51, for the purpose of distinguishing between multiple procedures performed on the same date of service, by the same provider.

SCOPE:

This payment policy applies to subsequent medical or surgical procedures, reported with modifier 51 on CMS-1500 claim forms or its electronic equivalent.

DEFINITIONS:

Modifier 51 – applied when there were multiple surgeries performed on the same day, during the same surgical session.

PROVIDER BILLING GUIDELINES:

Modifier 51 applies when a member receives multiple medical or surgical procedures on the same day, by the same physician and/or qualified health care professional during the same encounter. To account for overlap of the pre-procedure and post-procedure work, secondary and subsequent procedures may be subject to a payment reduction. In alignment with the Centers for Medicare and Medicaid Services (CMS), procedure codes that are subject to the multiple procedure payment reduction have a multiple procedure indicator of 2 or 3 as found in the CMS Physician Fee Schedule.

Billing expectations and reimbursement for modifier 51 is based on the procedure code's multiple procedure indicator found in the CMS Physician Fee Schedule:

1. *Multiple Procedure Indicator 0, 1, or 9*: the procedure should not be reported with modifier 51; if reported with this modifier, the claim line will be denied for incorrect coding

2. *Multiple Procedure Indicator 2*: if the procedure is reported with other procedures that have a multiple procedure indicator of 2, the procedure is subject to the multiple procedure payment adjustment
    a. Bill the procedure with the highest CMS Physician Fee Schedule 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

multiple procedure payment adjustment will be at 50% of the contracted rate

3. *Multiple Procedure Indicator 3 (Endoscopy)*: if multiple procedure codes with indicators 2 and/or 3 are billed on the same claim, apply the multiple endoscopic payment adjustment first, then the multiple procedure payment adjustment if applicable
    a. For endoscopy procedures in the same endoscopic family as defined by CMS, bill the endoscopic procedure with the highest CMS Physician Fee Schedule rate with modifier 51
        i. The endoscopy procedure billed with modifier 51 will be paid at 100% of the contracted rate
        ii. 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)
    b. If the endoscopy procedures are not in the same endoscopic family, the multiple procedure payment adjustment applies
    c. Use the total payment for related endoscopies as one endoscopic procedure when ranking for the multiple procedure payment adjustment

Modifier 51 cannot be billed with Modifier 78. When Modifier 51 is billed with Modifiers 62, 66, 80, 81, 82, or AS, the multiple procedure payment reduction will be applied to each modifier grouping (all claims lines with Modifier 80 will be ranked for the multiple procedure payment adjustment).

EXCLUSIONS

N/A

EXEMPTIONS

N/A

REFERENCES:

CMS, Medicare Claims Processing Manual, Pub. 100-04, Chap. 12, Sect. 40.6 - Claims for Multiple Surgeries

Tricare Reimbursement Manual 6010.61-M, April 1, 2015, Chap 1 Sect 16-Surgery, 3.1.1.1

Maryland Medical Assistance Program, 2020 Professional Services Provider Manual

APPROVALS

Reimbursement Policy Committee Date: 7/6/2020

Review/Revision Dates: 6/16/2020