 JOHNS HOPKINS <small>HEALTH PLANS</small>	Johns Hopkins Health Plans Reimbursement Policies Reimbursement Policies	<i>Policy Number</i>	RPC.049
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This document applies to the following Participating Organizations:

Johns Hopkins Advantage MD

Johns Hopkins Employer Health
Programs, Inc. (EHP)

Johns Hopkins Medical Services
Corporation (USFHP)

Priority Partners Managed Care
Organization, Inc.

Keywords: Administrative, Coding, HSCRC, Reimbursement

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I. PURPOSE

As part of our commitment to transparency, [Johns Hopkins Health Plan Reimbursement policies](#) are publicly accessible and include the criteria and supporting information used in payment determinations. This document provides a general overview of the administrative framework used to develop our reimbursement policies that support our Medical Policies, Provider Manuals, and other organizational guidelines. Our reimbursement policies are not intended to affect quality of care or interfere with medical decision-making, as providers are expected to exercise independent clinical judgment when delivering care to our members. Each Line of Business (LOB), including Commercial, Medicaid, Medicare Advantage, and others, is governed by a multi-tiered structure of regulatory authorities and contractual obligations, which may take precedence over specific guidance found in our reimbursement policies. These policies may also be superseded by specific provisions within a provider's contract that outline an agreed-upon alternative reimbursement arrangement.

II. GOVERNING PRINCIPLES FOR REIMBURSEMENT POLICIES

This section outlines the governing principles which may apply to our reimbursement policies. They are designed to reflect standard industry practices and ensure regulatory compliance. This list is provided for reference purposes only and does not imply a formal hierarchy, nor is it exhaustive.

- Adherence to Contractual Terms and Agreements
- Billing and Coding Accuracy
- Compliance with State and Federal Regulatory Guidelines, Mandates, and Regulations
- Documentation Requirements
- Fraud, Waste, and Abuse Prevention
- LOB Authoritative Guidance (e.g., CMS, TRICARE, Medicaid)


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- Medical Necessity
- Plan Benefit Adherence
- Prior Authorization (PA)
- Program Payment Integrity (PI)
- Utilization Management (UM)

III. GENERAL GUIDANCE FOR REIMBURSEMENT OF SERVICES

This section provides a general overview of the foundational principles and administrative standards that may influence how Johns Hopkins Health Plans (JHHP) processes and reimburses healthcare services. It outlines how payment policies can impact reimbursement for items and/or services submitted on a CMS-1500, UB-04 (CMS-1450), or their electronic equivalents.

1. Reimbursement policy guidance is generally based on factors unrelated to medical necessity.
2. Coverage under a member's benefit plan does not guarantee reimbursement; services must also meet other applicable requirements (e.g., authorization, site-of-service, medical necessity) on the date of service.
3. It is our standard practice to apply pre-payment edits, post-payment algorithms, and utilize other claim editing software to review or process claims and validate payments. Additionally, we may engage an external vendor or their designee to conduct audits of services rendered to our members.
4. Claims must accurately reflect the items and services provided to our members, and be fully supported by the patient's medical record. JHHP may request medical records, itemized bills, invoices, or other documentation before or after payment is issued.
 - Documentation requirements are compiled from: State and federal statutes, Code of Federal Regulations (CFR), CMS rulings and sub-regulatory guidance (CMS manuals), NCCI, and CMS Durable Medical Equipment (DME) guidance.
5. When applicable, JHHP will reimburse items or services that align with the Medicare Coverage Database or the member's plan guidance, including but not limited to:
 - Local Coverage Articles (LCA)
 - Local Coverage Determinations (LCD)
 - National Coverage Analyses (NCA)
 - National Coverage Determinations (NCD)
 - CMS Medicare Administrative Contractor (MAC) publications
6. Some items or services may be subjected to frequency editing logic (e.g., first in/first out, once in a lifetime, every 30 days). These measures are implemented to help mitigate erroneous or duplicative billing that may arise when identical or similar services are submitted within a defined timeframe by the same or different provider.
7. For Maryland waiver hospitals and other applicable provider sites, JHHP will process and pay claims in accordance with the Health Services Cost Review Commission (HSCRC) payment methodology.
8. Corrected claims are allowed for clerical errors (i.e., transposed characters, incorrect patient demographics, or other non-clinical mistakes) on the original claim submission.
 - Intentionally modifying clinical codes (e.g., CPT or diagnosis codes) to bypass claim edits or to retroactively meet medical necessity requirements, in order to obtain payment, is not allowed and may be considered fraudulent billing.
 - JHHP's definition of a "clerical error" is based on the definition outlined in [42 CFR 405.980\(a\)\(3\)](#) and this [CMS guidance](#).
 - Providers must address denials through the appropriate appeals process.
9. New or updated policies will be released on or after their effective date, on our website.
 - We reserve the right to update, clarify, or correct reimbursement policies at any time; updated versions will be released as needed.

