Reimbursement Policy

Non-Participating Provider

Policy Number: SCO 4.5
Version Number: 2
Version Effective Date: 11/01/2021

Product Applicability

☐ **All Plan+ Products**

Well Sense Health Plan

☐ Well Sense Health Plan

Boston Medical Center HealthNet Plan

☐ MassHealth MCO
☐ MassHealth ACO
☐ Qualified Health Plans/ConnectorCare/Employer Choice Direct
☒ Senior Care Options

Note: Disclaimer and audit information is located at the end of this document.

Policy Summary

The Plan reimburses covered services based on the provider's contractual rates with the Plan and the terms of reimbursement identified within this policy.

Prior-Authorization

Please refer to the Plan's Prior Authorization Requirements Matrix at www.bmchp.org.

Definitions

Non-Participating (Non-Par) Provider – A provider who has not entered into a formal, contractual agreement with the Plan for the member's product. A non-par provider is also referred to as an out of network provider.

+ *Plan* refers to Boston Medical Center Health Plan, Inc. and its affiliates and subsidiaries offering health coverage plans to enrolled members. The Plan operates in Massachusetts under the trade name Boston Medical Center HealthNet Plan and in other states under the trade name Well Sense Health Plan.

Provider Reimbursement

Non-participating providers must bill for Medicare covered services in accordance with Medicare guidelines in order to receive reimbursement for covered services. Non-participating providers should bill in the same manner they would Medicare except as identified in any of the Plan's SCO reimbursement policies.

Non-participating providers must bill for Medicaid only covered services in accordance with guidelines referenced in the Plan's MH/QHP reimbursement policies in order to receive reimbursement for covered services.

The Plan reimburses covered services provided by a non-participating provider only in one of the following instances:

- Prior authorization has been obtained in advance of the service being rendered; or
- Urgent/Emergency services are required
    - The Plan reimburses emergency and post stabilization services rendered by a non-participating provider until the attending emergency physician, or the provider actually treating the member, determines that the member is sufficiently stabilized for transfer or discharge, in accordance with 42 Code of Federal Regulations (CFR) 438.114.

The Plan reimburses covered services rendered by a non-participating provider with one of the following amounts:

- the lesser of 100% of the Medicare reimbursement rate for Medicare covered services in effect at the time of service or the provider's billed charges or;
- the lesser of 100% of the Medicaid reimbursement rate for Medicaid only covered services in effect at the time of service or the provider's billed charges or;
- a negotiated, single case rate described by the Plan in a Letter of Agreement (LOA).

Non-participating providers are allowed 365 days from the date of service to file claims for timely reimbursement.

Service Limitations

Balance Billing

Out of network providers may not balance bill a member for the difference between the Plan's reimbursement rate and the provider charges for any covered service.

Services Not Managed by the Plan:

The following services are not managed by the Plan:

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Service	Description
Behavioral Health	These services are managed by the Plan’s contracted vendor, Beacon Health Strategies.
DME	These services are managed by the Plan’s contracted vendor, Northwood, Inc.
Non-Emergency Transportation	These services are managed by the Plan’s contracted vendor, One Call Government Solutions, LLC.

Applicable Coding and Billing Guidelines

Claims from non-participating providers are subject to the Plan’s established clinical edits and billing and coding guidelines. Providers should reference all other Plan reimbursement policies for specific billing and coding guidelines.

Policy History

Original Approval Date	Original Effective Date	Policy Owner	Approved by
08/18/2020	10/01/2020	Payment Policy	Payment Policy Committee

Policy Revisions History			
Review Date	**Summary of Revisions**	**Revision Effective Date**	**Approved by**
10/19/2021	Annual review	11/01/2021	Payment Policy Committee

Other Applicable Policies

- All Plan reimbursement policies

References

- 42 CRF 438.114, Emergency and Post stabilization Services
- Medicare MA Payment Guide for Out of Network Payments

Disclaimer Information

This Policy provides information about the Plan's reimbursement/claims adjudication processing guidelines. The use of this Policy is neither a guarantee of payment nor a final prediction of how specific claim(s) will be adjudicated. Reimbursement is based on many factors, including member eligibility and benefits on the date of service; medical necessity; utilization management guidelines (when applicable); coordination of benefits; adherence with applicable Plan policies and procedures; clinical coding criteria; claim editing logic; and the applicable Plan – Provider agreement. Member cost-sharing (deductibles, coinsurance and copayments) may apply – depending on the member's benefit plan. Unless otherwise specified in writing, reimbursement will be made at the lesser of billed charges or the contractual rate of payment. Plan policies may be amended from time to time, at Plan's discretion. Plan policies are developed in accordance with applicable state and federal laws and regulations, and accrediting organization guidelines (including NCQA). The Plan reserves the right to conduct Provider audits to ensure compliance with this Policy. If an audit determines that the Provider did not comply with this Policy, the Plan will expect the Provider to refund all payments related to non-compliance. For more information about the Plan's audit policies, refer to the Provider Manual.

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