JOHNS HOPKINS HEALTH PLANS	Johns Hopkins Health Plans **Provider Relations and Network Innovation Reimbursement Policy**	*Policy Number*	RPC.038
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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 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 determination that you will be reimbursed. Services must meet 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 denote the services and/or procedures performed.

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. If a corrected claim is filed, it must comply with timely filing to be reprocessed through the claims system. Issues related to inconsistent, missing, conflicting, or unclear documentation must be resolved by the provider submitting the claim. 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 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 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 variations. When there is an update, policies will be published on our website.

II. PURPOSE

When applicable, JHHP requires providers to report the coding and sequencing of diagnosis codes in alignment with CMS, the National Center for Health Statistics (NCHS), the Department of Health and Human Services (HHS), and the Uniform Hospital Discharge Data Set (UHDDS), which is based on the International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM) for Coding and Reporting guidelines. Claims submitted to JHHP must be billed in accordance with laws, regulatory requirements, the abovementioned billing guidelines, provider contracts, and/or JHHP reimbursement policies.

III. POLICY STATMENT

The diagnosis codes contained in the International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM) have been adopted under HIPAA for all healthcare settings. This policy applies to all practitioners (participating and non-participating), hospitals, providers, or suppliers who submit claims to JHHP on a CMS-1500 or UB-04 (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.

*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. GENERAL BILLING GUIDELINES

1. In the context of the official coding guidelines, the term "provider" means a physician or any qualified healthcare practitioner who is legally accountable for establishing the patient's diagnosis.
2. 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. 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.
3. When ICD-10 codes are submitted incorrectly or when an inappropriate diagnosis is pointed to or linked as primary on the claim form, JHHP will deny the associated claim line.
4. Consistent with ICD-10 CM and UHDDS guidance, the circumstances of inpatient admission always govern the selection of principal diagnosis.
5. 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.
6. 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. Claims with the diagnosis code reported in the incorrect sequence may be denied.
7. When referring patients for laboratory or radiology services, providers are to report the most appropriate diagnosis code that reflects the reason for requesting these services.

8. The appropriate diagnosis code must be reported when billing for certain services and drugs. When the appropriate diagnosis is not reported, the calim may be pended for review or denied.
9. JHHP utilizes editing software programs to assign each case into an MS-DRG based on the reported diagnosis and procedure codes and demographic information (age, sex, and discharge status), where applicable.
10. In alignment with industry standards, JHHP utilizes CMS billing and coding edits for the ICD-10 codes reported, to validate correct coding on claims for patient admission and discharge.
11. Certain "Z" code diagnosis assignments may only be used as first-list or principal diagnosis.

    a. 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.
    b. A corresponding procedure code must accompany the appropriate Z code to describe any item, service, procedure, or drug being administered or rendered.
12. When coding claims, clinical evidence should be present in the patient's medical record to support the diagnosis code assignment. Issues related to inconsistent, missing, conflicting, or unclear documentation must be resolved by the provider submitting the claim.

V. ICD–10 CM OBSTETRICAL CODING

1. Obstetric cases require codes from chapter 15, codes in the range O00-O9A, Pregnancy, Childbirth, and the Puerperium.
    a. Refer to Chapter 15 for sequencing priority over codes from other chapters.
2. Chapter 15 codes may be used to describe pregnancy-related complications after the peripartum or postpartum period if the provider documents that a condition is pregnancy related. These codes are to be used only on the maternal record, never on the record of the newborn.
3. A code from category Z37 (Outcome of delivery), should be included on every maternal record when a delivery has occurred.
4. JHHP expects providers to report the appropriate obstetric abdominal/pelvic ultrasound codes in conjunction with an OB diagnosis, or the claim may be pended for review or denied.
    a. Refer to JHHP Obstetrical Services policy for additional diagnosis coding guidance.

VI. PRESENT ON ADMISSION (POA)

1. Consistent with CMS, JHHP requires all providers to report a Present on Admission (POA) Indicator with the appropriate diagnosis code, which is mandatory for all claims involving inpatient admissions to general acute care hospitals or other facilities.
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. Maryland Waiver Hospitals must report the POA indicator on all claims.
4. Providers should 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.
    a. Refer to JHHP Inpatient Reimbursement Guidelines policy for additional diagnosis coding guidance.

