



## Select Johns Hopkins Health Plans Reimbursement Policies Effective Jan. 20, 2026

**Effective Date:** Jan. 20, 2026 and as otherwise noted

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

**Type of Change:** New and updated policies and policy reminders

**Explanation of Change:** Johns Hopkins Health Plans has developed new, and updated existing, reimbursement policies. In addition, we offer our providers some reminders of current policy guidance, as listed below:

### New and Updated Policies

#### EHP - Applied Behavior Analysis (RPC.003)

**Update Effective:** Jan. 20, 2026

Billing guidance for Applied Behavior Analysis (ABA) services for EHP, previously outlined in RPC.003, has now been separated into a standalone policy. This update is intended to provide clearer direction for claims submitted for ABA service reimbursement.

- ABA services are covered when the member has a confirmed autism spectrum disorder (ASD) diagnosis (F84.0–F84.9, except F84.2) and may only be billed with CPT codes 97151–97158, 0362T, and 0373T.
- Provider type modifiers (HO, HP, HN, HM) must be reported for each line of ABA service billed, to identify the provider types authorized to deliver and bill for the services, and ensure payment is made in accordance with EHP plan benefits.
- All ABA CPT codes listed above may be rendered as a telehealth service.
- Johns Hopkins Health Plans will not reimburse ABA services utilized to replace or replicate activities that are the responsibility of the setting and environment where services occur (e.g., classroom aide, 1:1 teacher, tutor, vocational assistant/coach, respite services).
- BCaBAs, RBTs and BTs rendering ABA services cannot directly bill the plan and receive reimbursement.
- The billing and rendering provider for each ABA service delivered must report their NPI and taxonomy on the claim form.

#### USFHP - Applied Behavior Analysis (RPC.004)

**Update Effective:** Jan. 20, 2026

Billing guidance for ABA services under USFHP, previously outlined in RPC.003, has now been

separated into a standalone policy. This change is intended to provide clearer direction for claims submitted for ABA service reimbursement, in alignment with TRICARE's Comprehensive Autism Care Demonstration (ACD) program.

- ABA services are only covered when the member has a confirmed diagnosis of F84.0, by an approved ASD diagnosing/referring provider.
- Refer to [TRICARE Operations Manual - Chapter 18](#) for the necessary certification requirements and documentation standards, to provide and report ABA services.
- ABA services may only be reported with CPT codes 97151, 97153, 97155-97158, and 99366, and 99368.
  - Psychological testing and assessment are reimbursable when all criteria are met by ACD program requirements.
- Provider type modifiers (HO, HP, HN, HM) must be reported for each line of ABA service billed, to identify the provider types authorized to deliver and bill for the services, and ensure payment is made in accordance with [TRICARE Applied Behavior Analysis Maximum Allowed Amounts](#).
  - BCaBAs, RBTs and BTs rendering ABA services cannot directly bill the plan and receive reimbursement.
- In alignment with ACD program guidelines, CPT 97151, 97153, 97155, 97157 and 97158 cannot be conducted via telehealth, unless an exception applies.
- The billing and rendering provider for each ABA service delivered must report their NPI and taxonomy on the claim form.

### **Device, Implant and Skin Substitute (RPC.051)**

**New Effective: Jan. 20, 2026**

This policy outlines the coding guidelines for the appropriate reporting of devices, implants, and skin substitutes, as well as their associated procedures. It also covers the required coding for devices or implants acquired by the provider at no cost or at a reduced cost.

- In alignment with the [US Food & Drug Administration \(FDA\)](#), JHHP defines an implant as a device that is placed into a surgically or naturally formed cavity of the human body and is intended to remain there for a period of 30 days or more, when applicable.
- For hospital outpatient claims, each line item reported for implants, devices, and skin substitutes must include the revenue code, CPT/HCPCS code, diagnosis, modifier (if applicable) and the codes must accurately align with the descriptions of the associated codes be considered for payment; all items must be reported on the same claim for the same date of service (DOS).
  - If multiple codes are needed to represent distinct or independent items, procedures, or services under the same revenue code, providers should repeat the revenue code accordingly.
- Consistent with CMS guidelines, low-cost skin substitute products may only be reported with low-cost skin substitute procedures, while high-cost skin substitute products may only be reported with high-cost skin substitute procedures; mismatching the product to the procedure will result in a denial.

- CMS is responsible for maintaining the skin substitute products for low-cost and high-cost group assignments.
- Payment for an implant, device, supply or service that is inclusive (or bundled) into another service, item or procedure, is not separately reimbursable.

## Reminders

**Applicable to all Johns Hopkins Health Plans Reimbursement Policies:** 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. 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. Each of our health plans follows a multi-tiered framework of regulatory and contractual obligations, which may take precedence over specific guidance found in our reimbursement policies.

**Scope of Practice (RPC.009) - Update for this policy has been postponed.** The current [Scope of Practice](#) policy that became effective on 12/30/2023, will remain in effect until further notice.

**Anatomic Modifiers (RPC.032) - Effective 9/15/2023:** As a reminder, failure to apply the correct anatomical modifier to a CPT/HCPCS code may result in an under/over payment of a claim, improper denials, incorrect procedure bundling or frequency limitations, and/or potentially unnecessary medical record review.

- In alignment with NCCI and CMS guidance, the plan requires providers to report the appropriate anatomic modifier(s) to certain items, procedures and/or services, including (but not limited to):
  - Durable Medical Equipment, prosthetics, and orthotics
  - Surgical services
  - Imaging services (i.e., Ultrasounds, Radiology, MRI, Scans, Mammography)
  - Diagnostic and therapeutic services
  - Coronary procedures
- Anatomical modifiers are required (when applicable), regardless of diagnosis code description, to ensure alignment with procedures and/or services rendered.
- Appropriate documentation, in the patient's record, must support all codes billed.
- Consistent with CMS, modifiers 59, XU, XS, XP, XE shall not be used in place of an anatomical modifier, or to override, NCCI Procedure to Procedure (PTP) edits.

## REFERENCES

- CMS Regulations & Guidance
- COMAR - Maryland Department of Health (MDH)
- eCFR: 21 CFR § 812.3 Definitions

- Johns Hopkins Health Plans Reimbursement Policies
- MDH - Transmittals (maryland.gov)
- MDH Provider Information Site
- MDH Professional Claims Billing Guidance (CMS 1500)
- MDH Institutional Claims Billing Guidance (UB-04)
- Medicare Claims Processing Manual, Chapter 12
- Medicare Claims Processing Manual Chapter 17-Drugs and Biologicals
- National Uniform Billing Committee (UB-04)
- National Uniform Claim Committee CMS-1500 Claim
- NCCI for Medicare | CMS
- NCCI for Medicaid | CMS
- Novitas Solutions - Medicare Administrative Contractor
- TRICARE Manuals
- US Food & Drug Administration (FDA)

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