MA Payment Guide

for Out of Network Payments

10/01/08 Update

This is a guide to help MA plans in situations where they are required to pay the original Medicare rate to out of network providers. **This document is just a general outline of Medicare payments and as such, does not contain many of the payment details.** The payment rates described in this document do not apply to a plan's network providers. Nor do they apply in all cases to PFFS plans.

This guide is updated periodically, and a link to it can be found on

http://www.cms.hhs.gov/MedicareAdvtgSpecRateStats/downloads/oon-payments.pdf

Please direct questions, comments, or suspected inaccuracies in this guide to Bill London of CMS's Office of the Actuary: William.London@cms.hhs.gov .

Note that PFFS plans are permitted to establish their own fee-schedules and balance-billing rules, which, in some cases, differ from FFS payment rates and balance-billing rules. Although a non-network PFFS plan must reimburse all providers at least at the FFS payment rate, a provider treating an enrollee of a PFFS plan will need to carefully examine the fee-schedule and balance billing rules of a PFFS plan to decide if the terms and conditions of participation warrant a decision to treat and be "deemed" a contracting provider. A decision to treat a specific PFFS plan enrollee is ad hoc and does not require the provider to treat other PFFS plan enrollees. See section 150 of Chapter 4 of the Medicare Managed Care Manual. Go to http://www.cms.hhs.gov/Manuals/IOM/list.asp#TopOfPage and click 100-16.

Once again, please keep in mind that this payment guide does not apply to the network providers of a plan.

The first site to visit for payment descriptions is http://www.cms.hhs.gov/home/medicare.asp This site has a link for most services covered by Medicare.

The Medicare payment manuals can be accessed on: http://www.cms.hhs.gov/Manuals/IOM/list.asp

Fee schedules can be found on: http://www.cms.hhs.gov/FeeScheduleGenInfo/

All available Medicare Pricers are on: http://www.cms.hhs.gov/PCPricer/ They are generally updated quarterly.

Medicare cost report information (HCRIS) is on: http://www.cms.hhs.gov/CostReports/

The CMS online manual system can be found on http://www.cms.hhs.gov/Manuals/01_Overview.asp#TopOfPage

That page also has a hyperlink to the "CMS transmittals" page.

CMS transmittals communicate new or changed policies or procedures that will be incorporate into the CMS Online Manual System. Instead of first using the above hyperlink, one may go directly to the transmittals page:

http://www.cms.hhs.gov/transmittals/

Coverage decisions can be found on http://www.cms.hhs.gov/mcd/overview.asp , then clicking on "Medicare coverage". The Medicare National Coverage Determinations Manual can be directly accessed by clicking: http://www.cms.hhs.gov/Manuals/IOM/itemdetail.asp?filterType=none&filterByDID=-99&sortByDID=1&sortOrder=ascending&itemID=CMS014961

Another important resource for payment policies is http://www.cms.hhs.gov/MedlearnMattersArticles/ . It has a link to a search engine for these articles.

The Medicare Guide to Rural Health Services is on http://www.cms.hhs.gov/center/rural.asp

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Acute Care Hospital - Inpatient Services

These hospitals are paid a DRG amount using the Medicare prospective payment system (PPS) in all states except Maryland. Software called the Pricer is used to determine much of the payment for each discharge, and these payments vary by hospital.

DRG based payments paid for a discharge consist of operating and capital costs which include IME, DSH, outliers, and the new technology add on. A separate payment is made for hemophilia clotting factors.

Submitted charges are used for the calculation of outlier payments. Otherwise, original Medicare generally pays the PPS amount even if the submitted charge is lower.

The "pass-throughs" which are reflected in the Pricer but paid bi-weekly by original Medicare include:

1) DGME
2) Capital for the first 2 years of a new hospital (generally 85% of Medicare allowed capital costs)
3) Organ acquisition costs (excludes bone marrow transplants)
4) CRNA's- for small rural hospitals
5) Nursing and allied health education costs

Bad debt is not in the Pricer, and is paid bi-weekly.

Outliers:
Payment is 80% of the excess of the cost of an admission over the sum of the DRG payment (including IME and DSH) and a threshold amount. The threshold amount changes each year. The cost of an admission is generally determined by multiplying the hospital's cost to charge ratio by its charge.

Transfers from an acute care hospital to another acute care hospital:
For most DRG's, the first hospital is paid a per diem rate equal to the DRG amount divided by the average length of stay for that DRG. However on the first day, twice the per diem is paid. A maximum of the full DRG is paid to the first hospital. The second hospital is paid the full DRG. Certain DRGs have different policies for transfers.

Wrap around payments:
Medicare will make extra payments on behalf of members of regional PPO's when treated in certain acute care hospitals that qualify as "essential hospitals." All "essential hospitals" are, by definition, non-network. There are several conditions that must be met for the hospital to receive this extra payment.

Payment information for MA plans:
Since operating IME and DGME for inpatients are paid by FI's on behalf of MA members, they do not have to be paid by MA plans. However, "capital IME" does have to be paid by MA plans since it is part of the capital payment, not the IME cost.

MA plans do not need to pay the organ acquisition cost pass-through; but could instead pay the full cost for an organ acquisition for one of their own members. Please note that if one runs the Pricer with HMO=yes, the organ acquisition cost passthroughs as well as the graduate medical education costs are omitted.

There are 2 nursing and allied health (NAH) education payments reflected on the hospital cost reports:

1) cost based NAH amount – MA plans must pay to non-contracted hospitals
2) BBRA NAH add-on taken from DGME payments – MA plans do not have to pay to non-contracted hospitals. This is paid by FI's on behalf of MA members.

