Reimbursement Policy

Physician and Non-Physician Practitioner Services

Policy Number: 4.608  
Version Number: 11  
Version Effective Date: 01/01/2017

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  
- 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. Please reference the Provider Manual, medical policies and other reimbursement policies for additional information.

Prior-Authorization

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

Non-Physician Mid-level Practitioners
- Mid-Level Practitioners will be reimbursed 85% of the rates established in the Physician Fee Schedule.
- Payment is subject to reductions based on modifiers and clinical editing criteria.
- Fee Schedule Exceptions for Mid-Level Practitioners:
  Reimbursement for the following services is not reduced to 85%:
  - EPSDT add-on code S0302
  - tobacco cessation services
  - medical nutrition therapy
  - diabetes self-management training
  - the administration of a behavioral health screening reported with 96110
  - the $10 enhanced payment for selected primary care codes

Provider 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 please reference the Bilateral and Multiple Procedure Reductions reimbursement policy, and the General Clinical Editing and Payment Accuracy Review Guidelines reimbursement policy.

- 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 and modifier 66 is used to identify team surgeons. The Plan does not reimburse physician assistants for assisting at a surgical procedure.

- Multiple Procedures
  If more than one reimbursable surgical procedure is provided in a single operative session, the services may be subject to multiple procedure reductions. Use of modifier 51 on additional procedures is required. Note: In some cases, use of an additional modifier may be necessary. Please refer to the Bilateral and Multiple Procedure Reductions Reimbursement Policy for additional information.

- Bilateral Procedures
  If a surgical procedure provided in a single operative session is performed bilaterally, the full maximum fee is 150% of the payment group rate for the operative procedure.

- 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.

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• **Terminated Procedures**
  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.

**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. Services should be identified using modifier Q6.

All contracted providers using locum tenens physician services must follow the Plan’s credentialing guidelines for locum tenens physicians specified in the Provider Manual.

Locum tenens physician services are allowed for up to six months. If a locum tenens physician needs to be in place beyond six months, a physician needs to be fully credentialed. The physician may extend these services past the initial six months when required by the practice. To facilitate an extension beyond six months, notify the Plan 30 calendar days prior to the end of the locum tenens physician’s term so we can conduct the full credentialing process. Failure to notify the Plan will result in claim denials.

**Tobacco Cessation**
The Plan reimburses tobacco cessation counseling services when the following conditions are met:

- Individual sessions should offer at least 30 minutes of face-to-face counseling.
- Group sessions should offer a minimum of 90 minutes of counseling to a group with a minimum of 3 members and a maximum of 12 members.

*For MassHealth, this is limited to 16 sessions per 12 month cycle.*

**Evaluation and Management Services**
Please reference the General Clinical Editing and Payment Accuracy Review Guidelines reimbursement policy for further guidance regarding evaluation and management billing.

**Consultation Services**
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.


**Telephone Services**

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.

**Preventive Medicine Services**

- Preventive medicine services are represented with CPT codes 99381 through 99397. Preventive medicine CPT codes are used to identify the evaluation aspect of preventive medicine service rendered.
- When a preventive visit (99381-99397, 99429) and a problem-oriented visit (99201-99380) reported with modifier 25 are performed on the same day, for the same member, by the same provider, the Plan will reimburse the higher allowable service 100% of the contracted rate and the lesser allowed will be reimbursed at 50% of the contracted rate. This policy is applicable to professional services reported with an office place of service code.
- 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.

**Preventive Visit with Screening Services**

The Plan will not separately reimburse the following screening services when performed in conjunction with a preventive visit:

- G0101: Cervical or vaginal cancer screening; pelvic and clinical breast examination
- Q0091: Screening Papanicolaou smear; obtaining, preparing and conveyance of cervical or vaginal smear to laboratory

**New/Established Patient Visit with Visual Acuity Screening Services**

The Plan will not separately reimburse for visual acuity screening services when performed in conjunction with new/established patient evaluation and management code such as 99201-99215, unless appended with mod 59, XE, XP, XS, or XU to identify it as a significant and separately identifiable service.

