JOHNS HOPKINS HEALTH PLANS	Johns Hopkins Health Plans **Provider Relations and Network Innovation Reimbursement Policy**	*Policy Number*	RPC.035
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This document applies to the following Participating Organizations:

EHP | Johns Hopkins Advantage MD | Priority Partners | US Family Health Plan

Keywords: DRG, HAC, High Dollar Claims, Inpatient, Present On Admission

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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. Issues related to inconsistent, missing, conflicting, or unclear documentation must be resolved by the provider submitting the claim. If a corrected claim is filed, it must comply with timely filing to be reprocessed through the claims system. Corrected claims are for administrative errors on the claim (i.e., misspelled name, CPT/HCPCS code transposed, wrong DOB, missing modifier, etc.). Intentionally changing the CPT/HCPCS or diagnosis code in order to get the claim paid, after the billed service was denied, is not a correction. The medical records must match the services billed. Unless otherwise noted within the policy, our policies apply to both participating and nonparticipating providers and facilities.

JHHP policies apply to all practitioners, hospitals, providers, or suppliers 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.

II. PURPOSE

Consistent with CMS and industry standards, JHHP will reimburse providers who appropriately bill for covered, inpatient facility services, based on the calculated Diagnosis Related Groups (DRGs) methodology, and in accordance with federal, state, local and regulatory law. DRG payment rates, created by CMS, are based on the "average" cost of resources used in treating patients under a specific DRG to deliver care to a patient with a particular disease or condition.

III. POLICY STATMENT

This policy applies to inpatient (as applicable) hospital services provided to members of JHHP, by all Acute Inpatient Prospective Payment (IPPS) providers not classified as a CMS exempt hospital/facility or a Maryland Waiver Hospital. 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)). Each line of business possesses its own unique guidelines for benefit and payment purposes. As such, there a 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.

*Providers are responsible to review 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. JHHP aligns with CMS and the National Uniform Billing Committee (NUBC) Official UB-04 Data Specifications Manual for the required codes and code descriptions to be entered in the various form locators (FL).
   - In some cases, JHHP may vary from CMS and NUBC guidelines when a specific field is required or how the data is to be entered in a specific field.
2. Consistent with CMS and NUBC, JHHP requires providers to complete all of the required information on the UB-04 and for each in the Form Locators (FLs) field. If the information submitted is missing, incomplete, or invalid, the claim will be denied.
3. JHHP requires an itemized bill for any facility claim with billed charges that are equal to or greater than $75,000. Facility claims totaling $75K or more submitted to JHHP without an itemized bill may be denied due to missing information.
   - JHHP will utilize claim-editing software to identify and capture the splitting of high dollar claims submitted by the same provider.
4. To ensure that billed items or services are covered and are reasonable and necessary, JHHP may pend claims and conduct a review to prevent improper payment to providers.

5. As supported by Section 1815(a) and Section 1833(e) of the Social Security Act, Section 422.214(a)(2) of Title 42 of the Code of Federal Regulations (CFR), contract provisions and other relevant guidance, JHHP reserves the right to request itemized bills in order to confirm proper billing, prior to payment, when necessary. Any improper billing may result in payment reduction or denial for specific charges.
6. When applicable, JHHP will reimburse valid claims on the calculated DRG weight, only.
7. For patient readmission and Leave of Absence (LOA), JHHP will process claims based on CMS readmission guidelines and criteria.
8. When a member is readmitted as part of a planned readmission and/or placed on a leave of absence, to the same facility for the same, similar, or related condition, the admissions are considered to be one admission, and only one DRG will be reimbursed, unless the provider's contract states otherwise.
9. When the patient is on an LOA, the provider may not bill for the days of leave. If the patient does not return from an LOA, regardless of the reason, submit a discharge bill with the date of discharge as the date the patient actually left/began their LOA.
10. In accordance with CMS guidelines, all claims must include the discharge status code that most accurately reflects the discharge of the patient. The discharging facility is required to report the discharge disposition in the “Patient Discharge Status” field (FL 17), when discharging a patient from an inpatient stay.
11. A patient cannot be an inpatient of two institutions at the same time. When this happens, JHHP will follow the “first in, first out” logic and the subsequent claim will be denied.
12. All inpatient transfer/discharge bills from both PPS and non-PPS facilities, including those from waiver States, long-term care facilities, and excluded units will be classified by the Grouper software program into the most appropriate DRG.
13. To bill for patient transfers between IPPS hospitals and other institutions, please refer to the Medicare Claims Processing Manual Chapter 3 - Inpatient Hospital Billing, for additional instructions.

V. PRESENT ON ADMISSION (POA)

Consistent with CMS a Present on Admission (POA) Indicator reporting is mandatory for all claims involving inpatient admissions to general acute care hospitals or other facilities.