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- Occasionally, issues or delays may occur in updating configuration, system logic, or implementing edits within the claims platform which can affect the timing and application of policy guidance. In such cases, claims will be reprocessed after payment to correct any resulting discrepancies.
10. Claims must always be submitted with an ICD-10-CM code (diagnosis code) that represents the reason the procedure was done. The diagnosis code must be billed to the highest level of specificity and linked to the appropriate procedure code.
 11. Institutional, outpatient claims must include both a revenue code and a corresponding CPT or HCPCS code.
 - Each revenue code must be correctly paired with a CPT or HCPCS code on every line item.
 12. The guidance outlined in this document also extends to claims when JHHP is not the primary payor but is either the secondary or tertiary payor.


IV. AUTHORITATIVE SOURCES FOR POLICY AND BILLING GUIDANCE

All reimbursement policies are developed with consideration of the following resources, listed below. When authoritative or applicable guidance is unavailable, we may defer to CMS guidelines or, when needed, make a business decision to uphold fairness, consistency, and appropriate payment. This list is provided for reference purposes only. It does not imply a formal hierarchy, may not apply to all lines of business, and is not intended to be all-inclusive:

- Affordable Care Act (ACA)
- American Medical Association (AMA)
- Centers for Medicare & Medicaid Services (CMS)
- Clinical Laboratory Improvement Amendments of 1988 (CLIA)
- Code of Federal Regulations (CFR)
- Code of Maryland Regulations (COMAR)
- Current Procedural Terminology (CPT) Manual (CPT® is a registered trademark of the American Medical Association)
- Defense Health Agency (DHA)
- Food and Drug Administration (FDA)
- Guidance issued by a professional medical association recognized by JHHP
- Health Insurance Portability and Accountability Act of 1996 (HIPAA)
- Health Services Cost Review Commission (HSCRC)
- International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM)
- JHHP Provider Manuals
- JHHP Medical Policies
- Maryland Department of Health (MDH) Medicaid Guidance
- Medicare Coverage Database (i.e., LCDs, LCAs, NCAs, NCDs)
- National Committee for Quality Assurance (NCQA)
- National Correct Coding Initiative (NCCI) program
- National Uniform Billing Committee (NUBC)
- National Uniform Claim Committee (NUCC)
- TRICARE
- Uniform Hospital Discharge Data Set (UHDDS)
- U.S. Department of Health and Human Services (HHS)

V. IMPROPER BILLING AND PAYMENT DENIALS

1. When a claim is denied due to these reasons (e.g., missing information, claim errors, or conflicts with industry standard billing and coding guidelines), it is classified as an administrative denial, and not a clinical or medical necessity denial.

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2. In certain situations, reimbursement may not be approved or provided for items or services (including related associated ancillary services and associated institutional costs) that are not covered or not payable under the applicable plan's benefits or its governed authoritative source, unless a specific exception applies or alternative coverage criteria are outlined in an organizational policy. This guidance applies to, but is not limited to, the following situations:
 - A. Items or services that are:
 - Considered experimental, investigational or unproven
 - Deemed not medically necessary
 - Ordered, rendered or billed by an unauthorized provider
 - Paid by other organizations or provided without charge (e.g., auto insurance, workers compensation, Veterans Affairs)
 - B. A non-covered: primary service or procedure, condition, diagnosis, or treatment
 - C. Billing for items or services outlined in the CMS publication "Items and Services Not Covered Under Medicare," may be excluded from payment, unless an explicit exception applies.
3. Claims submitted for reimbursement with missing or incomplete information may be denied.
4. In alignment with NCCI guidance, payment for a procedure, service, item, or supply that is considered inclusive (or bundled) within another item, procedure or service should neither be reported separately nor reimbursed separately.
5. Intentionally modifying clinical codes (e.g., CPT or diagnosis codes) to bypass claim edits or to retroactively meet medical necessity requirements, in order to obtain payment, is not allowed and may be considered fraudulent billing.

