Providers Not Participating with Medicare

Policy Number: AS24P0003A1

Effective Date: January 1, 2025
Last Update: October 10, 2024

Payment Policy History

DATE	SUMMARY OF CHANGE
October 10, 2024	Aspirus establishes written policy for Providers Not Participating with Original Medicare. There are no changes to existing practices.

Applicable Product(s)

This policy applies to:

- Aspirus Health Plan Essential Rx
- Aspirus Health Plan Elite

Table of Contents

This page was intentionally left blank

Payment Policy Instructions

A payment policy assists in determining provider reimbursement for specific covered services. This payment policy is intended to provide a foundation for system configuration, work instructions, call scripts, and provider communications. A payment policy describes the rules for payment, which include applicable fee schedules, additional payment rules by regulatory bodies, and contractual terms. This policy is a general guideline and may be superseded by specific provider contract language.

Payment Policy Overview

This policy outlines the payment and billing requirements for providers not participating with Original Medicare.

Policy Definitions

TERM	NARRATIVE DESCRIPTION
Providers Participating in Original Medicare	Provider who has agreed to treat Medicare patients and always accepts assignment of benefits for services rendered. Accepting assignment means that the provider accepts the Medicare allowed amount for health care service(s) as payment in full (less the member out-of-pocket amount).
Providers Not Participating in Original Medicare	A provider who has agreed to treat Medicare patients but does not agree to accept assignment in all cases (they may accept assignment on a case-by-case basis). While these providers have agreed to accept Medicare insurance, they do not always accept Medicare's allowed amount for health care services as payment in full.
Providers Opting Out of Original Medicare	A provider who does not accept Medicare patients and has signed an opt-out affidavit to be excluded from Medicare programs. These providers should not bill Medicare programs except in emergency and urgent care service situations.
Emergency Care Services	Inpatient or outpatient hospital services that are necessary to prevent death or serious impairment of health and, because of the danger to life or health, require use of the most accessible hospital available and equipped to furnish those services. Congress intended that the term "emergency or urgent care services" not be

	limited to emergency services since they also included "urgent care services."
Urgent Services	Services furnished to an individual who requires services to be furnished within 12 hours to avoid the onset of an emergency medical condition.
Cost-Share	The portion of the allowed amount the health plan member is responsible to pay for. It is global term that includes copayment, coinsurance, and deductibles.
Limiting Charge	The maximum dollar amount that the Federal Government allows a non-participating physician to charge Medicare patients for a given service.
Original Medicare (aka Traditional Medicare)	The fee-for-service healthcare program managed by the federal government Centers for Medicare and Medicaid Services (CMS), including Medicare Part A and Part B services.

Enrollee Eligibility Criteria

This section of the policy provides information that is specific to the Aspirus Health Plan member, including information about the criteria the member must meet in order for the service(s) in the policy to be eligible for payment.

The member must be actively enrolled in a Aspirus Health Plan Medicare Advantage product for this policy to be applicable.

Eligible Providers or Facilities

Outlined below are the specific criteria a provider must meet in order for the service(s) in this policy to be eligible for payment.

This policy applies to providers administering services to Aspirus Health Plan Medicare Advantage members. See below for payment scenarios based on provider status.

Excluded Provider Types

Outlined below is information regarding providers who are not eligible to furnish the service(s) listed in this policy.

Providers and suppliers who are not eligible to apply for enrollment in the Original Medicare Program.

Modifiers, CPT, HCPCS and Revenue Codes

General Information

The Current Procedural Terminology (CPT®), Healthcare Common Procedure Coding System (HCPCS), and Revenue codes listed in this policy are for reference purposes only. Including information in this policy does not imply that the service described by a code is a covered or non-covered health service. The inclusion of a code does not imply any right to reimbursement or guarantee of claim payment.

Modifiers

The modifiers listed below are not intended to be a comprehensive list of all modifiers. Instead, the modifiers that are listed are those that must be appended to the CPT® / HCPCS codes listed below. Based on the service(s) provided, and the circumstances surrounding those services it may, based on correct coding, be appropriate to append an additional modifier(s) to the CPT® / HCPCS code.

When a service requires multiple modifiers, the modifiers must be submitted in the order listed below. If it is necessary to add additional modifiers, they should be added after the modifiers listed below.

