New and Updated Reimbursement Policies Provider Notification

The new and updated reimbursement policies listed below have been reviewed and approved by the Johns Hopkins Health Plans Reimbursement, Authorization, Coding and Configuration Committee (RAC). These updates and additions are effective as of **Dec. 12, 2026.**

The billing and coding guidance outlined in our reimbursement policies is applicable to both participating and non-participating providers, who report services on CMS-1500/837P and UB-04/837I claim forms, and those health plans specifically noted in the policy, unless an exception applies. Examples of applicable exceptions may include, but are not limited to, e.g., plan-specific mandates, prior authorization requirements, special contractual terms, unique benefit plan designs, etc.

Please note that the information below is not exhaustive of all applicable policy guidance; it is provided only as a general reference and serves only to summarize select key provisions of the policies. Full text copies of these policies will be available on or after the effective date on our website (JHHP Reimbursement Policies).

Providers are responsible for reviewing the plan's reimbursement policies for any billing or reporting requirements that differ from CMS, CPT, MDH, or TRICARE guidelines to avoid delays in claim processing or payment.

Reimbursement Policy	Key Points/Changes	Impacted Health Plans
Same Day Services (RCP.054)- New	To reduce improper payments, Johns Hopkins Health Plans will adjust, reduce, or deny payment when multiple, identical, same or similar services are billed for the same member on the same date of service and the claim is submitted without supporting documentation demonstrating that each service is distinct and separately identifiable, medically necessary, and independently covered. • This rule also applies when separate claims for the same or similar items or services are submitted for the same member on the same date of service by the same provider, or different provider of the same specialty, and contain identical or closely matching claim elements; in such cases, the plan will adjust, reduce, or deny payment if the services are suspected or determined to be unbundled, duplicative, repetitive, or overlapping. • The submission or acceptance of a claim or supporting documentation does not guarantee payment, as all claims	All, unless otherwise noted within the policy.

	remain subject to review for correct coding, coverage determination, and payment eligibility even after payment is made. **Example**: *When multiple E/M services are reported for a single patient on the same day by the same provider, payment will be adjusted, reduced, or denied if the claim is submitted without supporting documentation, regardless of the presence of modifier 25, as modifier 25 may not always be appropriate in situations such as reporting two E/M services when one is a per-day code or when a more comprehensive E/M code exists that accurately describes both services.*	
Laboratory Panel Testing (RPC.055) - New	When two or more single-test components that are included in a comprehensive laboratory panel are billed separately by the same provider on the same date of service, and their aggregate cost equals or exceeds the panel rate, reimbursement shall be limited to one unit of the most appropriate comprehensive panel code, per day, unless an exception applies. **Example**: *When any two or more of the single test codes (CPT 87491, 87591, and/or 87661) are separately reported for Sexually Transmitted Infections (STI) rendered by the same provider on the same date of service, payment will be limited to a single unit of 87801, regardless of the units billed for a single test code.* • All laboratory tests ordered on or performed on the same specimen shall be billed as if performed simultaneously. • In accordance with CMS, multiple tests to identify the same analyte, marker, or infectious agent shall not be reported separately. • Laboratory panel tests will be denied when reported with a diagnosis code for a non-covered condition. **Example**: *Payment will be denied when a claim is submitted for both a direct probe(s) and an amplified probe technique performed/billed on the same day by the same provider.*	All, unless otherwise noted within the policy.
Laboratory Services (RPC.034)- Updated	Policy guidelines have been updated to incorporate multiple billing and coding revisions that may affect reimbursement for certain services. These updates ensure continued alignment with regulatory requirements, industry standards, and organizational directives. Changes include, but are not limited to: • Policy template update • Enhanced policy language	All, unless otherwise noted within the policy.

	• Updates to billing and coding guidance in alignment with authoritative rules and regulations, applicable to the relevant health plan(s) • Updated lists, tables, references, and definitions within the policy • Removal of deleted codes and outdated guidance	