**Fluoride Varnish**

For eligible MassHealth members under age 21, physicians and other qualified healthcare professionals may apply medically necessary fluoride varnish once every three months. Fluoride varnish must be reported with 99188.

**Medical Nutrition Therapy/Diabetes Self-Management Training**

The Plan reimburses physicians and other qualified healthcare professionals for medical nutrition therapy (MNT) and diabetes self-management training (DSMT).

The following codes are reimbursed for MNT:

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- 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

Reference the Plan’s Medical Policy, Medical Nutrition Therapy in the Outpatient Setting or Office Setting, OCA 3.66, for specific prior authorization rules related to MNT.

The following codes are reimbursed 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. There may be instances where certain services may require the Plan to make exceptional accommodations by utilizing modifiers. In these instances, the Plan will give specific instructions on how to bill the applicable services.

**Practice Site Differential**
The Plan applies site of service rate differentials to specific procedure codes that are routinely performed in an office setting. The underlying rate structure for a specific service is based on a physician resource based relative value scale (RBRVS) fee schedule. This RBRVS structure includes two distinct types of relative value units (RVU), facility and non-facility, for each procedure code depending on the site of service. The below list of place of service codes define when the facility setting RVU will be paid by the Plan. All other locations would be reimbursed using the non-facility RVU values inherent in the fee schedule.

<table>
<thead>
<tr>
<th>POS Code</th>
<th>POS Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>05</td>
<td>Indian Health Service - free standing</td>
</tr>
<tr>
<td>06</td>
<td>Indian Health Service Provider-based Facility</td>
</tr>
<tr>
<td>07</td>
<td>Tribal 638 Free-standing Facility</td>
</tr>
</tbody>
</table>

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<th>Code</th>
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</thead>
<tbody>
<tr>
<td>08</td>
<td>Tribal 638 Provider-based Facility</td>
</tr>
<tr>
<td>19</td>
<td>Off Campus Outpatient Hospital</td>
</tr>
<tr>
<td>20</td>
<td>Urgent Care Facility</td>
</tr>
<tr>
<td>21</td>
<td>Inpatient Hospital</td>
</tr>
<tr>
<td>22</td>
<td>On Campus Outpatient Hospital</td>
</tr>
<tr>
<td>23</td>
<td>Emergency Room - Hospital</td>
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<tr>
<td>24</td>
<td>Ambulatory Surgical Center</td>
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<tr>
<td>26</td>
<td>Military Treatment Facility</td>
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<tr>
<td>31</td>
<td>Skilled Nursing Facility</td>
</tr>
<tr>
<td>34</td>
<td>Hospice</td>
</tr>
<tr>
<td>41</td>
<td>Ambulance – Land</td>
</tr>
<tr>
<td>42</td>
<td>Ambulance – Air or Water</td>
</tr>
<tr>
<td>51</td>
<td>Inpatient Psychiatric Facility</td>
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<tr>
<td>52</td>
<td>Psychiatric Facility -- Partial Hospitalization</td>
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<tr>
<td>53</td>
<td>Community Mental Health Center</td>
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<tr>
<td>56</td>
<td>Psychiatric Residential Treatment Center</td>
</tr>
<tr>
<td>61</td>
<td>Comprehensive Inpatient Rehabilitation Facility</td>
</tr>
</tbody>
</table>

**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
- Team surgeon/Co-surgeon services (modifiers 62 and 66)
- Unusual services (modifier 22)
- Those codes identified by the Plan as necessitating additional documentation

Claims requiring submission of a report must be mailed to the Plan. For more descriptive instructions on the submission of reports, please refer to the Claim Submission and Reimbursement section of the Provider Manual.

**Services Provided through Coverage Arrangements**

Providers rendering primary care services through a coverage arrangement will be paid at the rates specified in the rendering provider’s contract with the Plan. Failure to submit proper documentation during enrollment identifying a coverage arrangement will result in claim denials when caring for a member who is assigned to another provider’s panel. Providers should contact the Plan 30 days prior to any change in a coverage arrangement to ensure all terms of participation have been met by both providers involved.

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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 providers for prolonged services.