MODIFIER(S)	NARRATIVE DESCRIPTION
AK	Non Participating Physician (Critical Access Method II)
GJ	"Opt-Out" Practitioner, Emergency or Urgent Services

CPT and/or HCPCS Code(s)

Not applicable.

Revenue Codes

Not applicable.

Payment Information

General Information

Aspirus Health Plan follows Original Medicare guidance for providers who do not participate in the Aspirus Health Plan Medicare Advantage network(s). Aspirus Health Plan is required to reimburse these providers for covered services provided to Aspirus Health Plan Medicare Advantage members at an

amount that is no less than the amount that would be reimbursed under Original Medicare. Aspirus Health Plan expects providers to follow Medicare requirements regarding balance billing.

Aspirus Health Plan takes into consideration the provider's participation status with Original Medicare when determining payment for professional claims. When a provider does not participate in the Aspirus Health Plan Medicare Advantage network(s), total reimbursement will be determined based on the provider's status with Original Medicare under the following scenarios:

- Provider participates with Original Medicare;
- Provider does not participate with Original Medicare but accepted assignment;
- Provider does not participate with Original Medicare and did not accept assignment; or
- Provider has opted-out of Original Medicare.

Listed below is information explaining Aspirus Health Plan pricing and the source documents used to define how Aspirus Health Plan allowed amounts are determined.

Specific Reimbursement Scenarios

Providers Participating in Original Medicare

Professional Claims

Providers who do not participate in the Aspirus Health Plan Medicare Advantage network(s) but have elected to participate with Original Medicare will be reimbursed at the Original Medicare participating allowed amount based on the geographic location of the provider (less the member cost-share) for covered services.

Medicare participating providers may bill the member for any cost-share amount they owe but may not bill the member for the difference between their charge and the Aspirus Health Plan allowed amount.

Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) & Parenteral and Enteral Nutrition (DMEPEN)

The same guidelines associated with professional services apply to DMEPOS and DMEPEN services.

Providers Not Participating in Original Medicare, Accepting Assignment

Note: Aspirus Health Plan follows CMS guidance outlined in Chapter 1, Section 30.3.1 of the Medicare Claims Processing Manual as it relates to providers who must mandatorily accept assignment.

Professional Claims

Providers who do not participate in the Aspirus Health Plan Medicare Advantage network(s) and do not participate with Original Medicare but are accepting assignment will be reimbursed at 100% (Medicare guidance indicates a minimum reimbursement of 95%) of the Original Medicare allowed amount based on the geographic location of the provider (less the member cost-share) for covered services.

A Medicare non-participating provider is limited on the amount they may charge Medicare patients for their services. The actual charge may not exceed the limiting charge for the service.

Medicare non-participating providers who accept assignment may bill the member for any cost-share amount they owe but may not bill the member for the difference between their charge and the Aspirus Health Plan allowed amount.

Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) & Parenteral and Enteral Nutrition (DMEPEN)

The same guidelines associated with professional services apply to DMEPOS and DMEPEN services.

Providers Not Participating in Original Medicare, Not Accepting Assignment

Professional Claims

Providers who do not participate in the Aspirus Health Plan Medicare Advantage network(s) and do not participate with Original Medicare and are not accepting assignment will be reimbursed at 100% (Medicare guidance indicates a minimum reimbursement of 95%) of the Original Medicare allowed amount based on the geographic location of the provider (less the member cost-share) for covered services.

A Medicare non-participating provider is limited on the amount they may charge Medicare patients for their services. The actual charge may not exceed the limiting charge for the service.

The provider may bill the member for any cost-share amount they owe & the difference between the limiting charge and Aspirus Health Plan allowed amount.

Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) & Parenteral and Enteral Nutrition (DMEPEN)

CMS has not developed limiting charge amounts for DMEPOS or DMEPEN services. Accordingly, the provider's charge will replace the limiting charge amount for DME.

Other Considerations

Critical Access Hospitals (CAH) Method II Providers, Not Participating with Original Medicare

Professional Claims

CAH Method II practitioners have reassigned their billing rights for professional services to the CAH. Covered services rendered by a provider who practices under a Critical Access Method II hospital are reimbursed at the lesser of the billed charge or 115% of the Medicare Professional Fee Schedule.