VI. REMINDER OF PROVIDER OBLIGATIONS

- A. Providers are expected to maintain responsibility for the following obligations to ensure that their claims are processed and reimbursed accurately and in a timely manner (list is not all-inclusive):
 1. Consult with their own medical billing and coding professionals for guidance on appropriate billing practices, accurate claim submission, and support with authorizations, appeals, redeterminations, and other related matters. JHHP does not assume responsibility for, nor is it obligated to provide coding or billing education, training, or advice to providers.
 2. Submitting a clean claim.
 3. Review and adhere to the guidance outlined in our [JHHP Provider Manual](#), regarding benefit eligibility, referral and preauthorization requirements, claims and appeals information, timely filing requirements, and other matters.
 4. Review and adhere to the guidance outlined in their contractual agreements, and our reimbursement policies, including the "Exceptions and Exclusions" section.
 5. Working directly with their EDI vendor or clearinghouse to ensure accurate configuration of all required claim fields, as defined by the health plan, recognizing that a direct one-to-one field mapping may not always be available.

VII. EXCEPTIONS and EXCLUSIONS

1. In the State of Maryland, reimbursement for hospital services by all payers classified as Maryland Waiver Hospitals are based upon the rates as established by the Health Services Cost Review Commission (HSCRC) (COMAR 10.09.06.09(A) (1)). Freestanding, non-hospital based ASC's in the state of Maryland are not covered under the Maryland state waiver.
2. **AdvantageMD:** JHHP processes and reimburses claims in accordance with CMS guidance. Please consult the authoritative guidance found on the CMS website and Medicare Manuals to obtain additional specific information on policy, benefits, and coverage not addressed in this document or in the applicable reimbursement policy.
3. **Priority Partners:** JHHP processes and reimburses claims in accordance with the Maryland Medicaid Administration Professional Services Provider Manual and COMAR guidance. Please refer to MDH and COMAR for additional guidance not addressed in this document or in the applicable reimbursement policy.

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4. **USFHP:** JHHP will process and reimburse 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 document or in the applicable reimbursement policy.


VIII. CODES, TERMS and DEFINITIONS

Term	Definition
Clerical Errors	<p>In accordance with CMS guidelines, as outlined in the Medicare Claims Processing Manual, Chapter 34, section 10.4- Reopening and Revision of Claim Determinations and Decisions, JHHP defines clerical errors (including minor errors or omissions) based on the definition provided in 42 CFR 405.980(a)(3) as human or mechanical errors made by the provider or other party, and may include:</p> <ul style="list-style-type: none"> • Mathematical or computational errors • Transposition of procedure or diagnosis codes • Inaccurate data entry • Misapplication of a fee schedule • Computer system errors • Denial of claims as duplicates when the provider believes they were incorrectly identified as such • Incorrect data elements, such as provider number, use of a modifier, or date of service <p>Note: Clerical errors or minor errors are limited to errors in form and content, and that omissions do not include failure to bill for certain items or services; third party payer errors do not constitute clerical errors.</p> <p>The law provides that reopenings may be done to correct minor errors or omissions, that is, clerical errors, and JHHP has discretion in determining what meets this definition and therefore, what could be corrected through a reopening.</p>

IX. REFERENCES

This policy has been developed through consideration of the following:

- Affordable Care Act (ACA)
- American Medical Association (AMA)
- Centers for Medicare & Medicaid Services (CMS)
- Clinical Laboratory Improvement Amendments of 1988 (CLIA)
- Code of Federal Regulations (CFR)
- Code of Maryland Regulations (COMAR)
- Current Procedural Terminology (CPT) Manual (CPT® is a registered trademark of the American Medical Association)

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- Defense Health Agency (DHA)
- Food and Drug Administration (FDA)
- Guidance issued by a professional medical association recognized by JHHP
- Health Insurance Portability and Accountability Act of 1996 (HIPAA)
- Health Services Cost Review Commission (HSCRC)
- International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM)
- JHHP Provider Manuals
- JHHP Medical Policies
- Maryland Department of Health (MDH) Medicaid Guidance
- Medicare Coverage Database (i.e., LCDs, LCAs, NCAs, NCDs)
- National Committee for Quality Assurance (NCQA)
- National Correct Coding Initiative (NCCI) program
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X. APPROVALS

Date	Review/Revision	Reason For Modification	Approved By
10/02/2025	N/A	New	Reimbursement, Authorization and Configuration (RAC) Committee