JOHNS HOPKINS HEALTH PLANS	Johns Hopkins Health Plans **Reimbursement Policies** **Reimbursement Policies**	*Policy Number*	RPC.045
		Effective Date	03/15/2025
		Approval Date	01/06/2025
	Subject **Once In a Lifetime Procedures and Services**	*Supersedes Date*	N/A
		Original Date	03/15/2025
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This document applies to the following Participating Organizations:

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

Keywords: Genetic Testing, Once In a Lifetime

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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

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 for certain services, procedures, tests, and/or items, which can only be performed or rendered only once in a patient's lifetime. Claims billed with a code(s) identified by JHHP as a Once In a Lifetime (OIL) procedure or service will not be reimbursed more than once, even if reported by one or more physicians or other qualified healthcare professional(s). Due to changes in CMS and State guidance, and provider contracts, other codes may be applicable; in rare situations, certain exceptions may be applied.

III. POLICY STATMENT

This policy provides basic reimbursement guidance on the appropriate reporting of Once In a Lifetime (OIL) services or procedures that are within the provider's scope of practice, under state and federal law. Once in a Lifetime procedures/services, by the nature of their description and human anatomy, can be performed only once in a patient's lifetime. 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. This policy limits the frequency of reimbursement for certain items, tests, services and/or procedures identified by JHHP which can only be performed and/or reported or reimbursed, only once, during a patient's lifetime. OIL claims are subject to review.

- **Example**: *When an organ (e.g., eye[s], kidney[s], appendix, spleen) is removed from the body, it is necessary to report the appropriate CPT code to accurately describe the procedure that was performed (e.g., splenectomy, appendectomy). These types of procedures can only be performed once during a patient's lifetime.*

2. OIL services and procedures are not limited to a single CPT/HCPCS code, as they may also be represented by "Code Families", which are a group of CPT/HCPCS codes that describe the same or similar type of service. The CPT Professional contains groups of codes describing different approaches or methods to accomplish similar results. These codes are generally mutually exclusive of one another.

- **Example of Code Families:** *CPT codes 45110-45123 describe different proctectomy procedures and are mutually exclusive of one another. Other examples include groups of CPT codes for colectomy (44140-44160), gastrectomy (43620-43635), pancreatectomy (48140-48155), Appendectomy (44950, 44955, 44960, 44970), Circumcision (54150, 54160, 54161), Laryngectomy (31360 and 31365), and Splenectomy (38100 and 38102).*

3. Providers are responsible for verifying coverage and benefits, or if prior authorization or other requirements are mandatory, prior to services being rendered. Authorizations are not a guarantee of payment.

4. In accordance with CMS guidelines, providers are required to report the appropriate anatomic modifier with an OIL procedure code. Missing modifiers or the use of an inconsistent modifier may cause the claim to be processed incorrectly or denied.
   i. OIL services and procedures reported with certain modifiers may also be subject to payment reductions. Refer to JHHP Reimbursement policies for additional guidance.
5. When modifiers 53, 55, 56, or 58 are appended to the OIL procedure claim line, for a different date of service, whether the same code or a different code from the same Code Family, the claim will be reviewed for separate payment eligibility.
6. JHHP encourages cooperation among providers and facilities that perform OIL procedures or services for the same member, as it is important to reduce errors and avoid claim denials. The provider submitting the claim must resolve any issues related to inconsistent, missing, conflicting, or unclear documentation.
   - Evidence must provide relevant, sufficient and detailed information to understand the individual's current clinical status that establishes medical necessity for the service/procedure.
   - All documentation must be maintained in the patient's medical record and made available to JHHP upon request.
   - JHHP plans may conduct medical record documentation reviews on a randomly selected sample of providers who deliver services outside their regular scope of practice or assigned specialty.
7. JHHP reserves the right to deny certain OIL procedures or services determined to be experimental, investigational, or unproven (E/I/U). E/I/U services and procedures are not eligible for reimbursement.
8. JHHP will utilize the "first in, first out" payment methodology, when multiple providers bill for the same OIL service or procedure, for the same member.

V. EXCLUSIONS and EXEMPTIONS

PPMCO: JHHP will process claims submitted for OIL procedures and services, and will reimburse in accordance with 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 OIL 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.

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).
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