Reimbursement Policy

Outpatient Hospital

Policy Number: 4.17  
Version Number: 9  
Version Effective Date: 07/01/2015

Product Applicability

- All Plan* Products

Well Sense Health Plan  
- New Hampshire Medicaid  
- NH Health Protection Program

Boston Medical Center HealthNet Plan  
- MassHealth  
- Qualified Health Plans/ConnectorCare/Employer Choice Direct

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

Policy Summary

The Plan reimburses covered outpatient hospital services based on the provider’s contractual rates with the Plan and the terms of reimbursement identified within this policy. To determine reimbursement for any outpatient services preceding an inpatient admission, please refer to the Inpatient reimbursement policy, 4.112.

Prior-Authorization

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

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Definitions

Outpatient Hospital Services – Medical services provided to a member in a hospital outpatient department. Such services include, but are not limited to, emergency services, primary-care services, observation services, ancillary services, and day-surgery services.

General Outpatient Hospital Services Reimbursement

Payment Amount per Episode (PAPE)
The Plan reimburses Outpatient Hospital Services based on the EOHHS Payment Amount per Episode (PAPE) payment methodology. This is a per diem payment.

The following services are separately reimbursable from the PAPE rate:

- Professional fees
- Ambulance Services
- Laboratory Services
  - Hospitals will be paid for surgical pathology services rendered by hospital based physicians.
  - A professional component is only payable for services which require a written interpretation and report. Any other professional service rendered associated with a lab will be denied by the Plan.
- Early Intervention Services
- Home Health Services
- Audiology Dispensing Services

Hospital Based Physicians

The following rules apply to hospital based physicians:

- The hospital-based physician may not bill for any professional component of a service that is billed by the hospital.
- Hospitals may not bill for hospital based physician services related to the provision of audiology dispensing services.
- A hospital based dentist may not bill for any professional component of a service that is billed by the hospital.

Emergency Services

Emergency services rendered to a Plan member will be reimbursed in the same manner as any other outpatient service.
Service Exclusions

- 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 Serious Reportable Event (SRE)/Provider Preventable Condition (PPC), 4.610
- Experimental, Investigational, or Cosmetic services—including all supporting services even when those supporting services may be reimbursed under other circumstances
- Services rendered without prior Plan approval when required
- The Plan does not reimburse adult day health services for any member.
- The Plan does not reimburse adult foster care services for any member.
- Hospitals will not be reimbursed for outpatient services provided to any member who is concurrently an inpatient of any hospital.
- Hospitals will not be separately reimbursed for any outpatient hospital services when the member is admitted to the same hospital on the same date of service.

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.

Providers must bill the Plan using industry standard coding conventions to avoid claim denials. Please reference the Plan’s General Billing and Coding Reimbursement policy, 4.31 and the Provider Manual for specific coding and UB04 and CMS 1500 claim field requirements.

Section 1202 Billing Requirements for Primary Care Services

Effective 1/1/2013 – 12/31/2014 all Primary Care Services provided by eligible physicians and non-physician practitioners consistent with rules set forth in 42 CFR Part 447- Subpart G (Section 1202), must submit claims in accordance with plan billing requirements, claim form and provider identification number as outlined below.

Services applicable to Section 1202 billing requirements:

- Evaluation and Management Codes 99201-99499
- Vaccine Administration codes 90460-90461, 90471-90474
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### Primary Care Services Scenario

<table>
<thead>
<tr>
<th>Description</th>
<th>Claim Form</th>
<th>Identification Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physicians in an Non Entity Based Relationship who provide primary care services in any setting</td>
<td>CMS-1500</td>
<td>NPI</td>
</tr>
<tr>
<td>Physicians in an Entity Based Relationship who provide primary care services in a facility setting</td>
<td>CMS-1500</td>
<td>NPI</td>
</tr>
<tr>
<td>Non-physician practitioners - Primary care services provided by non-physician practitioners (e.g., physician assistants, nurse practitioners)</td>
<td>CMS-1500</td>
<td>Supervising MD’s name and NPI</td>
</tr>
<tr>
<td>Non-physician practitioners (e.g., physician assistants, nurse practitioners) in an Entity Based Relationship who provide primary care services in a facility setting</td>
<td>CMS-1500</td>
<td>Supervising MD’s name and NPI</td>
</tr>
</tbody>
</table>

