JOHNS HOPKINS HEALTH PLANS	Johns Hopkins Health Plans **Provider Relations and Network Innovation Reimbursement Policy**	*Policy Number*	RPC.028
		Effective Date	10/11/2024
		Approval Date	10/11/2024
	Subject **Supply Codes, Professional**	*Supersedes Date*	05/01/2021
		Original Date	N/A
		Page	1 of 5

This document applies to the following Participating Organizations:

EHP | Johns Hopkins Advantage MD | Priority Partners | US Family Health Plan

Keywords: Supplies

Table of Contents		Page Number
I.	ABOUT OUR REIMBURSEMENT POLICIES	1
II.	PURPOSE	2
III.	POLICY STATMENT	2
IV.	GENERAL BILLING GUIDELINES AND PAYMENT METHODOLOGY	2
V.	EXCEPTIONS and EXCLUSIONS	3
VI.	CODES, TERMS and DEFINITIONS	3
VII.	REFERENCES	4
VIII.	APPROVALS	4

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. Issues related to inconsistent, missing, conflicting, or unclear documentation must be resolved by the provider submitting the claim. If a corrected claim is filed, it must comply with timely filing to be reprocessed through the claims system. Corrected claims are for administrative errors on the claim (i.e., misspelled name, CPT/HCPCS code transposed, wrong DOB, missing modifier, etc.). Intentionally changing the CPT/HCPCS or diagnosis code in order to get the claim paid, after the billed service was denied, is not a correction. The medical records must match the services billed. Unless otherwise noted within the policy, our policies apply to both participating and nonparticipating providers and facilities.

JHHP policies apply to all practitioners, hospitals, providers, or suppliers 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

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

The purpose of this policy is to provide basic guidance on the appropriate reimbursement of supplies provided on the same day as an associated Evaluation and Management (E/M) visit or medical/surgical procedure. JHHP aligns with CMS and incorporates the cost of supplies into the relative value units (RVUs) of E/M services and procedures performed in a non-facility setting, rendered by network and non-network providers, who submit claims on a CMS-1500, or its electronic equivalent. When required, prior authorization must be obtained by the supplier/provider, prior to submitting the claim to JHHP for reimbursement. However, authorization does not guarantee payment as providers/suppliers must bill all covered items and/ or services within the provider's scope of practice, and in accordance with the members' covered plan benefits, and under state and federal law.

III. POLICY STATMENT

This policy is applicable to all supplies and surgical trays reported on CMS-1500 claim forms or its electronic equivalent, to a JHHC product, submitted by network and non-network physicians, providers, and suppliers. JHHP will align with regulatory, state and federal guidance to process claims as applicable to the member's plan. Each line of business possesses its own unique contract and guidelines for benefit and payment purposes. As such, there could be various factors that may impact reimbursement, including but not limited to legislative mandates, provider contracts, and/or the member's benefit coverage, prior authorization, including provisions addressing services rendered by non-participating providers, which may supplement, modify, or supersede this policy.

*Providers are responsible to review the **"EXCEPTIONS & EXCLUSIONS" Sections** below for specific plan guidance, as some guidelines in this policy may not be applicable to all health plans/products.*

IV. GENERAL BILLING GUIDELINES AND PAYMENT METHODOLOGY

1. There are a number of services/supplies that are covered and assigned a CPT/HCPCS code, but they are items or services for which JHHP will bundle payment into the payment for other related services. If JHHP receives a claim that is solely for a service or supply that must be mandatorily bundled, the claim for payment will be denied.
2. JHHP will utilize NCCI and MUE edits to process professional claims for supplies billed by providers/suppliers. When applicable, supplies and services reported for the same encounter will be bundled in alignment with CPT and CMS guidelines
   - Refer to the JHHP NCCI and MUE Edits Reimbursement Policy for additional guidance.
3. The appropriate modifier must be appended to the applicable CPT/HCPCS code and assigned in the correct modifier position, in order for the claim to be processed. Modifiers that are reported incorrectly and/or are missing, may cause a delay in processing or a denial of payment.
4. In alignment with CMS guidance, separate payment is never made for routinely bundled services and supplies. Routine supplies are not separately reimbursed and therefore are included in the general cost of the procedure or office visit, respectively.

