Reimbursement Policy

Physician and Non Physician Practitioner Services

Policy Number: SCO 4.608
Version Number: 3
Version Effective Date: 08/01/2021

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.the Plan.org.

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Definitions

Physician – a doctor of medicine, doctor of osteopathy, doctor of dental surgery or dental medicine, doctor of podiatric medicine or doctor of optometry and, with respect to certain specified treatment, a doctor of chiropractic legally authorized to practice by the State in which he/she performs this function.

Non-physician practitioner (NPP) – For the purpose of this policy a NPP is a physician assistant (PA), nurse practitioner (NP), clinical nurse specialist (CNS), or a certified nurse midwife (CNM).

Provider Reimbursement

Physician

Reimbursement for Physician services are made based upon the lower of the actual charge or the Medicare Physician Fee Schedule (MPFS) amount.

Non-Physician Practitioners (NPPs)

Physician Assistant (PA), Nurse Practitioner (NP), and Certified Nurse Specialist (CNS) services are reimbursed at the lower of the actual charge or 85 percent of what a physician is reimbursed under the Medicare Physician Fee Schedule.

Reimbursement for Certified Nurse Midwife (CNM) services is made at the lower of the actual charge or the Medicare Physician Fee Schedule amount for the same service performed by a physician.

Fee-for-Time Compensation Arrangements and Reciprocal Billing Arrangements

All contracted providers using fee-for-time compensation arrangements and reciprocal billing arrangements must follow the Plan's credentialing guidelines specified in the Provider Manual and the following:

- Fee-For-Time Compensation Arrangement services should be reported using modifier Q6.
- Reciprocal Billing Arrangements should be reported using modifier Q5.

The Plan follows the rules and guidelines set forth by the Centers for Medicare and Medicaid Services (CMS) related to Payment under Fee-For-Time Compensation Arrangements and Reciprocal Billing Arrangements.

Telehealth Services

The Plan reimburses three types of virtual professional services in accordance with the Centers for Medicare and Medicaid Services (CMS):

- Telehealth visits – the use of telecommunication technology for office, hospital visits and other services that generally occur in-person. The provider must use an interactive audio and video telecommunications system that permits real-time communication between the distant site and the patient at home. These visits are considered the same as in-person visits and are paid at the

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same rate as regular, in-person visits. For the most current list of applicable services refer to the Centers for Medicare and Medicaid Services website.

- Virtual Check-ins – A brief check in with an established patient and their practitioner via telephone or other telecommunications device to decide if an office visit or other service is needed. This can include a remote evaluation of recorded video and/or images submitted by an established patient. The communication is not related to a medical visit within the previous 7 days and does not lead to a medical visit within the next 24 hours (or soonest appointment available).
- E-visits – A communication between an established patient and their provider through an online patient portal. The patient must initiate the initial inquiry and communications can occur over a 7-day period.

Wellness Visits

The Plan reimburses wellness visits including an Initial Preventive Physical Examination (IPPE) and Annual Wellness Visits (AWV) in accordance with Medicare guidelines. Please see the "Applicable Coding and Billing Guidelines" section of this policy for billing and coding details.

When a wellness visit and a significant, separately identifiable, medically necessary Evaluation and Management (E/M) service is provided on the same day, the Plan may reimburse the additional service. Report the additional CPT code with modifier 25.

Evaluation and Management (E&M) Services Furnished Incident to Physician's Service

The Plan follows Medicare's criteria related to incident to services:

- Services rendered 'incident to' a physician's service should be billed under the employing physician's NPI, or in the case of a physician directed clinic the supervising physician's NPI, and are reimbursed as if the physician performed the service (no modifier required).
- Services rendered 'incident to' a non-physician practitioner's service should be billed under the employing practitioner's NPI, or in the case of a physician directed clinic the supervising practitioner's NPI, and are reimbursed as if the practitioner performed the service.
- Incident to billing is paid at 100% of the physician fee schedule, whereas the qualified practitioners billing under their own billing numbers are paid at 85% of the physician fee schedule. If service delivery does not meet all incident to criteria, but qualifies for billing by the practitioner, payment is made at 85% of physician fee schedule when billed by non-physician practitioners or 100% of fee schedule when billed by therapists.

Tobacco Cessation Counseling

The Plan reimburses tobacco cessation counseling services in accordance with Medicare guidelines. Please see the "Applicable Coding and Billing Guidelines" section of this policy for billing and coding details.

Diabetes Self-Management Training (DSMT)/Medical Nutrition Therapy (MNT)

The Plan reimburses physicians and other qualified healthcare professionals for DSMT and MNT in accordance with Medicare guidelines. Please see the “Applicable Coding and Billing Guidelines” section of this policy for billing and coding details.

