Payment Policy: Out of Network Providers

Reference Number:
Product Types: NHHF Medicaid
Effective Date: 1/1/2018
Last Review Date:

Coding Implications
Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Policy Overview
NH Healthy Families (NHHF) contracts with physicians, hospitals, and other health care providers and are designated as in-network providers. Physicians, hospitals, and other health care providers who are not contracted with NHHF are designated as out-of-network providers. This policy will describe the reimbursement for out-of-network providers.

Reimbursement
Non-Emergent Services
When NHHF members receive covered, prior authorized non-emergent services from out-of-network providers, NHHF reimburses for services using a fee schedule specifically developed for out-of-network claims. If the service is not priced on the NHHF out-of-network fee schedule, NHHF pays 25% of the out-of-network provider's charges.

Emergent Services
In accordance with the Deficit Reduction Act of 2005, NHHF will cover and pay for emergency services regardless of whether the provider that furnishes the services has a contract with NHHF. NHHF shall pay non-contracted providers of Emergency and Post-Stabilization services an amount no more than the amount that would have been paid under the NH DHHS Fee-For-Service system in place at the time the service was provided.

In the event the out-of-network provider disputes the paid amount, please follow the Appeals process located in the New Hampshire Healthy Families Provider Manual.

In summary, NHHF will pay:

Physicians
- The lesser of: NHHF's out-of-network fee schedule rate effective at the time of service, or the provider's billed charges or;
- When no NHHF out-of-network fee schedule rate exists, NHHF will reimburse a rate of 25% of the provider's billed charges

Hospitals (in-state)
- The lesser of: NHHF's out-of-network fee schedule rate effective at the time of service, or the provider's billed charges or;
- When no NHHF out-of-network fee schedule rate exists, NHHF will reimburse a rate of 25% of the provider's billed charges

Hospitals (out-of-state)

- Percent of billed charges based on the Deficit Reduction Act of 2005 for emergency room visits; with the exception of laboratory revenue codes reimbursing at the out-of-network fee schedule rate or;
- Non-emergency, the lesser of: NHHF's out-of-network fee schedule rate effective at time of service, or the provider's billed charges

Laboratories

- The lesser of: out-of-network independent laboratories will be reimbursed at 50% of NHHF's out-of-network fee schedule effective at the time of service, or the provider's billed charges

All services contemplated during, or as a result of, a patient encounter including further referral services such as lab or radiology must be prior authorized. NHHF will not reimburse non-emergent, out-of-network services for members when not prior authorized.

In accordance with New Hampshire Department of Health and Human Services, the out-of-network provider shall not bill the member for any services, including balance billing.

Related Policies
n/a

References
Deficit Reduction Act (DRA) of 2005 (Pub.L. No. 109-171)

Revision History	
1/1/2018	Original Policy Draft

Important Reminder
For the purposes of this payment policy, "Health Plan" means a health plan that has adopted this payment policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any other of such health plan's affiliates, as applicable.

The purpose of this payment policy is to provide a guide to payment, which is a component of the guidelines used to assist in making coverage and payment determinations and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage and payment determinations and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable plan-level administrative policies and procedures.

This payment policy is effective as of the date determined by Health Plan. The date of posting may not be the effective date of this payment policy. This payment policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy

between the effective date of this payment policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. Health Plan retains the right to change, amend or withdraw this payment policy, and additional payment policies may be developed and adopted as needed, at any time.

This payment policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This payment policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this policy are independent contractors who exercise independent judgment and over whom Health Plan has no control or right of control. Providers are not agents or employees of Health Plan.

This payment policy is the property of Centene Corporation. Unauthorized copying, use, and distribution of this payment policy or any information contained herein are strictly prohibited. Providers, members and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members and their representatives agree to be bound by such terms and conditions by providing services to members and/or submitting claims for payment for such services.

Note: For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this payment policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this payment policy.

Note: For Medicare members, to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs and LCDs should be reviewed prior to applying the criteria set forth in this payment policy. Refer to the CMS website at http://www.cms.gov for additional information.