Policy History

<table>
<thead>
<tr>
<th>Original Approval Date</th>
<th>Original Effective Date</th>
<th>Policy Owner</th>
<th>Approved by</th>
</tr>
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<tbody>
<tr>
<td>03/27/2009</td>
<td>03/27/2009</td>
<td>Payment Policy</td>
<td>Payment Policy Committee</td>
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Policy Revisions History

<table>
<thead>
<tr>
<th>Review Date</th>
<th>Summary of Revisions</th>
<th>Revision Effective Date</th>
<th>Approved by</th>
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<tbody>
<tr>
<td>12/18/2009</td>
<td>Revised to incorporate policy changes related to professional services in facility settings, site of service reimbursement, and the incorrect use of modifiers LT/RT for bilateral services.</td>
<td>12/18/2009</td>
<td>Payment Policy Committee</td>
</tr>
<tr>
<td>09/19/2011</td>
<td>Deleted definitions, non-covered services; revised to include mid-level clinician, medical nutrition therapy/Diabetes self-management training, and fluoride varnish; relocated specimen handling to General Clinical Editing Reimbursement Policy.</td>
<td>09/19/2011</td>
<td>Payment Policy Committee</td>
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<tr>
<td>04/01/2013</td>
<td>Policy update to same day preventive visit and a problem-oriented visit and preventive visit with screening.</td>
<td>04/01/2013</td>
<td>Payment Policy Committee</td>
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<tr>
<td>05/17/2013</td>
<td>Policy revision to New/Est. Visit with</td>
<td>05/17/2013</td>
<td>Payment Policy</td>
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<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 and product applicability section for BMC HealthNet Plan Qualified Health Plans, including ConnectorCare</td>
<td>12/02/2013, Payment Policy Committee</td>
</tr>
<tr>
<td>01/31/2014</td>
<td>Added ICD-10 coding</td>
<td>01/31/2014, Payment Policy Committee</td>
</tr>
<tr>
<td>12/17/2014</td>
<td>Updated coding for fluoride varnish application, added effective date for Section 1202 billing requirements, added X(EPSU)modifier statement</td>
<td>01/01/2015, Payment Policy Committee</td>
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<tr>
<td>09/20/2016</td>
<td>Annual review, new template, updated the midlevel clinician, practice site differential and modifier sections, removed applicable coding and billing section and section 1202 billing guidelines, added other applicable policies</td>
<td>01/01/2017, Payment Policy Committee</td>
</tr>
</tbody>
</table>

### Other Applicable Policies

**Reimbursement Policies**
- Bilateral and Multiple Procedure Reductions, 4.607
- General Billing and Coding Guidelines, 4.31
- General Clinical Editing and Payment Accuracy Review Guidelines, 4.108
- Provider Preventable Conditions and Serious Reportable Events, 4.610

**Medical Policies**
- Medical Nutrition Therapy in the Outpatient Setting or Office Setting, OCA 3.66

### References

- Boston Medical Center Health Net Plan; Provider Manual
- Centers for Medicare and Medicaid Services, CMS Manual System, Pub 100-04 Medicare Claims Processing, Transmittal 549, April 29, 20005, retrieved 5/2/2008
- Centers for Medicare and Medicaid Services, Medicare Benefit Policy Manual 100-02, Chapter 15 Covered Medical and Other Health Services

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• Centers for Medicare and Medicaid Services, Medicare Claims Processing Manual 100-04, Chapter 12 Physicians/Nonphysician Practitioners
• Commonwealth of Massachusetts; MassHealth Provider Manual Series; Physician Manual; Transmittal Letter PHY-113; created August 2006
• Commonwealth of Massachusetts; MassHealth Provider Manual Series; Physician Manual; Transmittal Letter PHY-120; created 1/1/2008
• Division of Health Care Finance and Policy Regulation 114.3 CMR 16.00; Surgery and Anesthesia Services
• Division of Health Care Finance and Policy Regulation 114.3 CMR 17.00; Medicine
• Division of Health Care Finance and Policy Regulation 114.3 CMR 40.00 – 40.06
• MassHealth Physician Bulletin 86

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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