These rules only apply to PPS hospitals, not cost hospitals such as critical access hospitals.

Item #1 is included on the cost reports on WS E Part A lines 14 and 15.
Item #2 is on line 11.01 that says "Nursing and Allied Health Managed Care." It is in effect, a redistribution of the DGME payment on line 11.

The DRG's are determined using the PRICER program. Hospital specific data is contained on the Provider Specific Files. The PRICER's on the Internet already contain the provider specific files and can be found on http://www.cms.hhs.gov/PCPricer/

Hospital payment details are on: http://www.cms.hhs.gov/AcuteInpatientPPS/

Hospital Cost Report Master File (HCRIS): The hospital cost report file is updated quarterly and can be found on http://www.cms.hhs.gov/CostReports/

Capital payments are calculated on worksheet L of the Medicare cost report. The IME add-on is reported on line 4.03 and the DSH add-on is reported on line 5.04. These line items are then added to the hospital's capital payment based on the federal rate to get the total capital payment on line 6.

Part of the calculation used to determine whether or not a hospital is eligible for the Medicare DSH add-on payment is based on the percentage of days for which their Part A entitled patients received SSI payments from the Social Security Administration (SSA). The SSA provides the SSI information to CMS and it is uploaded into the Medicare Provider Analysis and Review (MedPAR) file. CMS then pulls all of the Medicare days for each eligible hospital and determines the percentage of days for which the Medicare beneficiaries were simultaneously eligible for SSI and Medicare. The Medicare beneficiary days should include Medicare Advantage days. Hospitals should submit an informational-only bill to their FI or A/B MAC on a covered 11X TOB (type of bill) with Condition Code 04 in order to count Medicare Advantage days in the DSH Medicare fraction. Please see the DSH links below:

CMS Manual Instructions:
http://www.cms.hhs.gov/transmittals/downloads/R1311CP.pdf

CMS MLN Matters article:
http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5647.pdf

CMS Provider Inquiry Assistance Article:
http://www.cms.hhs.gov/ContractorLearningResources/downloads/JA5647.pdf

Medicare has a new policy to prohibit payments for certain hospital acquired conditions (HAC). These conditions are also referred to as "never events" since they should never happen. Medicare will eliminate the diagnosis codes identified as HACs when calculating DRGs. To the extent an MAO does not pay a non-contracting PPS hospital for a "never" event, the Medicare certified hospital cannot bill the member.

MAOs (and hospitals) have asked us to tell them whether an MAO must pay a **contracting** hospital for HACs. That's a question that the statute tells us not to answer, due to the "non-interference" clause at §1854(a)(6)(B)(iii) of the Social Security Act. On the other hand, MAOs are not required to withhold payment for HACs.

Hospital Outpatient

Services subject to outpatient PPS are paid by the APC methodology. Other services, such as lab, are usually paid on a fee schedule. Physician fees are paid on the physician fee schedule. Hospitals exempt from outpatient PPS include those in Maryland, Indian Health Service, and Critical Access Hospitals. The PPS services are priced using the outpatient code editor, and the outpatient Pricer.

As is the case with inpatient services, APC based payments are made even if the submitted charges for these facility costs are lower. However, the submitted facility charges are used for the calculation of outlier payments.

TOPS payments:
Transitional outpatient payments are made to those hospitals that are paid less under PPS than they would have been paid under the old cost system. These "hold-harmless" payments are called TOPS payments and were payable through the end of 2003 for most hospitals. Certain small hospitals (including small rural and small sole community hospitals) continue to be eligible for TOPS payments.

Outlier payments:
If the cost of a visit exceeds a threshold amount, the OPD is paid an outlier payment. The threshold amounts are subject to change each year.

OPD drugs:
See drug section.

Passthroughs:
The CMS Internet site has files showing payment amounts for those drugs and devices which are paid as a "pass-through". They are paid in addition to the APC payment.

Coinsurance:
Coinsurance amounts vary for each APC of each provider. Providers are allowed to waive coinsurance in excess of 20% for any given APC.

Payment information for MA plans:
OPD details are on:

http://www.cms.hhs.gov/HospitalOutpatientPPS/ The hyperlink in the left hand margin that says "Addendum A and Addendum B updates" shows APC and procedure codes.

Home Health

Payments are made on a PPS basis. The payment groups are called HHRG's. These payments cover episodes of care up to 60 days. Adjustments are made for short stays and for outliers. Durable medical equipment is excluded from PPS and is instead paid on a fee schedule.

The CMS home health page is http://www.cms.hhs.gov/center/hha.asp . This page has links to detailed information on how home health payments are determined. The HIPPS groups used in home health bills are explained on:
http://www.cms.hhs.gov/HomeHealthPPS/03_coding&billing.asp#TopOfPage

Master Cost Report File: See http://www.cms.hhs.gov/CostReports/

PPS payments are made even if they are greater than the submitted charge.

Payment information for MA plans:
MA organizations may only make LUPA (low utilization payment adjustment) payments in situations similar to those in which original Medicare does. That is, in the case of an episode with four or fewer visits, the LUPA applies. Otherwise, payments must be computed using the HIPPS system based on HHRGs and 60-day episodes of care.

Skilled Nursing Facilities

SNF is paid on PPS. A case-mix adjusted payment for varying numbers of days of SNF care is made using one of roughly 50 or so Resource Utilization Groups, Version III (RUG-III). The RUG is identified in the first 3 positions of the HIPPS code. There may be an add-on for AIDS patients.

