Reimbursement Policy

**Physician and Non Physician Practitioner Services**

**Policy Number:** SCO 4.608  
**Version Number:** 1  
**Version Effective Date:** 01/01/2016

**Product Applicability**

<table>
<thead>
<tr>
<th>Well Sense Health Plan</th>
<th>Boston Medical Center HealthNet Plan</th>
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<tr>
<td>New Hampshire Medicaid</td>
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<td>NH Health Protection Program</td>
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<td>Senior Care Options</td>
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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.
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
The plan reimburses physicians based on the provider’s contractual rates with the Plan and the Medicare Physician Fee Schedule.

Non-Physician Practitioners (NPPs)
- PA, NP, and CNS services are paid at 85 percent of what a physician is paid under the Medicare Physician Fee Schedule.
- Payment for Certified Nurse Midwife (CNM) services is made at 100 percent of the physician fee schedule amount for the same service performed by a physician.
- There is a separate payment policy for NPPs assistant-at-surgery services. See the surgical reimbursement section of this policy for guidelines.

Locum Tenens
- The Plan reimburses for locum tenens (temporary substitute) physician services in accordance with the contract terms established between the Plan and the practice through which the locum tenens physician works. To ensure accurate payment and avoid denials, practices that have previously requested participation for a locum tenens must seek clarification from the Plan regarding the locum tenens’ current status before billing the Plan.
- All contracted providers using locum tenens physician services must follow the Plan’s credentialing guidelines for locum tenens physicians specified in the Provider Manual.
- Services should be identified using modifier Q6.

Telehealth Services
The Plan reimburses telehealth services based on the guidelines set forth by The Centers for Medicare and Medicaid Services. For the most current list of applicable services refer to the Centers for Medicare and Medicaid Services website, https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/index.html?redirect=/telehealth/.

*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.
**Preventive Medicine Services**
The Plan reimburses the following preventative medicine services:

- **Initial Preventive Physical Examination (IPPE)**
  - One time reimbursable service
  - Reported with G0402
  - One time Electrocardiogram done as a screening for the IPPE should be reported with G0403, G0404 or G0405.

- **Initial Annual Wellness Visit (AWV)**
  - One time reimbursable service
  - Reported with G0438

- **Subsequent Annual Wellness Visit**
  - Reported with G0439
  - 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.

- **99387** - Initial comprehensive preventive medicine evaluation 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, new patient; 65 years and older

- **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

Modifier 25 should only be reported when a significant abnormality or pre-existing condition is addressed and additional work is required to perform the key components of a problem focused E&M service. If the problem-oriented service is minor, or if the code is not submitted with modifier 25 appended, no separate reimbursement will be allowed.

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

- When evaluation and management services are furnished incident to a physician’s service by a non-physician practitioner, the physician may bill the CPT code that describes the evaluation and management service furnished.

- When evaluation and management services are furnished incident to a physician’s service by a non-physician employee of the physician, not as part of a physician service, the physician bills 99211 for the service.
Tobacco Cessation
The Plan reimburses tobacco cessation counseling services reported with the following codes:

- 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
- G0436 - Smoking and tobacco cessation counseling visit for the asymptomatic patient; intermediate, greater than 3 minutes, up to 10 minutes
- G0437 - Smoking and tobacco cessation counseling visit for the asymptomatic patient intensive, greater than 10 minutes

Medical Nutrition Therapy (MNT)
The Plan reimburses physicians and other qualified healthcare professionals for MNT. The following codes are reimbursable for MNT:

- 97802 - Medical nutrition therapy; initial assessment and intervention, individual, face-to-face with the patient, each 15 minutes
- 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), 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

Diabetes Self-Management Training (DSMT)
The Plan reimburses physicians and other qualified healthcare professionals for DSMT. The following codes are reimbursable for DSMT:

- G0108 - Diabetes outpatient self-management training services, individual, per 30 minutes
- G0109 - Diabetes outpatient self-management training services, group session (2 or more individuals), per 30 minutes

Use of Modifiers
Refer to the most updated industry standard coding guidelines and Centers for Medicare and Medicaid Services guidelines for a complete list of modifiers and their usage.

Practice Site Differential
Under the Medicare Physician Fee schedule (MPFS) some procedures have separate rates for physicians’ services when provided in facility and nonfacility 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

There may be times when it is necessary to submit reports with the applicable claims. This is done when the applicable CPT/HCPCS codes do not identify the services enough for appropriate pricing.

Services requiring the submission of a report are:
- Unlisted CPT/HCPCS codes
- Unusual services (modifier 22)
- Reduced services (modifier 52)

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 the Bilateral and Multiple Procedure Reduction reimbursement policies.

Assistant at Surgery/Co-Surgeon/Team Surgeon Surgical Procedures
- Surgical assistants are identified on a claim 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.
- Co-surgeons are identified with modifier 62
- Team surgeons are identified with Modifier 66.
- 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.
- The AS modifier must be reported on the claim form when billing PA, NP or CNS assistant-at-surgery services.

Terminated 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.

The provider 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.
**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.

**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.

**Policy History**

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<td>10/21/2015</td>
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**Policy Revisions History**

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**Next Review Date**

2017

**Other Applicable Policies**

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

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.