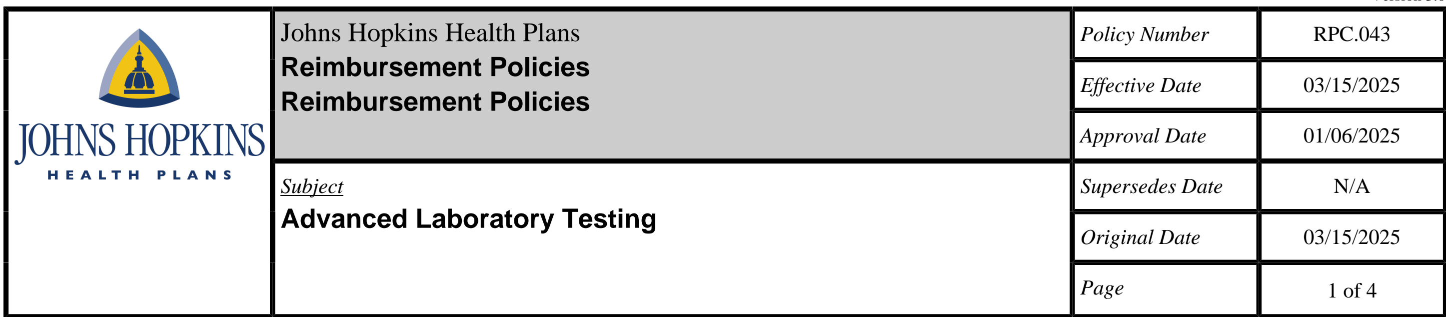

Johns Hopkins Health Plans **Reimbursement Policies** **Reimbursement Policies**	*Policy Number*	RPC.043
	Effective Date	03/15/2025
	Approval Date	01/06/2025
Subject **Advanced Laboratory Testing**	*Supersedes Date*	N/A
	Original Date	03/15/2025
	Page	1 of 4

This document applies to the following Participating Organizations:

EHP   Johns Hopkins Advantage MD   Priority Partners   US Family Health Plan

Keywords: Biomarker Tests, Genetic Testing, Molecular Pathology, Molecular Proprietary Laboratory Analyses (PLA)

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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. 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

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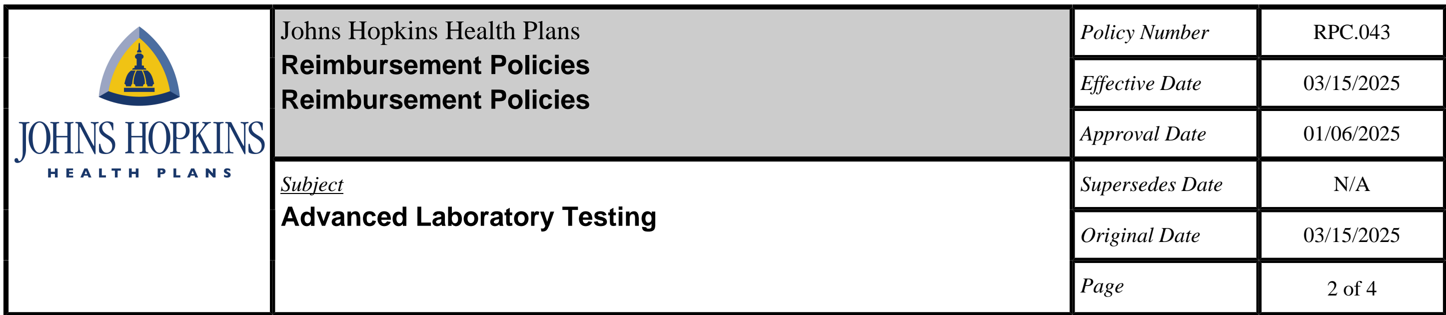

mandates in provider or state contracts, or state, federal or CMS contracts and/or requirements. If appropriate, when coding/ billing guidelines or current reimbursement policies are not followed, JHHP may:

- 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

JHHP allows for reimbursement of covered advanced laboratory testing (e.g., biomarker testing, molecular pathology, genetic testing, etc.), when billed in accordance with the member's applicable plan and coverage criteria, on the date of service. This policy applies to both participating and nonparticipating providers, who submit claims to JHHP on a CMS-1500 claim forms or UB-04 or their electronic equivalents.