Payment information for MA plans:
The SNF internet page is: http://www.cms.hhs.gov/SNFPPS/ This page also has a link to the quarterly Pricer. Further information is on: www.cms.hhs.gov/snfconsolidatedbilling

PPS payments may be payable even if they are greater than the submitted charge.

Clarification on SNF no payment and MA claims billing procedures may be found on:
http://www.cms.hhs.gov/transmittals/downloads/R1394CP.pdf

Swing Beds

Swing beds are paid on the skilled nursing facility PPS. Critical Access Hospital swing beds are exempt from PPS and are paid 101% of reasonable costs.

Critical Access Hospitals

These are certain small hospitals with limited lengths of stay for acute patients.

The inpatient and outpatient services, as well as swing beds, for these hospitals are paid on a reasonable cost basis. Ambulance is also paid costs if it is the only supplier within a certain number of miles. CAH's are generally paid 101% of costs.

If a physician elects to reassign their claims to the CAH (election of method II), the CAH is paid an extra 15% of Medicare's portion of the physician fee schedule amount. This election can only be made for hospital outpatient physician services.

The MA plan must also pay 115% of the Medicare physician fee schedule for physicians who have reassigned outpatient hospital claims under method II. In this case the hospital bills the physician services on the same bill as the hospital services. The MA plan then does what the FI's do; it pays the facility part of the bill to the hospital based on 101% of costs; and it pays 115% of the physician fee schedule to the hospital. The plan does not make payments directly to the physician if payments for a given service were paid directly to the hospital under method II.

Please note that the HPSA and PSA physician fee schedule bonuses apply under both method I (direct billing from the doctor for outpatient services in a CAH) and method II. In other words, under method II billing the HPSA and PSA bonuses are applied to the higher consolidated billing amount.

Payment information for MA plans:
FI's determine the interim payment amounts for each hospital based on their costs. For outpatient services, the payment amount is calculated by the FI's by multiplying the billed charges by the cost to charge ratio (ccr) for each hospital. Inpatient services are paid a per diem cost. The MA plan may ask the billing hospital to submit a copy of their most recent interim rate letter from their Medicare fiscal intermediary (FI). The CAH internet site is http://www.cms.hhs.gov/center/cah.asp . To access a helpful Q and A section on that page, click on "frequently asked questions" which is a hyperlink under the section called "resources". Please note that as is the case with other hospitals, plans are not required to cost settle with CAHs.

Physician Services

Physicians are paid using the lesser of billed charges, or the Medicare Physician Fee Schedule (MFS). A 10% bonus is paid if these services are furnished in a health professional shortage area (HPSA). An additional 5% PSA bonus is payable through at least 6/30/08 in areas designated by CMS as "physician scarcity areas". More details, including qualifying zip codes, can be found on http://www.cms.hhs.gov/HPSAPSAPhysicianBonuses/ and

http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5698.pdf

The fee schedule for physicians that do not participate in Medicare is 95% of the par fee schedule. Medicare pays 80% of the fee schedule payment after the Part B deductible is met, and the beneficiary coinsurance is 20%. Certain vaccines and a small number of other services may not be subject to either the deductible, the coinsurance, or both.

Psychotherapy, unless the patient is an inpatient in a hospital, has 50% coinsurance. Medicare calculates it's payment as 80% of 62.5% of the allowed charge.

Anesthesiologists have a unique payment under the MFS, and payment depends on base and time units as well as the participation of CRNA's.

Payments for physical therapy, speech, language, and occupational therapy have different rules, and some years are subject to annual payment limits per beneficiary. For example, so far in 2008, mostly for non-hospital settings, there are limits for PT and speech/language therapy combined; and a separate limit for OT. However, patients may qualify for exceptions to these limits, at least until 6/30/08, depending on medical necessity.

Medicare usually pays as follows for non-physician practitioner independent billings:

- Physician Assistants: 85% MFS
- Nurse Practitioner: 85% MFS
- Clinical Nurse Specialist: 85% MFS
- Registered dietician: 85% MFS
- Clinical Psychologist: 100% MFS
- Clinical Social Worker: 75% MFS
- Audiologist, Chiropractor, Podiatrist, Optometrist, and Dentist: 100% MFS
- Assistant at surgery: If a physician is the assistant, payment is 16% MFS. If a physician assistant is the assistant, payment is 85% times 16% MFS.
- Co-surgery: MFS increased by 25%; then split between 2 doctors. Each then paid 62.5% MFS.
- Nurse midwife: 65% MFS

Physicians and other qualified professionals will be eligible to receive lump sum transitional bonus incentive payments in 2008 that are contingent on the reporting of quality measures on claims incurred in the 6 months ending 12/31/07. This is called the PQRI bonus, and is limited to 1.5% of all physician fee schedule payments to a particular physician or qualified professional for covered professional services provided during the 6 month period. The actual payments to a specific provider however, are further limited by a cap that is determined using national data. This cap is based on 300% of national costs per measure and will not be known until 2008.

Bonus payments for claims incurred in a given year will be payable the following year in a lump sum. Therefore, for example, bonuses earned for claims incurred in 2008 will be

payable early in 2009. More information on the PQRI bonus payment is available at http://www.cms.hhs.gov/PQRI/

Payment information for MA plans:
The physician fee schedule details are on: http://www.cs.hhs.gov/center/physician.asp . Further information on HCPCS codes can be found on, or accessed from: http://www.cms.hhs.gov/apps/pfslookup/

Plans must also provide the "Welcome to Medicare" benefit, if applicable, under the same circumstances as original Medicare.

Note that the HPSA and PSA bonuses are payable only on 80% (original Medicare's portion) of the qualifying physician fee schedule payments. Plans should use CMS resources (see above) to identify HMSA and PSA areas by zip code and cannot require providers to use modifiers to the extent they are available and not required by original Medicare.