When a Method II practitioner does not participate in the Aspirus Health Plan Medicare Advantage network(s) and does not participate with Original Medicare, the AK modifier (Non-Participating CAH Method II Practitioner) must be utilized. These providers will be reimbursed at 100% (Medicare guidance indicates a minimum reimbursement of 95%) of the Original Medicare allowed amount based on the geographic location of the provider (less the member cost-share) for covered services.

Payment calculation example using Critical Access Hospital Method II methodology:

- Facility-specific MPFS amount times the non-participating physician reduction (0.95) minus member cost-share times 1.15)

  ((Facility MPFS * .95) - Member Cost Share) * 1.15

The provider may bill the member for any cost-share amount they owe but may not bill the member for the difference between their charge and the Aspirus Health Plan allowed amount.

Providers Opting Out of Original Medicare

General Opt Out Guidance

When a provider opts out of Original Medicare, they cannot be involved in any Medicare program including Aspirus Health Plan Medicare Advantage network(s) and are not entitled to any payment from Aspirus Health Plan. Medicare makes an exception for emergency care and urgent services. Except for emergency and urgent services, Aspirus Health Plan will deny claims received from providers who have opted out of Medicare.

Emergency Care or Urgent Services

In an emergency or urgent care situation, a provider who opts out of Medicare may treat a Aspirus Health Plan Medicare Advantage member (with whom there is no private contract) and bill Aspirus

Health Plan on behalf of the member. The provider may not charge the beneficiary more than the limiting charge amount established by Original Medicare and must submit a claim to Aspirus Health Plan on the member's behalf.

Use of the -GJ modifier (Opt-Out Physician/Practitioner Emergency or Urgent Services)

The -GJ modifier (Opt-out physician/practitioner emergency or urgent services) must be applied to each claim line. Use of this modifier attests that the service(s) furnished by an opt-out provider were emergent or urgent services.

If Aspirus Health Plan receives a claim from a provider who has opted-out of Medicare and the -GJ modifier is not appended to the claim line(s), Aspirus Health Plan will deny the claim. In addition, Aspirus Health Plan will deny reimbursement for emergency or urgent services if the provider and the Aspirus Health Plan member have entered a private contract prior to furnishing emergency or urgent services within the provider's two year opt out period.

Pricing of Emergency Care and/or Urgent Services- Professional Services

When an Opt-Out provider furnishes eligible emergency or urgent care services, Aspirus Health Plan will process the claim as if the provider is a non-participating provider. Providers in this scenario will be reimbursed at 100% (Medicare guidance indicates a minimum reimbursement of 95%) of the Original Medicare allowed amount based on the geographic location of the provider (less the member cost-share) for covered services.

Since Emergency and/or Urgent Care Services are considered covered services furnished by a nonparticipating physician or practitioner, the rules in effect absent of the opt-out apply. This means that providers in this scenario may choose whether they will accept assignment or not per Medicare guidelines. Aspirus Health Plan expects opt out providers to follow Medicare standards regarding balance billing.

Facilities and Other Providers That Do Not Participate with Original Medicare

Aspirus Health Plan follows Original Medicare pricing guidelines for providers who do not participate in Aspirus Health Plan Medicare Advantage network(s). Aspirus Health Plan is required to reimburse providers who do not participate in Aspirus Health Plan Medicare Advantage network(s) for covered services provided to Aspirus Health Plan Medicare Advantage members at an amount that is no less than the amount that would be reimbursed under Original Medicare. Providers are required to accept as payment in full, the amount that the provider would collect if the Aspirus Health Plan member were

enrolled in Original Medicare. Aspirus Health Plan expects providers to follow Original Medicare requirements regarding balance billing.

Billing Requirements and Directions

Billing Guidelines

Providers are required to submit claims on behalf of Aspirus Health Plan members.