VII. EXCEPTIONS and EXCLUSIONS

1. **PPMCO:** Please consult the authoritative guidance found in the Maryland Medicaid Manuals to obtain specific information on policy, benefits, and coverage not addressed in this policy, as JHHP will reimburse items and services in accordance with MDH guidance.

a. JHHP requires all providers (i.e., ordering, referring, rendering, servicing, billing) delivering services to Maryland Medicaid members to have an active enrollment status in the electronic Provider Revalidation and Enrollment Portal (ePREP) on the date of service.
b. Claims submitted by individual providers, provider groups and facilities who are inactive or unregistered in ePREP will not be reimbursed.
c. Providers are solely responsible for ensuring their information in the ePREP portal is valid and active.

2. **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 not addressed in this reimbursement policy.

VIII. CODES, TERMS and DEFINITIONS

Definition of Terms

Term	Definition
837I	The 837I (Institutional version) of the standard format used by institutional providers to transmit health care claims electronically. It is the electronic version of CMS-1450.
837P	The 837P (Professional version) of the standard format used by non-institutional providers to transmit health care claims electronically. It is the electronic version of the CMS-1500.
CMS-1450	The CMS-1450, also known as 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.
CMS-1500	The CMS-1500 form is the standard claim form used by a non-institutional provider or supplier to bill carriers when a provider qualifies for a waiver from the Administrative Simplification Compliance Act (ASCA) requirement for electronic submission of claims. Providers sending professional and supplier claims on paper must use Form CMS-1500 in a valid version.

"Code First"	Certain conditions have both an underlying etiology and multiple body system manifestations due to the underlying etiology. For such 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 is a “use additional code” note at the etiology code, and a “code first” note at the manifestation code. These instructional notes indicate the proper sequencing order of the codes, etiology followed by manifestation. “Code first” and “Use additional code” notes are also used as sequencing rules in the classification for certain codes that are not part of an etiology/ manifestation combination.
"Exclude Notes" (Type 1 & 2)	The ICD-10-CM has two types of excludes notes. Each type of note has a different definition for use but they are all similar in that they indicate that codes excluded from each other are independent of each other. • Excludes 1: A type 1 Excludes note is a pure excludes note. It means “NOT CODED HERE!” An Excludes1 note indicates that the code excluded should never be used at the same time as the code above the Excludes1 note. An Excludes1 is used when two conditions cannot occur together, such as a congenital form versus an acquired form of the same condition. • Excludes 2: A type 2 Excludes note represents “Not included here.” An excludes 2 note indicates that the condition excluded is not part of the condition represented by the code, but a patient may have both conditions at the same time. When an Excludes 2 note appears under a code, it is acceptable to use both the code and the excluded code together, when appropriate.
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.
Principal Diagnosis	The principal diagnosis is defined in the Uniform Hospital Discharge Data Set (UHDDS) as "that condition established after study to be chiefly responsible for occasioning the admission of the patient to the hospital for care." In determining principal diagnosis, coding conventions in the ICD-10-CM, the Tabular List and Alphabetic Index take precedence over these official coding guidelines. (See Section I.A., Conventions for the ICD-10-CM).
Uncertain Diagnosis	In accordance to the ICD-10-CM Official Guidelines for Coding and Reporting this guideline is applicable only to inpatient admissions to short-term, acute, long-term care and psychiatric hospitals. If the diagnosis documented at the time of discharge is qualified as "probable," "suspected," "likely," "questionable," "possible," or "still to be ruled out," "compatible with," "consistent with," or other similar terms indicating uncertainty, code the condition as if it existed or was established. The bases for these guidelines are the diagnostic workup, arrangements for further workup or observation, and initial therapeutic approach that correspond most closely with the established diagnosis.

IX. REFERENCES

This policy has been developed through consideration of the following:

- CMS ICD-10-CM Guidelines
- CMS ICD-10 Resources
- 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
- Johns Hopkins Health Plans Reimbursement Policies
- 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
- Medicare Claims Processing Manual Ch. 26 - Instructions for Completing Form CMS-1500 and the NSF Format
- National Uniform Billing Committee (NUBC)
- TRICARE Reimbursement Manual

- TRICARE Manuals - Display Chap 2 Sect 5.4

X. APPROVALS

Date	Review/Revison	Reason for Modification	Approved By
6/12/2024	New policy	N/A	Reimbursement Authorization and Coding Committee (RAC)