A physician who would be eligible to receive the 1.5% PQRI bonus for services furnished to a beneficiary not enrolled in an MA plan is entitled to this amount for services furnished to an MA plan enrollee in cases where the physician or practitioner is entitled to collect the amount that Medicare would pay for the service. If the physician indicates that he or she is participating in the voluntary reporting, an MA organization can decide to pay an extra 1.5% on all physician fee schedule claims as they are incurred. Remember that the 1.5% PQRI bonus is subject only to claims paid on the Medicare physician fee schedule, and is paid on 100% of the fee schedule amount, not just the plan's portion of the payment.

Alternatively, because it is not known in advance whether a physician will be entitled to the higher amount, and it is subject to a cap, an MA organization may wait until 2008 (or the year after the year for which a bonus payment is due) to pay the bonus. Each physician would need to let the organization know what percentage (capped at 1.5%) that particular physician earned for physician fee schedule services. The plan would then make a lump sum payment to each physician based on that percentage. This percentage would range from 0% to 1.5%.

Note that the PQRI bonus will increase from 1.5% to 2% effective for 2009 and 2010 reporting periods – payable in 2010 and 2011.

To obtain the composite PQRI bonus file for claims incurred in the last six months of 2007, for payments due from PFFS and non-contracting MA plans in 2008, please go to HPMS. Note that participation by physicians and qualified practitioners in the PQRI program was relatively limited in 2007.

A registered HPMS user can visit the Data Extract Facility from the Home Page of HPMS. There will be a link entitled "PQRI File" on the left navigation bar. In addition to the data file itself, the user is provided the data file and record layout in a memorandum posted to HPMS on 6/30/08.

In 2007 CMS had initially announced a proposed cut to the physician fee schedule beginning January 1, 2008, of 10.1%. Section 101 of the Medicare, Medicaid, and SCHIP Extension Act of 2007, (enacted December 29, 2007) established an update of .5% for claims with dates of service January 1, 2008 – June 30, 2008. Original Medicare contractors were able to process claims for services at this new, higher rate beginning January 7, 2008. All claims for dates of service January 1, 2008, and later, were paid by original Medicare at the new rate. New fee schedules were posted on contractors' websites on January 11, 2008. Therefore, MA plans must also pay this higher rate to all non-contracted physicians and non-physician practitioners for all claims with dates of service January 1, 2008, through June 30, 2008. The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) extended the physician fee schedule update through the remainder of 2008 and provided a 1.1% update for 2009.

Correct Coding Initiative

The "correct coding initiative" (CCI) is the name of the payment edits used by Medicare for physician, lab, and some other services. In addition, some of the CCI edits are incorporated into Medicare's "outpatient code editor" (OCE) which is used to pay outpatient hospital bills.

More information on CCI can be found on:
http://www.cms.hhs.gov/NationalCorrectCodInitEd/ In the left column of that internet page are hyperlinks to some of the CCI categories such as "medically unlikely edits".

A memo announcing the 2008 3rd quarter update can be found on:
http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6045.pdf

Payment information for MA plans:
Plans that are required to pay out of network providers using the same rates and rules of Medicare must use rules that are not more restrictive than the CCI edits or than the OCE, including the Local Medical Review Policies.

Ambulance

These services are paid on the ambulance fee schedule. Extra payments are made for ground transportation exceeding 50 miles, and for providers in certain rural areas. Ambulances are paid the lesser of the fee schedule, or the submitted charge.

Payment information for MA plans:
The ambulance fee schedule, and other detailed information, is on
http://www.cms.hhs.gov/AmbulanceFeeSchedule/ .

Ambulatory Surgical Centers

ASC's are paid on a fee schedule comprised of wage adjusted payment groups.

Payment information for MA plans:
The ASC fee schedule, including geographic adjustments and other detailed information, is on http://www.cms.hhs.gov/ASCPayment/

End Stage Renal Disease Facilities

ESRD facilities are paid, for routine services, an amount called a composite rate. Composite rates are geographically adjusted. They also vary depending on whether a facility is hospital based or independent. Non-routine services may be billed separately. A drug add-on, the percentage of which is subject to change each year, is applied to the composite rate. Epoetin has different payments depending on whether or not it is billed by an ESRD facility.

Some facilities receive additional payments to their ESRD composite rates that are called "exception" payments. Beginning 4/1/05, a new case mix adjusted PPS payment system was established.

Payment information for MA plans:
The composite rates are on the internet. Payments are described in chapter 8 of the Medicare Claims Processing Manual (see internet link above). Detailed information on ESRD can be found on: http://www.cms.hhs.gov/home/medicare.asp . On that page, there are 4 hyperlinks on ESRD under the heading "End Stage Renal Disease". The ESRD calculator is on http://www.cms.hhs.gov/PCPricer/02e_ESRD_Pricer.asp

Master Cost Report File – The renal facility cost report file is accessible by a hyperlink called "Renal Facility" found on: http://www.cms.hhs.gov/CostReports/

Durable Medical Equipment

Medicare payment for durable medical equipment (DME), prosthetics and orthotics (P&O), parenteral and enteral nutrition (PEN), surgical dressings, and therapeutic shoes and inserts is based on the lower of either the actual charge for the item or the fee schedule amount calculated for the item.

Competitive bidding payment amounts were to replace the current Medicare Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) fee schedule payment amounts for selected items in selected competitive bidding areas (CBAs) beginning with July 1, 2008. See http://www.cms.hhs.gov/DMEPOScompetitivebid/ for information. However, Section 154 of the Medicare Improvements for Patients and Providers Act of 2008 delays this program until 2009.

