Non-Participating Provider Reimbursement

Reimbursement Policy ID: RPC.0101.PA02

Recent review date: 08/2026

Reimbursement policies and their resulting edits are based on guidelines from established industry sources, such as the Centers for Medicare and Medicaid Services (CMS), the American Medical Association (AMA), state and federal regulatory agencies, and medical specialty professional societies. Reimbursement policies are intended as a general reference and do not constitute a contract or other guarantee of payment. The health plan may use reasonable discretion in interpreting and applying its policies to services provided in a particular case and may modify its policies at any time.

In making claim payment determinations, the health plan also uses coding terminology and methodologies based on accepted industry standards, including Current Procedural Terminology (CPT®); the Healthcare Common Procedure Coding System (HCPCS); and the International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM), and other relevant sources. Other factors that may affect payment include medical record documentation, legislative or regulatory mandates, a provider's contract, a member's eligibility in receiving covered services, submission of clean claims, other health plan policies, and other relevant factors. These factors may supplement, modify, or in some cases supersede reimbursement policies.

This reimbursement policy applies to all health care services billed on a CMS-1500 form or its electronic equivalent, or when billed on a UB-04 form or its electronic equivalent.

To the extent that any procedure and/or diagnosis codes are specified in this policy, such inclusion is provided for reference purposes only, may not be all inclusive, and is not intended to serve as billing instructions. Listing of a code in this policy does not imply that the service described by the code is a covered or non-covered health service. Benefit coverage for health services is determined by federal, state, or contractual requirements and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other Policies and Guidelines may apply.

Policy Overview

This policy addresses reimbursement for providers not participating with the health plan or located out of the state.

Exceptions

N/A

Reimbursement Guidelines

Reimbursement shall be 100% of the Medicare allowed amount less all applicable cost-sharing amounts and will be reduced by a percentage amount that is equivalent to the percentage reduction in Medicare payments made by CMS resulting from mandatory federal budget reductions that are effectuated through the sequestration process or by other means.

Definitions

N/A

Edit Sources

I. Current Procedural Terminology (CPT) and associated publications and services.
II. International Classification of Diseases,10th Revision, Clinical Modification (ICD-10-CM).
III. Healthcare Common Procedure Coding System (HCPCS).
IV. Centers for Medicare and Medicaid Services (CMS)
V. Medicare Fee Schedule(s)
VI. 42 C.F.R. §438.114

Attachments

N/A

Associated Policies

N/A

Policy History

09/2026	• Removed the next review date • Replaced the plan name with “the health plan”
08/2026	Reimbursement Policy Committee Approval
07/2026	Biennial Review • No major changes
06/2025	Minor updates to formatting and syntax
04/2025	Revised preamble
12/2024	Reimbursement Policy Committee Approval