III. POLICY STATMENT

This policy provides basic reimbursement guidance on the appropriate reporting of advanced laboratory testing services that are within the provider's scope of practice, under state and federal law. Each line of business possesses its own unique guidelines for benefit and payment purposes. As such, JHHP will align with regulatory, state and federal guidance to identify physician and non-physician services that are eligible as reimbursable or non-reimbursable, as applicable to the member's plan.

*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. BILLING GUIDELINES AND PAYMENT METHODOLOGY

1. Many benefit plans limit coverage of advanced laboratory testing and procedures, including (but not limited to):
   i. Biomarker Tests
   ii. Cytogenetics
   iii. Genetic testing
   iv. Molecular Cytopathology Procedures (Flow Cytometry, In Situ Hybridization)
   v. Molecular pathology tests
   vi. Molecular Multianalyte Assays with Algorithmic Analyses (MAAA)
   vii. Molecular Proprietary Laboratory Analyses (PLA)
   viii. Cytogenetics

Please refer to the applicable benefit plan language to determine benefit availability and terms, conditions and limitations of coverage for these services.

2. The physician who treats a patient may only order lab tests for a specific medical problem. Documentation in the patient's medical record must support the medical necessity for each test ordered. JHHP will not reimburse for laboratory tests **not** specifically ordered by the physician.
3. Providers are responsible to verify coverage and benefits, or if a prior authorization or other requirements are mandatory, prior to services being rendered. Authorizations are not a guarantee of payment.
4. JHHP plans may conduct medical record documentation reviews on a randomly selected sample of primary care practitioners or providers who deliver services outside their regular scope of practice or assigned specialty.

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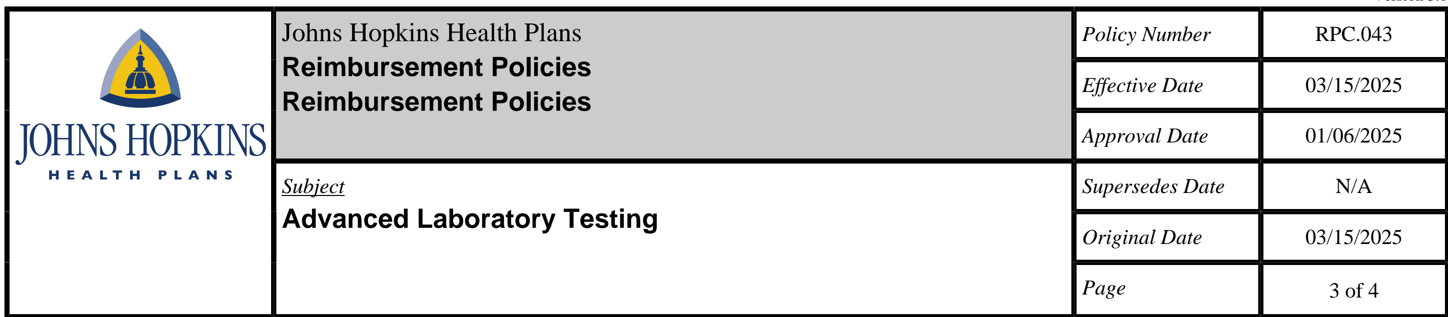

   i. Refer to the JHHP resources and guidelines for all of our health plans for additional information for Medical Record Standards Documentation.

5. JHHP may use an outside vendor, such as *EviCore by Evernorth* to manage certain laboratory services, authorizations, as well as utilizing their clinical guidelines.
   i. Once per pregnancy or Once in a Lifetime (OIL) tests and/or procedures are not limited to a single CPT code, but may be represented by Code Families, which are a group of CPT codes that describe the same or similar type of service.
6. In accordance with CMS guidelines, cooperation among ordering and referring providers and facilities that perform laboratory tests is important to reducing errors and avoiding claim denials. As such, laboratories submitting claims to JHHP for reimbursement are responsible for obtaining supporting documentation, which clearly establishes medical necessity for each test or treatment requested by the ordering, referring, and/or servicing provider.
   i. Evidence must provide relevant, sufficient and detailed information to understand the individual's current clinical status that establishes medical necessity for the request.
   ii. All documentation must be maintained in the patient's medical record and made available to JHHP upon request.
7. Laboratory tests determined to be experimental, investigational, or unproven (E/I/U) by JHHP are not eligible for reimbursement.
8. This policy is cross-supported by other JHHP Reimbursement Policies.