CMS will issue contractor instructions and accompanying MLN Matters articles with more information.

Additional payment information for MA plans:
It is appropriate for plans that offer non-network coverage to tell members that they should use only Medicare certified DMEPOS suppliers. Other payment details, including the non-competitive bidding fee schedule, are on
http://www.cms.hhs.gov/DMEPOSFeeSched/ .

Clinical Lab

Payments are generally based on the lab fee schedule. Certain small hospitals are paid a higher rate, or based on their costs instead of the fee schedule.

Payment information for MA plans:
The lab payment details are on http://www.cms.hhs.gov/ClinicalLabFeeSched/

Part B Drugs

Most, but not all, drugs for PPS hospital inpatients are not billable since they are assumed to be included in the DRG payments.

When the outpatient department of a hospital bills for drugs, the cost is generally included in the APC payment. However an extra payment for certain new drugs are payable for the first 2 or 3 years. Also, during the transition to APC's, other drugs may have extra payments. Most Part B drugs that are not paid on prospective payment or on costs are paid based on a percentage of the Average Sales Price (ASP) methodology.

Payment information for MA plans:
The drug fee schedule, and other details on Part B drug payments, can be found on http://www.cms.hhs.gov/McrPartBDrugAvgSalesPrice/

Federally Qualified Health Centers

The FQHC allowed charge is the lesser of an "all inclusive rate" or a national per-visit limit. The all inclusive rate is determined for each center based on historical costs. There is a separate national limit for urban and for rural facilities, and these limits are subject to change each year.

Medicare pays FQHC's 80% of the above, and the beneficiary pays 20% of the actual charge. Coinsurance of 20% of charges, not the all-inclusive payment, applies to FQHC's as well as RHC's. FQHC services are not subject the to Part B deductible.

The all-inclusive methodology, as well as the Part B deductible exemption, applies only to "FQHC services", not to other services preformed at an FQHC. See section 1861 [aa] of the Social Security Act for covered FQHC/Medicare Part B Services.

Wrap around payments:
Medicare will make extra payments to certain FQHC's that have written contracts with MA plans for rates below the lesser of the FQHC's 'all inclusive rate' or national per visit limit. However, certain conditions must be met such as requiring that contracted rates are not less than rates for similar services provided outside of an FQHC setting. These extra payments only apply to services of an FQHC which qualify as "FQHC services".

Payment information for MA plans:
The MA plan must pay 80% of the allowed charge, plus 20% of the actual charge, minus the plan's copay. The plan may request the FI approved rate from the billing FQHC.

The internet site is: http://www.cms.hhs.gov/center/fqhc.asp

Flu, hepatitis B, and pneumonia shots

For both FQHCs and RHCs (see below) there are special rules related to MAO reimbursement to non-contracting and "deemed" providers when a flu, hepatitis B, or pneumonia shot is the only service provided.

RHCs and FQHCs do not get paid the all inclusive rate for flu, hepatitis B, or pneumococcal vaccines if they are the only service during a visit. However, the costs of these vaccines are included in the all inclusive rate. If one visits an RHC or FQHC for a different covered service (regardless of whether or not they get a vaccine during the same visit), the all inclusive rate is paid. But if the only service provided during a visit is one of these vaccines, then Medicare pays nothing for that visit. Under original Medicare, the plan keeps track of the vaccine costs on a log or roster. The roster is then submitted to the FI at the end of the year.

At settlement, the FI looks at the total of the all inclusive rates paid during the year, plus the vaccine costs reported on the roster. This sum represents the RHC's or FQHC's costs. The RHC or FQHC is then paid the difference between 80% of the lesser of (the per visit costs, or the national limit - except there is no limit for hospital based RHCs). In calculating the number of visits for the per visit costs, a visit that includes only a flu, hepatitis, or pneumonia shot does not count as an RHC or FQHC visit. Therefore the all inclusive rate is inflated to include these shots; but the rate is not paid when only the flu/hepatitis B/pneumonia shot is provided (and no other RHC or FQHC service is provided).

MA plans are required to pay the cost for the shots only (as reflected on each facility's roster). This amount should be much less than the all inclusive rate. The plan might want to discourage members from going to an FQHC/RHC if the member only needs a shot.

More detailed information for Private Fee For Service Plans:
PFFS Plans that use a "non-network model"

These plans must pay providers the same way other types of MA plans must pay their out of network providers. Therefore, when reimbursing FQHCs by a non-network PFFS Plan, the MA Plan must pay rates equal to what the provider would have received under original Medicare, except that like all MA plans, they are not required to "cost" settle with out of network providers. MA Plans pay 80% of the lesser of the all-inclusive rate or the national limit, plus 20% of the FQHC's actual charge, minus the Plan member's copay. There is no wrap-around payment due from CMS.

Medicare services not covered under the FQHC "all-inclusive rate" are to be paid at the same rate that the FQHC would receive under original Medicare.

PFFS Plans that use a "network model"

For in-network providers:

Plans negotiate t*erms and conditions* with and execute written agreements with FQHCs. CMS will pay a wrap-around payment to contracting FQHCs if applicable requirements are met. The requirements include a contracted payment rate between the Medicare Advantage organization and the FQHC that is not less than the level and amount of payment that the Plan would make for similar services provided by a non-FQHC provider. CMS will pay an additional amount to make the FQHC whole, up to the equivalent of the allowed charge which FQHCs would receive for covered FQHC services under original Medicare. Medicare Part B services not covered under the "all-inclusive rate" are not eligible for CMS wrap-around payment.

