

Out of Network Provider Services

Policy

Mass General Brigham Health Plan negotiates rates with physicians, hospitals, and other health care providers. These providers are called in-network, and they agree to accept Mass General Brigham Health Plan contracted rates. Physicians, hospitals, and other health care providers who do not accept Mass General Brigham Health Plan contracted rates are called out-of-network providers.

Policy Definition

Some of the health plans administered or insured by AllWays Health Partners provide out-of-network health care coverage; however, some of our health plans cover out-of-network services only for treatment of an emergent or urgent condition. Members with out-of-network benefits may use doctors and other health care providers who are not in the AllWays Health Partners network or participating providers for non-emergency services, as well. These providers are called out-of-network for elective services.

Authorization Requirements

Various services and procedures require referral and/or prior authorization. Referral and prior authorization requirements can be located [here](#).

All claims are subject to audit services and medical records may be requested from the billing provider.

Reimbursement

Covered services are defined by the member's benefit plan. The manner in which covered services are reimbursed is determined by the Mass General Brigham Health Plan in compliance with existing federal and state regulations including the No Surprises Act for commercial claims submitted for dates of service on or after 01/01/2022. Member liability amounts may include but are not limited to copayments; deductible(s); and/or co-insurance; and will be applied dependent upon the member's benefit plan and in compliance with existing federal regulations including the No Surprises Act.

No Surprises Act eligible services, including emergency service, air ambulance services and certain professional services rendered by out of network provider at a in network hospital or ambulatory surgical center will apply for the appropriate Qualified Payment Amount (QPA).

Provider Payment Guidelines

Non-NSA eligible services will be reimbursed using a fee schedule developed specifically for out-of-network claims.

This fee schedule is derived using usual and customary fees. If the service submitted is not priced on the Mass General Brigham Health Plan out-of-network fee schedule, network provider's charges. In the event the provider disputes the paid amount, Mass General Brigham Health Plan and the provider may negotiate a rate as follows:

Services that qualify for the No Surprise Billing Act- Federally required Open Negotiation period and Independent Dispute Resolution (IDR) if elected by the out of network provider.

Services that do not qualify for the No Surprise Billing Act-Standard pricing policy will apply, including a single case agreement when warranted.

NSA-Eligible Out of Network Services

*Reimbursement complies with NSA regulations, including the QPA-Qualified Payment Amount, option for Independent Dispute Resolution after open negotiation period.

The member's cost sharing cannot exceed the cost sharing that applies to the Qualified Payment Amount, regardless of the final rate paid to the out of network provider.

Non-NSA Eligible Out of Network Services are reimbursed as follows:

- The lesser of: Mass General Brigham Health Plan out-of-network fee schedule rate in effect at the time of service, or the provider's billed charges or;
- When no Mass General Brigham Health Plan out-of-network fee schedule rate exists, Mass General Brigham Health Plan will reimburse a rate of 50% of the provider's billed charges or;
- A negotiated rate, captured in a single case rate, described by Mass General Brigham Health Plan as a Letter of Agreement (LOA)

Mass General Brigham Health Plan Does *Not* Reimburse

- Services not covered under the member's benefit plan
- Non-emergent, out-of-network services for HMO members, when not prior authorized

References

[MA Payment Guide for Out of Network Payments \(cms.gov\)](#)

Provider Payment Guidelines

Publication History

Out-of-Network Provider Services	Owner: Network Management
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May 12, 2016	<i>Original documentation</i>
January 1, 2019	<i>Document restructure; codes, code descriptor and references updated</i>
March 1, 2022	<i>Updated reimbursement information regarding the No Surprise Billing Act and administrative edits</i>
January 1, 2023	<i>Document rebrand</i>

This document is designed for informational purposes only. Claims payment is subject to member eligibility and benefits on the date of service, coordination of benefits, referral/authorization/notification and utilization management guidelines when applicable, adherence to plan policies and procedures, claims editing logic, and provider contractual agreement. In the event of a conflict between this payment guideline and the provider's agreement, the terms and conditions of the provider's agreement shall prevail. Payment policies are intended to assist providers in obtaining Mass General Brigham Health Plan's payment information. Payment policy determines the rationale by which a submitted claim for service is processed and paid. Payment policy formulation takes into consideration a variety of factors including: the terms of the participating providers' contract(s); scope of benefits included in a given member's benefit plan; clinical rationale, industry-standard procedure code edits, and industry-standard coding conventions.

Mass General Brigham Health Plan includes Mass General Brigham Health Plan, Inc., and Mass General Brigham Health Plan Insurance Company.