# RB.028.C Centers for Medicare & Medicaid Services (CMS) and Department of Human Services (DHS) Payment Systems Update and Maintenance Payment Systems

**Original Implementation Date: 03/21/2022**
**Version [C] Date: 01/12/2026**
**Last Reviewed Date: 01/12/2026**

## PRODUCT VARIATIONS

This policy applies to all Jefferson Health Plans/Health Partners Plans lines of business unless noted below.

Application of Claim Payment Policy is determined by benefits and contracts. Benefits may vary based on product line, group, or contract. Payment may vary based on individual contract.

## POLICY STATEMENT

**Centers for Medicare & Medicaid Services (CMS) Medicare Payment Systems**:

The following payment policy applies to all CMS payments systems applicable to Provider in accordance with their provider participation agreement, including but not limited to:

- All CMS Medicare Fee Schedules (herein CMS Payment Systems).
- Medicare Inpatient Prospective Payment System (IPPS).
- Medicare Outpatient Prospective Payment System (OPPS).

Payer shall have up to sixty (60) days from the date of CMS publication to implement any applicable updates to CMS Payment Systems. Until updated in Payer's systems, Payer will pay based on the prior version of the CMS payment system and claims paid prior to Payer's implementation date shall not be subject to retrospective claims reconsiderations (or adjustments), unless such delayed implementation resulted in non-payment of a Covered Service.

In the event Payer exceeds the above sixty (60) day timeframe, Payer shall reprocess all claims back to the applicable CMS Payment System update effective date.

CMS Medicare Fee Schedule payments are final and are not subject to adjustment based on traditional Medicare quality performance or pay-for-performance programs. This policy applies to all lines of business whose reimbursement methodology is based on the CMS Fee Schedule. Providers

are required to comply with all CMS-published billing requirements and specifications when submitting claims and must include all information required by traditional Medicare.

**DHS Medicaid Payment Systems (Excluding FQHCs AND RHCs)**:
The following payment policy applies to all DHS Medicaid payments systems applicable to Provider in accordance with their provider participation agreement, including but not limited to:

- All DHS Medicaid Fee Schedules (herein DHS Payment Systems).
- APR DRG Grouper.
- Medicare OPPS.

Payer shall have up to sixty (60) days from the date of DHS publication to implement any applicable updates to DHS Payment Systems. Until updated in Payer's systems, Payer will pay based on the prior version of the DHS Payment System and claims paid prior to Payer's implementation date shall not be subject to retrospective claims reconsiderations (or adjustments), unless such delayed implementation resulted in non-payment of a Covered Service.

**DHS Medicaid Payment Systems for FQHCs and RHCs**:

The following payment policy applies to the FQHC/RHC prospective payment system per visit rates applicable to Provider in accordance with their provider participation agreement.

Payer shall have up to sixty (60) days from the date of DHS publication to implement any applicable updates to DHS Payment Systems. Until updated in Payer's systems, Payer will pay based on the prior version of the DHS Payment System.

Within ninety (90) days from the date of DHS publication of PPS rate adjustments, Payer shall adjust all applicable claims back to the PPS rate change effective date.

This is not applicable to Medicare Advantage and Individual and Family Plans lines of business.

## POLICY GUIDELINES

In the event Payer's HealthChoices agreement with DHS conflicts with the claim reconsideration timeframe limitations set forth in the applicable Provider Participation Agreement, Payer and Provider agree to follow the requirements set forth in the DHS HealthChoices agreement.

## CODING

*Note: The Current Procedural Terminology (CPT®), Healthcare Common Procedure Coding System*

*(HCPCS), and the 10th revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10) codes that may be listed in this policy are for reference purposes only. Listing of a code in this policy does not imply that the service is covered and is not a guarantee of payment. Other policies and coverage guidelines may apply. When reporting services, providers/facilities should code to the highest level of specificity using the code that was in effect on the date the service was rendered. This list may not be all inclusive.*



| CPT Code | Description |
|---|---|
| N/A | N/A |

| HCPCS Code | Description |
|---|---|
| N/A | N/A |

| ICD-10 Codes | Description |
|---|---|
| N/A | N/A |

## BENEFIT APPLICATION

This Reimbursement Policy does not constitute a description of benefits. Rather, this assists in the administration of the member's benefits which may vary by line of business. Applicable benefit documents govern which services/items are eligible for coverage, subject to benefit limits, or excluded completely from coverage.

## DESCRIPTION OF SERVICES

N/A.

## DEFINITIONS

N/A.

## DISCLAIMER

Approval or denial of payment does not constitute medical advice and is neither intended to guide nor influence medical decision making.

Policy Bulletins are developed to assist in administering plan benefits and constitute neither offers of coverage nor medical advice.

This Policy Bulletin may be updated and therefore is subject to change.

## POLICY HISTORY

This section provides a high-level summary of changes to the policy since the previous version.

| Summary | Version | Version Date |
|---|---|---|
| 2026 Adhoc review. Revisions made to policy statement. | C | 01/12/2026 |
| 2024 review. Revisions made to policy statement. | B | 12/17/2024 |
| New policy. | A | 3/1/2022 |

## REFERENCES

N/A.



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