General Information

Aspirus Health Plan will follow Medicare guidelines related to pricing and processing claims including, but not limited to the use of:

- Geographic adjustments established by CMS;
- Regulatory pricing adjustments required by CMS;
- Claim edits
  - NCCI edits
  - Procedure to Procedure edits (PTP)
  - Medically Unlikely Edits (MUE)
  - Add-on Code Edits
  - Facility Edits;
- The definition of services included and excluded in the global surgical package;
- Multiple surgical reduction; and bilateral procedures reductions;
- Increases or decreases to the allowed amount based on the modifier(s) appended to a claim line;
- National (NCD) and Local (LCD) coverage document criteria;
- Decreases to the allowed amount based on the type of provider who rendered the service, where applicable; and
- Regulatory decreases or increases applicable to Aspirus Health Plan.

Prior Authorization, Notification, and Threshold Information

Prior Authorization, Notification, and Threshold Requirements

Aspirus Health Plan does update authorization, notification, and threshold requirements from time-to- time. The most current prior authorization requirements can be found here.

Related Payment Policy Information

Outlined below are other policies that may relate to this policy and/or may have an impact on this policy.

POLICY NUMBER	POLICY TITLE

Aspirus Health Plan payment policies are updated from time to time. The most current Aspirus Health Plan payment policies can be found here.

Source Documents and Regulatory References

Claim Submissions

CMS Internet Only Manual (IOM), Publication 100-02, Medicare Claims Processing Manual, Chapter 1, Section 70.8.8

Section 1848((4) (A) of the Social Security Act

Section 1842(b)(6)(A)) of the Social Security Act

Taxonomy

CMS Taxonomy Information

National Uniform Claim Committee - Provider Taxonomy (nucc.org)

Medicare Provider and Supplier Taxonomy Crosswalk | CMS Data

NPI

CMS – NPI: What You Need to Know

National Provider Identifier Standard (NPI) | CMS

Claims Edits, NCD's, LCD's

Medicare NCCI Medically Unlikely Edits | CMS

Medicare NCCI Procedure to Procedure (PTP) Edits | CMS

Medicare NCCI Add-on Code Edits | CMS

NCCI for Medicare | CMS

Participating and Non-Participating Medicare Providers

MA Payment Guide for Out of Network Payments (cms.gov)

Medicare Claims Processing Manual 100-04

- Medicare Claims Processing Manual, Chapter 1, Section 30
- Medicare Claims Processing Manual, Chapter 4

Medicare Managed Care Manual 100-16

- Medicare Managed Care Manual, Chapter 4
- Medicare Managed Care Manual, Chapter 6

MLN901344 How to Use the PFS Look-Up Tool (cms.gov)

Opting Out of the Medicare Program

Manage Your Enrollment | CMS

Medicare Benefit Policy Manual 100-02

- Medicare Benefit Policy Manual, Chapter 15

MLN Matters SE1311 Revised

Non-Covered Services

MLN906765 – Items & Services Not Covered Under Medicare (cms.gov)

Provider Payment Dispute Resolution

Provider Payment Dispute Resolution for Non-Contracted Providers | CMS

Disclaimer

"Payment Policies assist in administering payment for Aspirus Health Plan benefits under Aspirus Health Plan benefit Plans. Payment Policies are intended to serve only as a general reference resource regarding Aspirus Health Plan administration of health benefits and are not intended to address all issues related to payment for health care services provided to Aspirus Health Plan members. When submitting claims, all providers must first identify member eligibility, federal and

state legislation or regulatory guidance regarding claims submission, Aspirus Health Plan provider participation agreement contract terms, and the member-specific Evidence of Coverage (EOC) or other benefit document. In the event of a conflict, these sources supersede the Payment Policies. Payment Policies are provided for informational purposes and do not constitute coding or compliance advice. Providers are responsible for submission of accurate and compliant claims. In addition to Payment Policies, Aspirus Health Plan also uses tools developed by third parties, such as the Current Procedural Terminology (CPT®), InterQual guidelines, Centers for Medicare and Medicaid Services (CMS), the Minnesota Department of Human Services (DHS), or other coding guidelines, to assist in administering health benefits. References to CPT® or other sources in Aspirus Health Plan Payment Policies are for definitional purposes only and do not imply any right to payment. Other Aspirus Health Plan Policies and Coverage Determination Guidelines may also apply. Aspirus Health Plan reserves the right, in its sole discretion, to modify its Policies and Guidelines as necessary and to administer payments in a manner other thanas described by Aspirus Health Plan Payment Policies when necessitated by operational considerations."