V. EXCLUSIONS and EXEMPTIONS

PPMCO: JHHP will process claims submitted for Advanced Laboratory Testing, and will reimburse in accordance to the Code of Maryland Regulations (COMAR) and Maryland Department of Health (MDH). Please consult the authoritative guidance found in these manuals to obtain additional, specific information on policy, benefits, and coverage not outlined in this 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.
- Providers are solely responsible for ensuring their information in the ePREP portal is valid and active.

USFHP: JHHP will process and reimburse Advanced Laboratory Testing 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 outlined in this policy. Please refer to the following information for additional guidance: TRICARE Laboratory Developed Tests and TRICARE Genetic Testing And Counseling.

VI. CODES, TERMS and DEFINITIONS

Definition of Terms

Term	Definition
Medically Unlikely Edit (MUE)	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.
Same Group Physician and/or Other Qualified Health Care Professional	All physicians and/or other qualified health care professionals of the same group who report with the same Federal Tax Identification Number (TIN).

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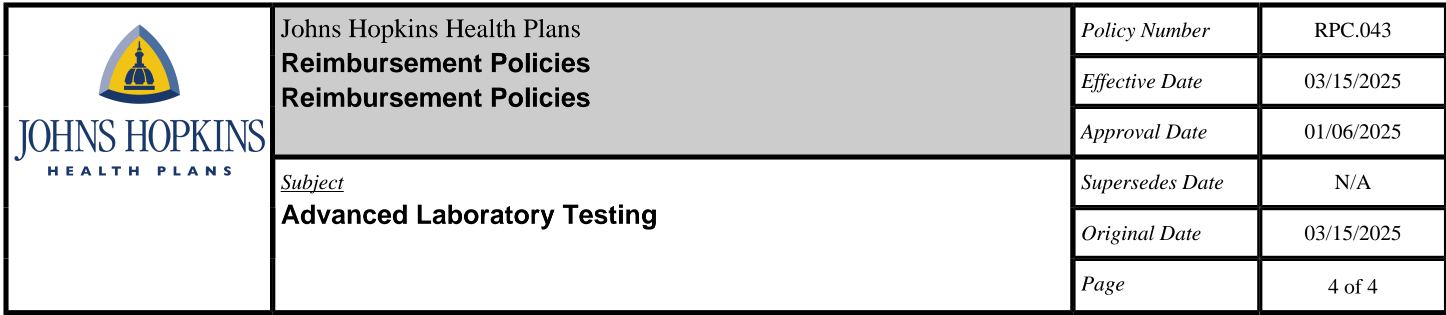

Scope of Practice	Scope of practice refers to those activities that a person licensed to practice as a health professional is permitted to perform, which is increasingly determined by statutes enacted by state legislatures and by rules adopted by the appropriate licensing entity.

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
- Maryland Medicaid Professional Services Provider Manual
- Medicare Claims Processing Manual CH. 1 - General Billing Requirements
- Medicare Claims Processing Manual CH. 12- Physicians/Nonphysician Practitioners
- Medicare Claims Processing Manual CH. 23- Fee Schedule Administration and Coding Requirements
- Medicare Physician Fee Schedule Data Base (MPFSDB)
- MLN909221 – Complying with Documentation Requirements for Lab Services
- NCCI for Medicare | CMS
- TRICARE Laboratory Developed Tests
- TRICARE Operations Manual
- TRICARE Genetic Testing And Counseling
- TRICARE Reimbursement Manual

VIII. APPROVALS

Date	Review/Revision	Reason For Modification	Approved By
1/06/2025	New	New policy	Reimbursement, Authorization and Coding Committee (RAC)

IX. POLICY NOTIFICATION CHART

	Yes/No	If yes in 2nd column, notify the following department of policy revisions:
Does this policy relate to NCQA?	No	Quality Improvement
Does this policy relate to Qlarant/MDH requirements?	No	Quality Improvement
Does this policy relate to DHA contractual requirements?	No	USFHP Administration

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