1. Refer to the UB-04, also known as the CMS-1450, Data Specifications Manual and the ICD-10-CM Official Guidelines for Coding and Reporting to facilitate the assignment of the POA indicator for each "principal" diagnosis and "other" diagnoses codes reported on claim forms UB-04 and 837 Institutional.

2. Providers shall ensure that any resequencing of diagnosis codes prior to claims submission to JHHP also includes a resequencing of the POA Indicators.

3. Issues related to inconsistent, missing, conflicting, or unclear documentation must be resolved by the provider.

4. Maryland Waiver Hospitals must report the POA indicator on all claims

VI. HOSPITAL ACQUIRED CONDITIONS (HAC) and HEALTHCARE ASSOCIATED INFECTIONS (HAI)

1. In accordance with Federal law and CMS regulations, JHHP is required to identify at least two conditions that are (a) high cost or high volume or both, (b) result in the assignment of a case to a DRG that has a higher payment when present as a secondary diagnosis, and (c) could reasonably have been prevented through the application of evidence based guidelines. As such, CMS identified 14 categories of conditions that were selected for the CMS HAC payment provisions.
2. JHHP follows CMS billing, coding and payment guidance for all claims identified as HAC/HAI.

3. CMS can revise the list of conditions from time to time, so providers are responsible to check the CMS ICD-10 HAC List for updated information.
4. Consistent with CMS, a POA Indicator for all diagnoses reported on claims involving inpatient admissions to general acute care hospitals.
5. Hospitals will not receive additional payment for cases in which one of the selected HAC/HAI was not present on admission. That is, the case would be paid as though the secondary diagnosis were not present.
6. Please refer to the JHHP Non-Payment of Preventable Adverse Events (PAE) policy for additional billing guidance.

VII. ICD–10 CM CODING

A. ????JHHP has edits in place to capture inappropriate diagnosis coding combinations which identifies ICD-10-CM diagnosis codes that are mutually exclusive and cannot be reported together.
B. Consistent with ICD-10 CM and UHDDS guidance, the circumstances of inpatient admission always govern the selection of principal diagnosis.
C. Diagnosis codes are to be used and reported at their highest number of characters available and to the highest level of specificity documented in the medical record.
D. When ICD-10 codes are submitted incorrectly or when an inappropriate diagnosis is pointed to or linked as primary on the claim form, JHHP may deny the associated claim line.
E. ICD-10-CM guidelines that denote mutually exclusive codes, representing two conditions that cannot be reported together, will be denied. Providers are to report codes in alignment with the Excludes 1 or Excludes 2 guidelines when submitting claims.
   - For certain conditions, the ICD-10-CM has a coding convention that requires the underlying condition be sequenced first, if applicable, followed by the manifestation. Wherever such a combination exists, there are instructional notes to indicate the proper sequencing order of the codes.
F. Claims with the diagnosis code reported in the incorrect sequence will be denied.
G. Certain Z codes may only be used as first-listed or principal diagnosis.
H. Certain Z codes are so non-specific, or potentially redundant with other codes in the classification, that there can be little justification for their use in the inpatient setting.
I. Corresponding procedure code must accompany a Z code to describe any procedure performed.

VIII. EXCEPTION & EXCLUSIONS

I. **EXCLUSIONS:**
   A. Maryland hospitals are exempt from DRG payment reductions. These hospitals have an agreement with CMS and the state of Maryland.
   B. Those hospitals and hospital unit identified by CMS, such as the following, are exempt from reporting the POA Indicator and are exempt from HAC/HAI Payment Reductions:
      - Critical access hospitals (CAH)
      - Rehabilitation hospitals and units
      - Long-term care (LTC) hospitals
      - Psychiatric hospitals and units
      - Children’s hospitals
      - Prospective Payment System-exempt cancer hospitals
      - Veterans Affairs (VA) hospitals
      - Short-term acute care hospitals located in U.S. territories (Guam, Puerto Rico, the U.S. Virgin Islands, the Northern Mariana Islands, and American Samoa)

- Religious nonmedical health care institutions

C. **USFHP**: Refer to the TRICARE Reimbursement Manual for TRICARE Hospital Reimbursement- DRG-Based Payment System and Methodologies.

II. **EXCEPTIONS:**

1. Maryland Waiver Providers are to bill inpatient services in accordance to the HSCRC rules and regulations and will be reimbursed under the HSCRC payment methodology.
2. **PPMCO:** JHHP will process and reimburse claims in accordance with Maryland Medicaid Administration reimbursement guidance.
3. **USFHP**: Refer to the TRICARE Manuals for TRICARE Hospital Reimbursement and DRG-Based Payment System and Methodologies.

