JOHNS HOPKINS HEALTH PLANS	Johns Hopkins Health Plans **Provider Relations and Network Innovation Reimbursement Policy**	*Policy Number*	RPC.006
		Effective Date	02/01/2024
		Approval Date	11/29/2023
	Subject **Gap Fill Fee Schedule**	*Supersedes Date*	10/01/2016
		Original Date	N/A
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This document applies to the following Participating Organizations:

Advantage MD	EHP	Priority Partners	US Family Health Plan

Keywords: Fee Schedule, Gap Fill, Reimbursement

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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. Unless otherwise noted within the policy, our policies apply to both participating and nonparticipating providers and facilities.

JHHP policies apply to all providers (e.g., practitioners, hospitals, suppliers, non-physician providers, etc.) 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.

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II. PURPOSE

JHHP uses a process to establish fees called gap-filling. This policy is to provide general billing and reimbursement guidance for gap-filling. Gap-filling allows JHHP to establish a price for a covered service or item that aligns with the statutory requirements for each line of business, which possesses its own unique guidelines for benefit and payment purposes. JHHP will align with regulatory, state and federal guidance to identify services that are eligible as reimbursable or non-reimbursable, in accordance with the member's plan.

III. POLICY STATEMENT

JHHP aligns with CMS guidance for gap-filling billing and reimbursement methodologies, when applicable. In addition, JHHP will use industry standard pricing for covered items or services, for which fee schedule amounts are not established. This policy is applicable for both participating and nonparticipating providers, who submit claims to JHHP on a CMS-1500 or CMS-1450 or their electronic equivalents. Each line of business 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 this policy. In some instances, a prior authorization/referral may be required for certain types of care, items and services, but it is not a guarantee of payment. Providers are responsible for verifying the individual member's contract for specific plan benefits and to obtain prior authorization/reauthorization before an item, procedure or service is rendered.

*Providers are responsible for reviewing 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. A. JHHP first looks to identify comparable services or items for which a fee schedule amount already exists, as existing fee schedule amounts are based on average reasonable charges for items paid during the base year.
   B. When no fee schedule exists, JHHP determines whether a comparable CPT/HCPCS codes exists based on the purpose and features of the procedure, item device, nature of the technology, and other factors, and then applies that fee to the item or service.
   C. Providers shall report an item or service with the most comprehensive CPT/HCPCS code that describes the item or service performed and must not unbundle the code.
   D. Under certain circumstances, JHHP may utilize an industry standard gap-fill fee schedule methodology, at their discretion.
   E. Providers must ensure that the documentation in the patient's medical record supports the level of service(s) reported, or payment can be denied.
   F. Providers are responsible for obtaining prior authorization/reauthorization before services are rendered to a JHHP member. Additionally, providers are responsible for determining if a CPT/HCPCS code requires prior authorization/ reauthorization; an authorization is not a guarantee of payment.

V. EXCEPTIONS & EXCLUSIONS

1. A. Maryland Waiver Providers are required to bill items and services in accordance to the Health Services Cost Review Commission (HSCRC) rules and regulations, and will be reimbursed under the HSCRC payment methodology.

B. **AMD:** JHHP will process and reimburse claims in accordance with Medicare guidelines. Please consult the authoritative guidance found on the CMS website to obtain additional specific information on policy, benefits, and coverage.

C. **PPMCO:** JHHP will process and reimburse claims in accordance with Maryland Medicaid guidance. Please consult the authoritative guidance found in the Maryland Medicaid website to obtain additional specific information on policy, benefits, and coverage.

D. **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.

VI. 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
- Medicare Claims Processing Manual CH. 23 - Fee Schedule Administration and Coding Requirements
- TRICARE Reimbursement Manual

VII. APPROVALS

Date	Review/Revision	Reason for Modification	Approved By
11/29/2023	Revision	Policy format and language updated. Add AdvantageMD to policy.	Reimbursement Policy Committee (RPC)