5. Prior authorization and/or referral may be required for certain items/services. The billing provider is responsible to obtain the applicable referral and/or authorization prior to submitting the claim to JHHP for reimbursement, or the claim may be denied.
6. The appropriate diagnosis code(s) is required to be used and reported at the highest number of characters available and to the highest level of specificity documented in the medical record, to support the item/service billed.
    - When ICD-10 codes are submitted incorrectly or when an inappropriate diagnosis is pointed to or linked as primary on the claim form, JHHP will deny the associated claim line.
7. JHHP may conduct medical record documentation reviews on a randomly selected sample of suppliers or providers who bill for items or services outside their regular scope of practice or assigned specialty.
    - Refer to the JHHP resources and guidelines for all of our health plans for additional information for Medical Record Standards Documentation.

V. EXCEPTIONS and EXCLUSIONS

1. **PPMCO:** Routine items/supplies/services are reimbursed in accordance to the Maryland Medicaid Administration Professional Services Provider Manual. Please consult the authoritative guidance found in the MDH and COMAR guiance to obtain additional specific information on policy, benefits, and coverage not addressed in this reimbursement policy.
    - JHHP requires all providers (i.e., ordering, referring, rendering, servicing, billing) delivering services to Maryland Medicaid members to have an active enrollment status in the electronic Provider Revalidation and Enrollment Portal (ePREP) on the date of service.
    - Claims submitted by individual providers, provider groups and facilities who are inactive or unregistered in ePREP will not be reimbursed.
    - Providers are solely responsible for ensuring their information in the ePREP portal is valid and active.
2. **USFHP:** JHHP will process and reimburse routine items/supplies/service claims in accordance with TRICARE guidance. Please consult the authoritative guidance found in the TRICARE Manuals to obtain additional specific information on policy, benefits, and coverage not addressed in this reimbursement policy.

VI. CODES, TERMS and DEFINITIONS

Term	Definition
Evaluation and Management (E/M) Services	Per the CPT manual, E/M services (CPT 99202-99499) guidelines have sections that are common to all E/M categories and sections that are category specific. These guidelines are to be used by the reporting physician or other qualified healthcare Professional to select the appropriate level of service. The E/M section of the CPT® manual is divided into broad categories and further divided into sub-categories of E/M services.
Medically Unlikely Edit	An MUE is the maximum units of service (UOS) reported for a HCPCS/CPT code on the vast majority of appropriately reported claims by the same provider/ supplier for the same member on the same date of service.

National Correct Coding Initiative (NCCI) Program	CMS developed the National Correct Coding Initiative (NCCI) program to promote national correct coding methodologies and to control improper coding that leads to inappropriate payment of claims. The coding policies are based on coding conventions defined in the American Medical Association's Current Procedural Terminology (CPT) Professional, national and local Medicare policies and edits, coding guidelines developed by national societies, standard medical and surgical practice, and/or current coding practice. The NCCI program includes 3 types of edits: • NCCI Procedure-to-Procedure (PTP) edits • Medically Unlikely Edits (MUEs) • Add-on Code (AOC) Edits • Physician or Other Qualified Health Care Professional
Physician or Other Qualified Health Care Professional	A Physician or Other Qualified Health Care Professional is an individual who is qualified by education, training, licensure/regulation (when applicable), and facility privileging (when applicable) who performs a professional service within his/her scope of practice and independently reports that professional service.
Same Individual Physician or Qualified Health Care Professional	The same individual rendering health care services reporting the same Federal Tax Identification number.

VII. REFERENCES

This policy has been developed through consideration of the following:

- COMAR- Maryland Department of Health- Maryland Medicaid Administration
- CPT Copyright American Medical Association. All rights reserved. CPT® is a registered trademark of the American Medical Association
- Johns Hopkins Health Plans Reimbursement Policies
- Medicare Claims Processing Manual Chapter 12 - Physicians/Nonphysician Practitioners
- Medicare Benefit Policy Manual CH.15– Covered Medical and Other Health Services
- Medicare Claims Processing Manual CH. 26- Completing and Processing Form CMS-1500 Data Set
- NCCI Policy Manual for Medicaid
- NCCI Policy Manual for Medicare
- TRICARE Manuals

VIII. APPROVALS

Date	Review/Revision	Reason for Modification	Approved By

JOHNS HOPKINS HEALTH PLANS	Johns Hopkins Health Plans **Provider Relations and Network Innovation Reimbursement Policy**	*Policy Number*	RPC.028
		Effective Date	10/11/2024
		Approval Date	10/11/2024
	Subject **Supply Codes, Professional**	*Supersedes Date*	05/01/2021
		Original Date	N/A
		Page	5 of 5

10/11/2024	Revision	Policy formatting, language updated, and references updated	Reimbursement Policy Committee (RPC)
4/01/2021	Review	Policy language and guidance updated	Reimbursement Policy Committee (RPC)
10/26/2020	Review	Policy language and guidance updated	Reimbursement Policy Committee (RPC)