The payment rates specified by the Plan should be the same for all providers of a similar type regardless of whether they are in or out of the Plan's network. However, higher member copays can be imposed for using out-of-network providers of a specific type, when applicable conditions are met – see 42 CFR 422.114(c).

For out-of-network providers:

Any out-of-network FQHC providing services to an enrollee of a Private Fee-For-Service Plan is not entitled to an FQHC supplemental payment. Federal law requires a written agreement between the Plan and FQHC in order for the supplemental wrap-around payment to come into play – see 42 CFR 422.316. However, if the FQHC becomes part of the network through an executed, written contract with the MA organization sponsoring the PFFS Plan, then the FQHC could be eligible for wrap-around payments from CMS for services provided to PFFS Plan enrollees receiving services on dates on or after the date the written contract is executed.

Rural Health Clinics

RHC's are paid the lesser of the provider specific "all inclusive rate" or a national per-visit limit. The all inclusive rate is determined for each center based on historical costs. If an RHC is part of a hospital with less than 50 beds, the limit does not apply. It also does not apply for certain rural sole community hospital based RHC's which may have more than 50 beds, but has a low volume of services.

Coinsurance of 20% of charges, not the all-inclusive payment, applies to FQHC's as well as RHC's. The national per visit limit is subject to change each year. RHC services are subject to the Part B deductible which is based on billed charges.

The all-inclusive methodology applies only to "RHC services", not to other services preformed at an RHC such as lab, the technical components of diagnostic tests, etc. The method of payment for these non-RHC services would be the same as for other similar services processed by the Part B carrier in the case of freestanding RHCs, or the Part A fiscal intermediary in the case of hospital-based RHCs.

Payment information for MA plans:
The plan may request the FI or carrier approved rates from the billing RHC. The MA plan must pay 80% of the allowed charge, plus 20% of the actual charge, minus the plan's copay. The internet site is: http://www.cms.hhs.gov/center/rural.asp

Long Term Care Hospitals

These hospitals used to be paid reasonable costs for inpatient services, but were put on a DRG type of system a few years ago. There was a 4 year blend to the new payments. They are now past the blending period are paid 100% PPS.

Outliers for inpatient services:
The outlier payment is a certain percentage of the excess of the cost of an admission over the sum of the DRG payment (including IME and DSH) and a threshold amount. The threshold amount is subject to change each year. There are also outlier adjustments for certain short stays. OPD has different outlier rules.

The internet site is:
http://www.cms.hhs.gov/LongTermCareHospitalPPS/01_overview.asp

The following site has additional information including an updated list of all long term care hospitals:
http://www.cms.hhs.gov/LongTermCareHospitalPPS/08_download.asp#TopOfPage

The Pricer is on http://www.cms.hhs.gov/PCPricer/07_LTCH.asp#TopOfPage .

Inpatient Rehabilitation Hospitals

These hospitals are paid using the Inpatient Rehabilitation Facility Prospective Payment System (IRF PPS). A case-mix adjusted payment is made using case mix groups (CMGs) for varying numbers of days of IRF care. The IRF web site is:
http://www.cms.hhs.gov/InpatientRehabFacPPS/ The Pricer is on
http://www.cms.hhs.gov/PCPricer/06_IRF.asp#TopOfPage

Psychiatric Hospitals

There is a new PPS payment system for both freestanding psychiatric hospitals and certified psychiatric units of general acute care hospitals. This system is called the inpatient psychiatric facility prospective payment system and is referred to as either IPF PPS or IPFPPS.

Old system- TEFRA
The reasonable cost is defined in TEFRA as a base year cost per discharge for each hospital increased to the payment year using legislated increase factors. This is also referred to as the hospital's target. Bonuses or relief payments may also be payable if the actual costs for the year are less than, or greater than the target respectively. There are plans to eventually implement a new prospective payment system (PPS) for psychiatric hospitals.

New system – Inpatient Psychiatric Facility PPS (IPFPPS)
For hospital fiscal years beginning after 1/1/05, the payments will be a blend of 75% of the old TEFRA payment and 25% of the new PPS payment. The first PPS payment period for all hospitals will extend to 6/30/06, after which all PPS updates will be for the 12 month periods beginning 7/1. The second payment period uses a blend of 50% TEFRA/ 50% PPS, and the third and last transition year uses 25% TEFRA/ 75% PPS. There is a "stop/loss" adjustment which sets the PPS payment to no less than 70% of the TEFRA amount for this 3 year transition period.

The new PPS system uses a federal per diem base amount which is then adjusted for DRG's, comorbidities, age, rural add-on, teaching add-on, outlier payments , wage index, the presence of an emergency department, and ECT treatment. There is also an extra payment which tapers down during the first 21 days of an admission. There are further rules concerning readmissions.

Outlier payments are effective after a per stay loss of a threshold amount that is subject to change each year (adjusted for the wage index, rural, teaching, etc). Different rules are used for Community Mental Health Centers.

Detailed information on payments for psychiatric hospitals may be found on http://www.cms.hhs.gov/InpatientPsychFacilPPS/01_overview.asp .

Medicare Dependent Hospitals

These are hospitals that:

1) are located in a rural area,
2) have no more than 100 beds, and
3) at least 60% of their days or discharges are for patients entitled to Medicare Part A (including MA)
4) are not classified as a Sole Community Hospital

These hospitals are paid PPS. In addition, if for any given full year the hospital specific rate (cost based target rate) is greater than the Federal rate (PPS), the hospital is paid a certain percentage of the difference which may change over time. The Pricer compares the PPS rate to the hospital specific rate for each service, but the final settlement compares the PPS payments to the hospital specific rate for the entire year.