Practice Site Differential

Under the Medicare Physician Fee schedule (MPFS) some procedures have separate rates for physicians’ services when provided in facility and non-facility settings. In accordance with CMS, the Plan applies a practice site differential to those codes based on the site of service. The Plan follows CMS guidelines when determining which place of service code receives the facility or non-facility designation.

Services Requiring the Submission of a Report

Submission of reports may be required when the applicable CPT/HCPCS codes do not adequately identify the services for appropriate pricing.

Services requiring the submission of a report are:

- Unlisted CPT/HCPCS codes
- Unusual services (modifier 22)
- Discontinued Service (modifier 53)
- Surgical team (modifier 66)
- Medical supervision for more than four concurrent anesthesia procedures is provided (modifier AD)

Surgical Reimbursement

Reimbursement for a surgical procedure performed at an office is inclusive of both the technical and professional components, when applicable. For further guidance regarding reimbursement for surgical assistants and multiple and bilateral procedures, please reference the *General Clinical Editing and Payment Accuracy Review Guidelines, SCO 4.108* and the *Bilateral and Multiple Procedure Reduction, SCO 4.607* reimbursement policies.

Assistant at Surgery/Co-Surgeon/Team Surgeon Surgical Procedures

The Plan reimburses assistant at surgical procedures with the following modifier requirements:

- Claims for surgical assistants must be submitted by appending either modifiers 80, 81, 82 or AS. When applicable, the Plan requires the submission of additional modifiers to identify the assistant’s credentials.
- Claims for co-surgeons must be submitted with modifier 62
- Claims for team surgeons must be submitted with modifier 66
- PA, NP or CNS assistant-at-surgery services must be submitted with modifier AS

For assistant-at-surgery services performed by physicians, the fee schedule amount equals 16 percent of the amount otherwise applicable for the surgical payment.

An assistant-at-surgery service furnished by PAs, NPs and CNSs is reimbursed at 85 percent of 16 percent (13.6%) of what a physician is paid under the MPFS for surgical services.

Terminated/Canceled Procedures

The Plan will not reimburse a provider for any surgical procedures that are canceled or postponed, for any reason, before the procedure is initiated. If a procedure is terminated after the procedure is initiated, providers must submit an operative report for any claim submitted that includes charges for a terminated procedure. If a report is not submitted, the claim line will be denied. Reimbursement for a terminated procedure will be determined based on the documentation submitted with the claim. Providers reference the Plan's reimbursement policy, *Modifiers, SCO 4.23.*

Service Limitations

- The Plan does not consider pre-employment screenings a medically necessary service and therefore does not cover this service as a benefit to members. All claims submitted for pre-employment screening services should indicate diagnosis code Z02.1, Z02.3 or Z02.89.
- The Plan does not reimburse claims for copies of medical records requested by the member or the member's treating physician under any circumstance.
- The Plan does not reimburse consultation codes 99241-99255. These services should be billed with the appropriate outpatient/office or inpatient evaluation and management codes.
- Physician work resulting from telephone calls is considered to be an integral part of the pre-work and post-work of other physician services, and the fee schedule amount for those services has been calculated to include payment for telephone calls. As such, no additional reimbursement is allowed for CPT codes pertaining to telephone services.

Applicable Coding and Billing Guidelines

Applicable coding is listed below, subject to codes being active on the date of service. Because the American Medical Association (AMA), Centers for Medicare & Medicaid Services (CMS), and the U.S. Department of Health and Human Services may update codes more frequently or at different intervals than Plan policy updates, the list of applicable codes may not be all inclusive. These codes are not intended to be used for coverage determinations.

Split Claim Billing

All related services must be reported on one claim. Subsequent related claims received after the initial claim will be denied. The initial claim must be resubmitted as a replacement claim.

Use of Modifiers

Refer to the most updated industry standard coding guidelines and Centers for Medicare and Medicaid Services (CMS) guidelines for a complete list of modifiers and their usage. Providers may also reference the Plan's reimbursement policy, *Modifiers, SCO 4.23.*

