JOHNS HOPKINS HEALTH PLANS

PROVIDER NOTICE

Provider Relations Department: 888-895-4998 (Option 4)

New & Updated Reimbursement Policies

Effective Date: July 5, 2024

Health Plans Affected: Advantage MD, Employer Health Programs (EHP), Priority Partners, US Family Health Plan (USFHP)

Type of Change: Reimbursement

Explanation of Change:
John Hopkins Health Plans has updated and released new reimbursement policies.

Reminder: Each health plan 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, including provisions addressing services rendered by non-participating providers, which may supplement, modify, or supersede a policy. Johns Hopkins Health Plans 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.

(RPC.011) National Drug Code (NDC) Reporting – *New*

- Johns Hopkins Health Plans will now align with CMS, AMA CPT, and NCCI guidance for the appropriate reporting and reimbursement of NDC claims and their associated services.
- When applicable, all required information must be included on claim in order to be reimbursed. Claims submitted to Johns Hopkins Health Plans with missing or incomplete information (e.g., without the appropriate or required: modifier, number of units, NDC, HCPCS, etc.) will cause a delay in processing or for the claim to deny.
- A corresponding diagnosis and appropriate procedure code must accompany an NDC number to process the claim.
- When billing for oral anti-cancer drugs, the claim may be pended for review or denied, if the appropriate diagnosis code is not reported.
- When the member's plan benefits requires prior authorization for a certain drug, and an NDC is listed as part of the authorization, the NDC must match the authorized drug that was approved at the time of the member's precertification/authorization was issued. If the NDC number does not match the preapproved drug, the claim may be denied.
- Johns Hopkins Health Plans will now require providers to report the JW and JZ modifier on drugs and biologicals from single-dose containers or single-use packages, when applicable.
- Unlisted drugs and J-code drugs will be pended for review.
- **Priority Partners** - Providers who participate in the Vaccines For Children (VFC) program must append the SE modifier to the vaccine serum code or the code will be denied. In alignment

with Maryland state regulations, Johns Hopkins Health Plans pays on the serum code rather than the vaccine administration code.

(RPC.012) Durable Medical Equipment, Prosthetics, Orthotics and Services (DMEPOS) – *New*

- Johns Hopkins Health Plans will align with CMS billing guidance and reimbursement methodologies for DMEPOS, PEN items, surgical dressings, and therapeutic shoes.
- The use of anatomic modifiers may be necessary when DMEPOS claims are submitted to Johns Hopkins Health Plans for reimbursement.
- Requests for items that are custom-built for the patient to their physical specifications and/or a physician's prescription, are subject to medical review.
- Johns Hopkins Health Plans will cover oxygen equipment, supplies and accessories in alignment with CMS guidance.
- For certain items/services, Johns Hopkins Health Plans may utilize the Master List of DMEPOS Items*, maintained by CMS, which are subject to one or both of the following prior to delivery: 1) a face-to-face encounter and written order 2) prior authorization requirements.
- All claims billed to Johns Hopkins Health Plans for DMEPOS require a written order/prescription from the treating practitioner to be communicated to the supplier before submitting a claim for payment.
- Only physicians and certain types of non-physician practitioners are eligible to order or refer items or services for Johns Hopkins Health Plans members.
- Chiropractors are not permitted to prescribe DMEPOS items. All services or items ordered or referred by a chiropractor will be denied.

(RPC.007) Anesthesia Processing Guidelines – *Updated*

- Unless otherwise specified in this policy, minutes are to be reported on the claim for anesthesia services.
- Johns Hopkins Health Plans will deny claims when coding conflicts with NCCI edits.
- E/M examinations by anesthesia providers are not to be reported separately from the anesthesia time as these services are considered part of the anesthesia service.
- For interval time periods during which the patient does not require monitoring by an anesthesia practitioner, this time would not be included in the anesthesia time calculation. However, if it is medically necessary for the anesthesia practitioner to continuously monitor the patient during the interval time and not perform any other service, the interval time may be included in the anesthesia time, but must be clearly documented in the patient's medical record.
- All OB anesthesia services must be submitted using minutes. Providers are to report total minutes and start and stop times. Do not report base units.
- CPT code 01996 is separately payable on dates of service after surgery, but not on the date of surgery. NOTE: When billing CPT 01967 with CPT 01968, Johns Hopkins Health Plans will only allow one unit for the first hour for CPT 01967 and one unit for each subsequent hour for CPT 01967.
- In accordance with CMS reimbursement methodologies, status B codes are bundled into another procedure and are not eligible for separate reimbursement.
- Johns Hopkins Health Plans does not recognize "Qualifying Circumstances" when CPT codes 99100-99140 are billed; Johns Hopkins Health Plans will not allow additional units for physical status modifiers.
- **Priority Partners -** In accordance with MDH guidance, Johns Hopkins Health Plans does not reimburse anesthesia in the same way as Medicare. Providers are to refer to the Maryland Medicaid Administration Professional Services Provider Manual for additional billing guidance.
- **USFHP** - Johns Hopkins Health Plans will process and reimburse anesthesia 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.

(RPC.014) NCCI and MUE Edits – *Updated*

- Johns Hopkins Health Plans will deny claims when coding conflicts with NCCI edits.
- Providers who report a code with units greater than the MUE value assigned, the line and/or claim will deny.
- The KX modifier is used to show services for transgender, ambiguous genitalia, and intersex patients. If an NCCI gender-specific procedure edit conflict occurs, the KX modifier alerts Johns Hopkins Health Plans that it isn't an error and allows the claim to continue processing.
- Procedures shall be reported with the most comprehensive CPT code that describes the services performed. Providers/suppliers must not unbundle or separately report for services that can be described by a more appropriate HCPCS/CPT code.
- Maryland Waiver Providers are required to bill services in accordance to the Health Services Cost Review Commission (HSCRC) rules and regulations, and will be reimbursed under the HSCRC payment methodology.
- Policy language updated; Key Definitions, Background, Coding, and References sections updated; includes new tables with information on MAI and CCMI.

To view the Johns Hopkins Health Plans Reimbursement Policies, please go to: ***HopkinsHealthPlans.org > For Providers > Policies > Reimbursement Policies*.**

REFERENCES*:

- CMS Regulations & Guidance
- CMS Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS)
- CMS Transmittal 12183
- CMS MLN SE20007 - Standard Elements for DMEPOS Order, and Master List of DMEPOS Items Potentially Subject to a Face-to-Face Encounter and Written Orders Prior to Delivery and, or Prior Authorization Requirements
- COMAR- Maryland Department of Health- Maryland Medicaid Administration
- Maryland Medicaid DME/DMS/Oxygen Approved List of Items
- Maryland Medicaid Ordering, Referring, and Prescribing (ORP) Providers
- Medicare Benefit Policy Manual CH.15– Covered Medical and Other Health Services
- 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 Claims Processing Manual CH. 26- Completing and Processing Form CMS-1500 Data Set
- Medicare National Coverage Determinations (NCD) Manuals
- Medicare NCD 280.1- Durable Medical Equipment Reference List
- NCCI for Medicaid | CMS
- NCCI for Medicare | CMS
- TRICARE Manuals
- National Provider Identifier Standard (NPI) website

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