In addition, in some years, these hospitals may or may not have a cap on their DSH payments.

The DRA extended the Medicare Dependent Hospital program through the year 2011.

Sole Community Hospitals

These hospitals are generally paid the greater of PPS or the hospital specific rate (HSR) for a full year. As is the case with Medicare Dependent Hospitals, PRICER calculates the greater of the 2 for a given service. For OPD services, Medicare makes an add on payment for some services of certain qualifying SCH's.

Payment information for MA plans:
The PPS hospital transfer payment reduction to the first hospital only applies to the PPS rate. It does not apply to the HSR since this rate is already reduced to reflect the lower cost of patients who are transferred out of the hospital.

Low Volume Hospitals

If a hospital has under 800 discharges per year, and is more than 25 miles from the closest acute care hospital, CMS makes an additional payment not to exceed 25%.

Cancer Hospitals

These hospitals are paid based on the lesser of their actual costs or their TEFRA limited costs. Payment adjustments are then made depending on the difference between these 2 costs. Routine costs are generally reimbursed on an interim basis using a per-diem amount, but with limits. Ancillary costs are reimbursed using a payment to charge ratio. Cancer hospitals are also eligible for outlier payments.

For OPD services, these hospitals have a different reimbursement methodology which is more cost based than regular acute care hospitals.

Payment information for MA plans:
The FI rate letters would show the interim per diems for inpatient, and the cost to charge ratios for outpatient. A listing of Medicare PPS excluded Cancer hospitals can be found on: http://www.cms.hhs.gov/AcuteInpatientPPS/10_PPS_Exc_Cancer_Hosp.asp

Children's Hospitals

Same basic methodology as for Cancer Hospitals.

Clinical Trials:

Medicare pays for qualified clinical trials. These claims are coded using a QV modifier, and/or a diagnostic code of V70.7. There are a couple of other modifiers for clinical trials used in certain situations.

Clinical Trial links: **Detailed information on clinical trials may be found on:**
http://www.cms.hhs.gov/ClinicalTrialPolicies/

Payment information for MA plans:
Medicare will reimburse qualifying clinical trial claims on behalf of MA members. Providers need to submit the bills to the carriers, intermediaries, and MACs using the proper modifiers and ICD-9 codes.

Bad Debts

Most PPS hospitals and SNF's are paid 70% of bad debt by Medicare.

Certain clinics receive 100% bad debt reimbursement from Medicare. Skilled nursing facilities (SNFs) used to get 100%, but now get 70% for most of their Medicare patients

who are not on Medicaid. ESRD facility bad debt payments are capped so that their Medicare reimbursement does not exceed their costs.

Bad debts only include coinsurance for which a beneficiary is directly responsible to pay. For example, it does not include payments due from a Medigap policy. The collection efforts for Medicare patients generally have to match the collection efforts for non-Medicare patients.

The general bad debt policy is set forth in regulations at Sec. 413.80 and the Provider Reimbursement Manual (PRM) (CMS Pub. 1501), Part 1, Chapter 3). Bad debt policy for ESRD Facilities is set forth in a separate regulation at Sec. 413.178 and is further discussed below.

For ESRD: At the end of the year, Medicare recognizes a facility's Medicare bad debts. However, under current regulations, bad debt payments are capped so that total Medicare reimbursement (composite rate plus bad debt payments) does not exceed the total cost to serve Medicare patients.

Payment information for MA plans:
CMS policy is that MA plans are not required to pay their members' unpaid cost sharing. In any case, Medicare will not reimburse providers for bad debt payments incurred by MA members.

Balance billing:

Medicare allows physicians to balance bill up to 15% of the non-par MFS if they do not participate and do not accept assignment. Par physicians cannot balance bill. The non-par MFS is 95% of the par MFS. Therefore the balance billing limit is an extra 9.25% of the par MFS. Medicare pays 80% of the non-par MFS. The beneficiary is responsible for 20% of the non-par MFS plus 100% of the balance billing amount.

The balance billing that is allowed for durable medical equipment has no set limit. Medicare pays 80% of the MFS and the beneficiary is responsible for the other 20% plus 100% of the balance billing amount.

Under Medicare, balance billing is not allowed for most other services including hospital, SNF, home health, and lab. However, the OPD coinsurance percentage can vary by procedure and be more than 20%.

Some states have balanced billing rules for Medicare patients that are more restrictive than Medicare’s own rules. As of 2007, states with balance billing prohibitions or limits included Connecticut, Massachusetts, Minnesota, New York, Ohio, Pennsylvania, Rhode Island and Vermont. Of course after 2007, there could be additional states with their own limits.

Payment information for MA plans:
Private fee for service plans can choose in their terms and conditions whether or not to allow balance billing. They can choose to allow all types of providers to balance bill up

to 15%. Therefore, their balance billing can be more than that allowed by original Medicare and more than would otherwise be allowed under State law due to MA preemption authority.

Cost settlements:

Medicare makes estimated (interim) payments to hospitals and clinics when claims are submitted which are at least partially reimbursed based on their reasonable costs rather than a fee schedule. FI's attempt to make the interim payments as accurate as possible. After the hospital's fiscal year ends, the FI's settle with the providers for the difference between interim payments and actual reasonable costs.

Payment information for MA plans:

CMS policy is to not require plans to agree to settle with providers. Therefore, following the FI settlement, plans are not required by CMS to pay providers, and providers would not be required by CMS to refund money to plans. In any case, FI's will not include MA members in their settlements with providers.