### Original Approval and Effective Dates

<table>
<thead>
<tr>
<th>Original Approval Date</th>
<th>Original Effective Date</th>
<th>Policy Owner</th>
<th>Approved by</th>
</tr>
</thead>
<tbody>
<tr>
<td>07/05/2006</td>
<td>08/01/2006</td>
<td>Payment Policy</td>
<td>Payment Policy Committee</td>
</tr>
</tbody>
</table>

### Policy Revisions History

<table>
<thead>
<tr>
<th>Review Date</th>
<th>Summary of Revisions</th>
<th>Revision Effective Date</th>
<th>Approved by</th>
</tr>
</thead>
<tbody>
<tr>
<td>02/10/2010</td>
<td>Additional specifications added to clarify observation times, eligibility changes during admissions, and reformatting.</td>
<td>02/10/2010</td>
<td>Payment Policy Committee</td>
</tr>
<tr>
<td>09/30/2010</td>
<td>Changed “Never Events” to “Serious Reportable Events (“SREs”)” in the Service Exclusions section; added clarification language to the Eligibility Gaps during Admission section; added language identifying observation as not separately payable on the same date as an inpatient admission</td>
<td>09/30/2010</td>
<td>Payment Policy Committee</td>
</tr>
<tr>
<td>09/19/2011</td>
<td>Deleted definitions and PAPE specific reimbursement terms</td>
<td>09/19/2011</td>
<td>Payment Policy Committee</td>
</tr>
<tr>
<td>02/01/2012</td>
<td>Updated coding and Service</td>
<td>02/01/2012</td>
<td>Payment Policy</td>
</tr>
</tbody>
</table>

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<tr>
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<th>Committee</th>
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</thead>
<tbody>
<tr>
<td>11/13/2013</td>
<td>Added ACA billing requirements</td>
<td>11/13/2013, Payment Policy Committee</td>
</tr>
<tr>
<td>12/02/2013</td>
<td>Updated template, product applicability section, and references for BMC HealthNet Plan Qualified Health Plans, including ConnectorCare</td>
<td>12/02/2013, Payment Policy Committee</td>
</tr>
<tr>
<td>12/17/2014</td>
<td>Added Section 1202 effective date</td>
<td>01/01/2015, Payment Policy Committee</td>
</tr>
<tr>
<td>05/28/2015</td>
<td>Annual review, removed service limitations, new template, removed Commonwealth Care, Commonwealth Choice, added section related to PAPE payment</td>
<td>07/01/2015, Payment Policy Committee</td>
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### Next Review Date

2016

### Other Applicable Policies

**Reimbursement Policies:**
- Dental Services, 4.15
- Early Intervention, 4.3
- General Billing and Coding Guidelines, 4.31
- General Clinical Editing and Payment Accuracy Review Guidelines, 4.108
- Hearing Aid Dispensing and Repairs, 4.111
- Home Health, 4.7
- Inpatient Hospital, 4.112
- Observation Services, 4.36
- Physician and Non Physician Practitioner Services, 4.608
- Serious Reportable Event (SRE)/Provider Preventable Condition (PPC), 4.610
- Transportation, 4.113
- Vision Services, 4.38

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5 of 6
References

- 130 CMR 410 – Outpatient Hospital
- 114.1 CMR 36.00 – Acute Care Hospital
- 244 CMR 4.00 – Hospital-Based Non-Physician Practitioners
- Contract between The Office of Health and Human Services (EOHHS), and Boston Medical Center HealthNet Plan MassHealth
- Form of Contract between the Commonwealth Health Insurance Connector Authority and Boston Medical Center HealthNet Plan
- BMC HealthNet Plan Qualified Health Plans, including ConnectorCare Evidence of Coverage

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.