IX. CODES, TERMS and DEFINITION

Definition of Terms

Term	Definition
837I	The 837I (Institutional) is the standard format used by institutional providers to transmit health care claims electronically.
CMS-1450	The CMS-1450, also known as the UB-04, is the standard claim form to bill facility claims when a paper claim is allowed. CMS allows providers to bill using a paper claim when the providers fulfill the Administrative Simplification Compliance Act (ASCA) exception to electronic claims provisions.
Diagnosis-Related Group (DRG)	Each DRG has a payment weight assigned to it, based on the average resources used to treat patients in that DRG.
Hospital Acquired Conditions (HAC)	HACs are conditions that a patient develops while in the hospital being treated for something else. These conditions cause harm to patients.
Healthcare Associated Infections (HAI)	HAIs, also known as healthcare-associated infections, are nosocomially acquired infections that are not present or incubating at the time of admission to a hospital. These infections are usually acquired after hospitalization.

Institutional Providers	In accordance with CMS, Institutional Providers include: • Hospitals • Skilled Nursing Facilities (SNFs) • End Stage Renal Disease (ESRD) providers • Home Health Agencies (HHAs) • Hospice Organizations • Outpatient Physical Therapy/Occupational Therapy/ Speech Pathology Services • Comprehensive Outpatient Rehabilitation Facilities (CORFs) • Community Mental Health Centers (CMHCs) • Critical Access Hospitals (CAHs) • Federally Qualified Health Centers (FQHCs) • Histocompatibility Laboratories • Indian Health Service (IHS) Facilities • Organ Procurement Organizations • Religious Non-Medical Health Care Institutions (RNHCIs) • Rural Health Clinics (RHCs)
Inpatient Prospective Payment System (IPPS)	A system of payment for operating costs of acute care hospital inpatient stays based on prospectively set rates. Under IPPS, each case is categorized into a diagnosis-related group (DRG). Each DRG has a payment weight assigned to it, based on the average resources used to treat patients in that DRG.
IPPS Transfers Between Hospitals	A discharge of a hospital inpatient is considered to be a transfer if the patient is admitted the same day to another hospital. A transfer between acute inpatient hospitals occurs when a patient is admitted to a hospital and is subsequently transferred from the hospital where the patient was admitted to another hospital for additional treatment once the patient's condition has stabilized or a diagnosis established.
Leave of Absence (LOA)	Hospitals may place a patient on a LOA when readmission is expected and the patient does not require a hospital level of care during the interim period.

Medicare Severity Diagnosis Related Groups (MS-DRGs)	MS-DRGs are a patient classification system which provides a means of relating types of patients a hospital treats (i.e., its case mix) to the costs incurred by the hospital. Payment for inpatient hospital services is made on the basis of a rate per discharge that varies according to the MS-DRG to which a member's stay is assigned. All inpatient transfer/discharge bills from both PPS and non-PPS facilities, including those from waiver States, long-term care facilities, and excluded units are classified by the Grouper software program into one of 745 diagnosis related groups (DRGs).
National Uniform Billing Committee (NUBC)	The National Uniform Billing Committee (NUBC) makes its UB-04 manual available through its website. This manual contains the updated specifications for the data elements and codes included on the CMS-1450 and used in the 837I transaction standard.
Present On Admission (POA)	POA is defined as present at the time the order for inpatient admission occurs present at the time the order for inpatient admission occurs. Conditions that develop during an outpatient encounter (including emergency department, observation, or outpatient surgery) are considered POA.
Repeat Admissions/Readmissions	A patient who requires follow-up care or elective surgery may be discharged and readmitted or may be placed on a leave of absence.
Uniform Billing-04 (UB-04)	This form, also known as the CMS-1450, is a uniform institutional provider bill suitable for use in billing multiple third party payers. The National Uniform Billing Committee (NUBC) maintains lists of approved coding for the form.

CMS POA Indicator and Definitions

POA Indicator	Definition
Y	Diagnosis was present at time of inpatient admission.
N	Diagnosis was not present at time of inpatient admission.
U	Documentation insufficient to determine if the condition was present at the time of inpatient admission.
W	Clinically undetermined. Provider unable to clinically determine whether the condition was present at the time of inpatient admission.
1	Unreported/Not used. Exempt from POA reporting.

HAC/HAI Procedure Codes and Diagnosis Code List

Codes
Please refer to CMS for the latest CMS HAC List.

X. REFERENCES

This policy has been developed through consideration of the following:

- CMS Hospital-Acquired Conditions
- 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 Billing Form CMS-1450 and the 837I Booklet
- Medicare Claims Processing Manual CH. 1 - General Billing Requirements
- Medicare Claims Processing Manual CH. 3- Inpatient Hospital Billing
- Medicare Claims Processing Manual CH. 25- Completing and Processing the Form CMS-1450 Data Set
- National Uniform Billing Committee (NUBC)
- TRICARE Reimbursement Manual
- TRICARE Reimbursement Manual Chapter 6 Diagnosis Related Groups (DRGs)

XI. APPROVALS

Date	Review/Revision	Reason for Modification	Approved By
9/25/2024	Revision	Updated policy language and guidance	Reimbursement Policy Committee (RPC)
9/13/2023	N/A	New Policy	Reimbursement Authorizations and Coding Committee (RAC)