Reimbursement Policy

Outpatient Hospital

Policy Number: SCO 4.17
Version Number: 3
Version Effective Date: 12/01/2021

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.

+ *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

The Plan reimburses outpatient hospital services based on the Medicare Outpatient Prospective Payment System (OPPS). Reference the Medicare OPPS guidelines for detailed claim reporting requirements.

Ambulatory Payment Classification (APC) Groups

Each HCPCS code for which separate payment is made under the OPPS is assigned to an ambulatory payment classification (APC) group. A hospital may receive more than one APC payment for the services furnished to a patient on a single day.

Composite APCs

Composite APCs provide a single payment for a comprehensive diagnostic and/or treatment service that is defined, for purposes of the APC, as a service typically reported with multiple HCPCS codes. When HCPCS codes that meet the criteria for payment of the composite APC are billed on the same date of service, the Plan makes a single payment for all of the codes.

Comprehensive APCs

Comprehensive APCs provide a single payment for a primary service, and payment for all adjunctive services reported on the same claim is packaged into payment for the primary service. With few exceptions, all other services reported on a hospital outpatient claim in combination with the primary service are considered to be related to the delivery of the primary service and packaged into the single payment for the primary service.

Packaged Services

Packaged services are items and services that are considered to be an integral part of another service that is paid. No separate payment is made for packaged services, because the cost of these items and services is included in the APC payment.

Multiple Procedure Reductions

When multiple surgical procedures are furnished during the same operative session, the full rate is paid for the surgical procedure with the highest rate and 50% is paid for any other surgical procedure(s) performed at the same time in accordance with OPPS payment rules.

Bilateral Procedures

If a reimbursable surgical procedure provided in a single operative session is performed bilaterally, the full maximum fee is 150% of the payment rate for the operative procedure. Modifier 50 should be reported with the surgical procedure performed bilaterally. The number of units reported should be one (1).

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Discontinued/Terminated Procedures

50% of the full rate is paid if a procedure for which anesthesia is either planned or not planned is discontinued after the enrollee is prepared and taken to the room where the procedure is to be performed but before anesthesia is provided.

Report modifier 73 for procedures that are discontinued after the patient has been prepared for the procedure and taken to the procedure room but before anesthesia is provided. Modifier -73 is used for these procedures.

Report modifier 52 for procedures for which anesthesia is not planned that are discontinued, partially reduced or cancelled after the patient is prepared and taken to the room where the procedure is to be performed.

Procedures that are discontinued, partially reduced or cancelled after the procedure has been initiated will be paid the full payment amount. Modifier 74 is used for these procedures.

Cancelled Procedures

The Plan will not reimburse a surgical center for any surgical procedures that are cancelled or postponed, for any reason, before the patient is taken into the treatment or operating room. Cancellations under these circumstances should not be reported.

Services Reimbursed Separately from OPPS Methodology

The following services may be reimbursed separately at the respective fee schedule or prospective payment rates.

- Ambulance services
- Physical therapy, occupational therapy, and speech-language pathology (special rules for wound care)
- Dialysis services paid under the ESRD composite rate
- Separately payable clinical laboratory services
- Take-home surgical dressings
- Separately payable non-implantable durable medical equipment (DME) and prosthetics paid under the DMEPOS fee schedule
- Certain preventive services

Off-Campus Provider Based Department (PBD)

Non-Excepted off-campus provider-based departments will be reimbursed at a payment rate under the Medicare Physician Fee Schedule. Non-Excepted PBD of a hospital are required to report modifier “PN” on each claim line with a HCPCS for non-excepted items and services including those for which payment will not be adjusted, such as separately payable drugs, clinical laboratory tests, and therapy services.

Excepted off-campus provider based department (PBD) will be reimbursed under the OPPS methodology. The Plan requires that providers report modifier “PO” on each claim line with a HCPCS

for excepted services, procedures, and/or surgeries furnished in an off-campus provider-based department (PBD) of the hospital.

The PO and PN modifiers are not to be used for on-campus departments, or dedicated emergency departments.

Off-campus provider based dedicated Emergency Departments will be reimbursed under the OPPS methodology. Outpatient hospitals are required to report modifier "ER" on each claim line with a HCPCS for services furnished in an off-campus provider-based Emergency Department. The off-campus provider based Emergency Departments that meets CMS definition of a dedicated Emergency Department is required to bill with modifier "ER".

Service Limitations

The following services are not reimbursed by the Plan:

- Serious Reportable Events ("SREs")/Provider Preventable Conditions (PPCs)– for additional information, refer to the Quality Management section of the Provider Manual as well as the Plan's reimbursement policy *Provider Preventable Conditions and Serious Reportable Events, SCO 4.610*
- Experimental, Investigational, or Cosmetic services – including all supporting services even when those supporting services may be reimbursed under other circumstances
- Hospitals will not be reimbursed for outpatient services provided to any member who is concurrently an inpatient of any hospital.

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.

Late Charges

The Plan does not accept claims submitted with a late charge type of bill. Claims must be submitted as a replacement claim.

Policy History

Original Approval Date	Original Effective Date	Policy Owner	Approved by
09/09/2015	01/01/2016	Payment Policy	SCO Product Subgroup

Policy Revisions History			
Review Date	**Summary of Revisions**	**Revision Effective Date**	**Approved by**
10/20/2020	Product Applicability and Logo changes, annual review	01/01/2021	Payment Policy Committee
11/16/2021	Annual review	12/01/2021	Payment Policy Committee

Other Applicable Policies

- General Billing and Coding Guidelines, SCO 4.31
- General Clinical Editing and Payment Accuracy Review Guidelines, SCO 4.108
- Inpatient Hospital, SCO 4.110
- Modifiers, SCO 4.23
- Provider Preventable Conditions (PPC) and Serious Reportable Events (SRE), SCO 4.610

References

- Centers for Medicare and Medicaid Services Medicare Claims Processing Manual 100-04, Chapter 4 Part B Hospital

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.