Medicare Coverage Database:

The Medicare coverage database is on: http://www.cms.hhs.gov/mcd/overview.asp This site lists all national and local coverage determinations. Plans must abide by the national determinations in all geographic areas, and the local determinations in affect in the locality of the provider.

Special Rules for services of VA and military providers:

If a member who is not eligible for veterans or other military related benefits receives treatment in a non-network military facility (e.g., VA or DOD hospital), the hospital must accept as payment in full the amount it would normally get paid from original Medicare. The member would be responsible only for the plan's out-of-network or emergency/post-stabilization care copays, and the plan would be responsible for the remainder. This is the same situation that applies to all non-network hospitals. However, Medicare payments to military treatment facilities are determined differently than payments to other facilities.

Inpatient rates can be found, by Fiscal Year, on the DOD website, at: www.dod.mil\comptroller\rates\index.html Those rates are multiplied by the weighting factor that can be found on the TriCare website, at: www.tricare.osd.mil\drgrates\

Special Rules for services of non-contracting providers:

Facility services not arranged by the MA plan:

Notwithstanding the above, CMS regulations state that if a non-network facility such as a hospital, SNF, or HHA renders services which were not arranged by the plan, a non-PFFS MA plan may pay the lesser of the original Medicare amount or the billed amount. For more information, please see the last section of the following link: http://www.cms.hhs.gov/manuals/downloads/mc86c06.pdf Note that a PFFS plan must always pay a non-contracting provider the original Medicare amount, even if a lesser amount is billed.

Plan Contact Information:

Providers may use the following links to obtain contact and mailing information for medical claims related to MA plan members

General MA directory with addresses and phone numbers.
http://www.cms.hhs.gov/HealthPlansGenInfo/

Provides mailing addresses for the MA claims processing contacts.
http://www.cms.hhs.gov/HealthPlansGenInfo/claims_processing.asp#TopOfPage

Q & A's:

1) **Q:** What happens if a member wants to upgrade his/her durable medical equipment?

   A: For Medicare covered services, only non-par providers may balance bill. Unlike for physician services, there is no 15% balanced billing limit for durable medical equipment. Non-par DME suppliers who do not accept assignment can balance bill up to whatever their usual charge is for the item.

   But patients can upgrade from a covered to a non-covered device. For example, if the CMN (certificate of medical necessity) from the doc is for a manual wheelchair, but the patient wants a power scooter instead, and if the doc says that it's ok for the patient to get the power scooter even though it's not medically necessary, then Medicare will only pay 80% of the manual chair. (On the other hand, if the CMN is for the scooter, then Medicare pays 80% of the scooter's fee schedule).

   Just for an example, assume the manual chair has a charge of $300, but a fee schedule of $250. Assume that the scooter has a charge of $3000, but a fee schedule of $2000. If a patient has a CMN for a manual chair but opts for the scooter and the provider is par, Medicare pays 80% of $250. The patient pays 20% of 250 plus $2,700 for a total of $2,750.

   If the provider is non-par, Medicare pays the same (80% of 250). The patient would then pay $3000 minus 80% of 250 for a total of $2,800. Plans should follow the same rules as Medicare when reimbursing non-contracting providers and when patients upgrade at their own expense. Keep in mind that Medicare will often rent covered equipment before purchasing it.

2) **Q:** How does balance billing work if a PPO (not a PFFS) member uses an out of network provider?

   A: "Providers of services" (defined in §1861(u) of the Social Security Act to include hospitals, SNFs, HHAs and etc.) cannot balance bill any MA plan enrollee due to §1866(a)(1)(O) of the Act. The regulation is 42 CFR §422.214(b).

   Physicians and other providers cannot balance bill unless they are also permitted to balance bill under the original Medicare program. Under the original Medicare program physicians can only balance bill if they are non-Participating with Medicare

and if they do not accept Assignment on a specific claim. In that case they can balance bill up to the "limiting charge" – see §1848(g) of the Act – which is up to 115% of the non-Participating physician fee schedule. [See §1852(k)(1) of the Act and 42 CFR §422.214(a).] It is important to note that when an MA PPO enrollee uses a non-contracting physician or other provider (other than a "provider of services"), that enrollee is only responsible for the cost sharing under the MA plan. When and if a physician (or other provider) is permitted to balance bill and actually does so, it is the legal responsibility of the MA organization to pay the additional amount and to indemnify the enrollee from charges above the plan cost sharing for the service.

3) **Q:** Do MA enrollees count towards the 25 day average length of stay for LTCHs?

A: For purposes of determining whether a LTCH is meeting the >25 day ALOS requirement, under regulations at 42 CRF 412.23(e)(2), we count total days for Medicare patients. This means that as long as the Medicare program is issuing a payment for services delivered to a bene, even as secondary payer, the data goes is in our system and we count the total days of the stay. If a patient was a dual beneficiary (Medicare and Medicaid), and ran out of Medicare days so that Medicaid took over primary payment responsibility, we would count all days of the stay for this calculation. When last I inquired, our systems did not "speak" to the systems used by Medicare Advantage plans, since the Medical Advantage plans negotiate their own arrangements with various hospitals. If this is still the case, we cannot access LOS data for those patients and they are not counted towards meeting a LTCH's ALOS requirement.

4) **Q:** Do critical access hospitals (CAHs) receive a DSH payment or something comparable to DSH?

A: There is no specific DSH payment for a critical access hospital. The purpose of DSH for a DRG hospital is that the DRG might not cover the extra costs incurred by people who are poor. (That's the purpose of DSH- to recognize that poor people require more services for a given condition). But to the extent that a facility such as a CAH incurs more expenses due to treating poor people, this extra cost will automatically show up in their costs, and therefore be reimbursed by Medicare.