JOHNS HOPKINS HEALTH PLANS	Johns Hopkins Health Plans **Provider Relations and Network Innovation Reimbursement Policy**	*Policy Number*	RPC.004
		Effective Date	12/30/2023
		Approval Date	09/27/2023
	Subject **National Provider Identifier (NPI)**	*Supersedes Date*	10/01/2016
		Original Date	12/30/2023
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This document applies to the following Participating Organizations:

Advantage MD EHP Priority Partners US Family Health Plan

Keywords: NPI, Ordering Provider, Referring Provider, Servicing Provider, Tax Identification Number

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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. Unless otherwise noted within the policy, our policies apply to both participating and nonparticipating providers and facilities.

JHHP policies apply to all providers (e.g., practitioners, hospitals, suppliers, non-physician providers, etc.) 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

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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

In compliance with the National Provider Identifier Regulation (published in the Federal Register on January 23, 2004), JHHP requires a health care provider who is a "covered entity", as defined in the HIPAA Regulations as specified by 45 Code of Federal Regulations (C.F.R.) § 162.923(c)), to report their the National Provider Identifier (NPI) for all administrative and financial transactions adopted under HIPAA.

III. POLICY STATMENT

Claims submitted to JHHP must be billed in accordance with state laws, regulatory requirements, CMS billing guidelines, provider contracts, and JHHP administrative guides and reimbursement policies. As such, JHHP requires any person or organization that furnishes, bills, or is paid for health care in the normal course of business, regardless of whether they conduct transactions electronically or on paper or conduct any covered transactions, to include their NPI on the claim form.

IV. BILLING GUIDELINES AND PAYMENT METHODOLOGY

A. There are two types of health care providers in terms of NPIs (Type 1 and Type 2). JHHP requires providers to report the appropriate NPI on the claim.
B. HIPAA covered entities must share their NPI with other providers, health plans, clearinghouses, and any entity that may need it for billing purposes.
C. In accordance with federal regulations, health care providers who transmit health information in connection with any standard transaction are required to report their NPI on the claim, even if they use business associates, such as billing agencies, to prepare the transactions.
D. JHHP requires that the NPI be used on all claims submitted to the health plan, to identify the ordering provider, the referring provider, and/or prescriber in ordered for claim to be processed.
E. Providers not using the appropriate NPI will receive a denied claim due to not billing in compliance with HIPAA regulations.
F. NPIs registered with JHHP and match the information on our Provider files. Claims received without a registered NPI and Tax Identification Number (TIN) may be delayed or rejected.
G. When medical students, interns or residents who render or bill for services, prescribe medications for patients, refer patients to other health care providers, or order test for patients from other health care providers, must identify themselves as the ordering, rendering or referring provider on the claim.
H. Business associates of a covered entity are indirectly required to comply with HIPAA Administrative Simplification requirements. As such, a covered entity is responsible for the noncompliance of its business associate where the business associate does not comply.

V. EXCEPTIONS

N/A

VI. EXCLUSIONS

N/A

VII. CODES, TERMS and DEFINITIONS

Term	Definition
Business Associate(s)	A business associate is defined at 45 C.F.R. § 160.103 and generally includes any person, including a partnership, corporation, or other public or private entity, that functions or functions or activities related to electronic transactions adopted under HIPAA or provides certain other listed services to a covered entity. Members of a covered entity's workforce are not business associates.
Covered Entity	In accordance with CMS, a covered entity is defined at 45 C.F.R. § 160.103 as a health plan, healthcare clearinghouse, or a healthcare provider who transmits any health information in electronic form in connection with a transaction for which a standard has been adopted. Under 45 C.F.R. § 162.923(c), covered entities may use a business associate, including a health care clearinghouse, to conduct a transaction covered by this part. If a covered entity chooses to use a business associate to conduct all or part of a transaction on behalf of the covered entity, the covered entity must require the business associate to do the following: (1) comply with all applicable requirements of this part and (2) require any agent or subcontractor to comply with all applicable requirements of this part.
Health Insurance Portability and Accountability Act of 1996 (HIPAA)	HIPAA is a federal law that required the creation of national standards to protect sensitive patient health information from being disclosed without the patient's consent or knowledge. The US Department of Health and Human Services (HHS) issued the HIPAA Privacy Rule to implement the requirements of HIPAA.
National Provider Identifier (NPI)	The NPI is a HIPAA Administrative Simplification Standard. The NPI is a unique identification number for covered health care providers. Covered health care providers and all health plans and health care clearinghouses must use the NPIs in the administrative and financial transactions adopted under HIPAA. The NPI is a 10-position, intelligence-free numeric identifier (10-digit number). This means that the numbers do not carry other information about healthcare providers, such as the state in which they live or their medical specialty. The NPI must be used in lieu of legacy provider identifiers in the HIPAA standards transactions.

National Provider Identifier (NPI) Type 1	NPI Type 1 (one)- healthcare providers who are individuals, including physicians, dentists, and all sole proprietors. An individual is eligible for only one NPI.
National Provider Identifier (NPI) Type 2	NPI Type 2 (two)- health care providers who are organizations, including physician groups, hospitals, nursing homes, and the corporation formed when an individual incorporates him/herself. Organizations must determine if they have “subparts” that need to be uniquely identified in HIPAA standard transactions with their own NPIs. A subpart is a component of an organization healthcare provider that furnishes healthcare and is not itself a separate legal entity.
Standard Transaction(s)	A transaction is an electronic exchange of information between two parties to carry out financial or administrative activities related to health care. Under HIPAA, certain standard transactions for the electronic exchange of healthcare data. These transactions include (but not limited to): • Payment and remittance advice • Claims status • Coordination of benefits • Claims and encounter information • Enrollment and disenrollment • Referrals and authorizations • Premium payment HIPAA covered entities who conduct any of these transactions electronically must use an adopted standard from ASC X12N or NCPDP (for certain pharmacy transactions).

VIII. REFERENCES

This policy has been developed through consideration of the following:

- COMAR- Maryland Department of Health- Maryland Medicaid Administration
- Code of Federal Regulations (C.F.R.)
- CPT Copyright American Medical Association. All rights reserved. CPT® is a registered trademark of the American Medical Association
- Health Insurance Portability and Accountability Act of 1996 (HIPAA)
- National Plan and Provider Enumeration System (NPPES)
- National Provider Identifier Standard (NPI) website.
- TRICARE Manuals

IX. REVISION HISTORY

Date	Review or Revision	Reason for Modification	Approved By

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9/27/2023	Revision	Updated policy language & references. Added Terms, Codes, and Definitions section.	Reimbursement Policy Committee (RPC)