Wellness Visits		
CPT/HCPCS Code	**Description**	**Instructions**
Initial Preventive Physical Examination (IPPE)		
G0402	Initial preventive physical examination; face-to-face visit, services limited to new beneficiary during the first 12 months of Medicare enrollment	• Limited to (1) per lifetime not later than the first 12 months after the patient's Medicare Part B benefits eligibility date.
G0403	Electrocardiogram, routine ecg with 12 leads; performed as a screening for the initial preventive physical examination with interpretation and report	
G0404	Electrocardiogram, routine ecg with 12 leads; tracing only, without interpretation and report, performed as a screening for the initial preventive physical examination	
G0405	Electrocardiogram, routine ecg with 12 leads; interpretation and report only, performed as a screening for the initial preventive physical examination	
Annual Wellness Visit (AWV) Health Risk Assessment (HRA)		
G0438	Annual wellness visit; includes a personalized prevention plan of service (pps), initial visit	• G0438 cannot be billed within 12 months of an IPPE visit. • G0438 is limited to (1) per lifetime. • G0439 is limited to (1) per 12-month period. • In the event that a member selects a new health professional to complete a subsequent AWV, the new health professional will continue to bill the subsequent AWV with HCPCS G0439.
G0439	Annual wellness visit, includes a personalized prevention plan of service (pps), subsequent visit	
99387	Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory	• 99387 cannot be billed within 12 months of an AWV.

	guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; 65 years and older	• 99397 is limited to (1) per 12-month period. • In the event that a member selects a new health professional to complete a subsequent IPPE, the new health professional will continue to bill the subsequent IPPE with HCPCS 99397.
99397	Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient; 65 years and older	

Diabetes Self-Management Training (DSMT)* / Medical Nutrition Therapy *(MNT)		
CPT/HCPCS Code	**Description**	**Instructions**
Diabetes Self-Management (DSMT)		
G0108	Diabetes outpatient self-management training services, individual, per 30 minutes	• Bill one unit per each 30-minute increment • DSMT is not reimbursed when performed on the same date of service as MNT. • DSMT services cannot be billed as “incident to” services.
G0109	Diabetes outpatient self-management training services, group session (two or more), per 30 minutes	
Medical Nutrition Therapy (MNT)		
97802	Medical nutrition therapy; initial assessment and intervention, individual, face-to-face with the patient, each 15 minutes	• MNT is not reimbursed when performed on the same date of service as DSMT.
97803	Medical nutrition therapy; re-assessment and intervention, individual, face-to-face with the patient, each 15 minutes	
97804	Medical nutrition therapy; group (2 or more individuals), each 30 minutes	
G0270	Medical nutrition therapy; reassessment and subsequent intervention(s) following second referral in same year for change in diagnosis, medical condition or treatment regimen (including additional hours needed for renal disease),	

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	individual, face-to-face with the patient, each 15 minutes	
G0271	Medical nutrition therapy, reassessment and subsequent intervention(s) following second referral in same year for change in diagnosis, medical condition, or treatment regimen (including additional hours needed for renal disease), group (2 or more individuals), each 30 minutes	

Tobacco Cessation Counseling	
CPT/HCPCS Code	**Description**
99406	Smoking and tobacco use cessation counseling visit; intermediate, greater than 3 minutes up to 10 minutes
99407	Smoking and tobacco use cessation counseling visit; intensive, greater than 10 minutes

Policy History

Original Approval Date	Original Effective Date	Policy Owner	Approved by
10/21/2015	01/01/2016	Payment Policy	SCO Product Subgroup

Policy Revisions History			
Review Date	**Summary of Revisions**	**Revision Effective Date**	**Approved by**
05/19/2019	Annual Review, new template	07/01/2019	Payment Policy Committee
07/20/2021	Annual review. Added references to Modifiers reimbursement policy.	08/01/2021	Payment Policy Committee

Other Applicable Policies

Reimbursement Policies

- Bilateral and Multiple Procedure Reduction, SCO 4.607
- General Billing and Coding Guidelines, SCO 4.31
- General Clinical Editing and Payment Accuracy Review Guidelines, SCO 4.108
- Modifiers, SCO 4.23

References

- Centers for Medicare and Medicaid Services, Medicare Benefit Policy Manual 100-02, Chapter 15 Covered Medical and Other Health Services
- Centers for Medicare and Medicaid Services, Medicare Claims Processing Manual Chapter 1 - General Billing Requirements
- Centers for Medicare and Medicaid Services, Medicare Claims Processing Manual 100-04, Chapter 12 Physicians/Nonphysician Practitioners
- Centers for Medicare and Medicaid Services, Pub 100-04 Medicare Claims Processing, Transmittal 2656
- Centers for Medicare and Medicaid Services, Medicare Claims Processing Manual, Chapter 18 - Preventive and Screening Services
- Centers for Medicare and Medicaid Services, Medicare General Information, Eligibility, and Entitlement Manual, Chapter 5
- Fee-for-Time Compensation Arrangement: CMS Internet Only Manual (IOM), Publication 100-04, Medicare Claims Processing Manual, Chapter 1, Section 30.2.1.I - 30.2.14

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.