MA Payment Guide for Out of Network Payments

6/01/2011 Update

This is a guide to help MA and other Part C organizations in situations where they are required to pay at least the original Medicare rate to out of network providers. **This document is a general outline of Medicare payments as of the above date 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.

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

http://www.cms.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 .

Coordinated care plans, such as HMOs and PPOs, and PACE plans are generally required to reimburse non-contracting providers at least the original Medicare rate for Medicare covered services. PFFS plans are permitted to establish their own fee-schedules and balance-billing rules, which, in some cases, differ from original Medicare payment rates and balance-billing rules. Although a non-network PFFS plan must reimburse all providers at least the original Medicare 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.

Since MAOs must use certified Medicare providers of services – 1852(a)(1)(A) of the Act and 42 CFR 422.204(b)(3) – when a provider of services is under an Original Medicare sanction such as DPNA (denial of payment for new admissions), the MAO will need to make other arrangements for admissions of MA plan enrollees until that Original Medicare sanction is lifted.

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.gov/home/medicare.asp This site has a link for most services covered by Medicare.

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

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

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

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

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

The above site also has a hyperlink to the "CMS transmittals" page.

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

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

Coverage decisions can be found on http://www.cms.gov/mcd/overview.asp , then clicking on "Medicare coverage". The Medicare National Coverage Determinations Manual can be directly accessed by clicking: http://www.cms.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.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.gov/center/rural.asp

Table of Contents

Table of Contents 3
Acute Care Hospital - Inpatient Services 4
Hospital Outpatient 6
Home Health 7
Skilled Nursing Facilities 7
Swing Beds 8
Critical Access Hospitals 8
Physician Services 8
Correct Coding Initiative 12
Ambulance 13
Ambulatory Surgical Centers 13
End Stage Renal Disease Facilities 13
Durable Medical Equipment 14
Clinical Lab 14
Part B Drugs 14
Federally Qualified Health Centers 15
Rural Health Clinics 17
Long Term Care Hospitals 17
Inpatient Rehabilitation Hospitals 18
Psychiatric Hospitals 18
Medicare Dependent Hospitals 18
Sole Community Hospitals 19
Low Volume Hospitals 19
Cancer Hospitals 20
Children's Hospitals 20
Clinical Trials: 20
Bad Debts 20
Balance billing: 21
Health Information Technology bonuses: 21
Cost settlements: 21
Medicare Coverage Database: 22
Special Rules for services of VA and military providers: 22
Special Rules for services of non-contracting providers: 22
Plan Contact Information: 23
Payment Dispute Resolution Process for Non-contracted and Deemed Providers: 23
Provider Identification Numbers: 24
Q & A's: 24

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 also paid bi-weekly.

Pass-throughs are usually calculated on a per diem basis for routine costs and using a cost to charge ratio for ancillary costs.

Outliers:
Payment is 80% of the excess of the cost of an admission over the sum of the DRG payment (including IME, DSH, and new technology) 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.

Transfers from an acute care hospital to a critical access hospital:
Effective October 1, 2010, the transfer regulations at 42 CFR 412.4(b) include IPPS hospital transfers to a Critical Access Hospital (CAH) and a transfer to a non-participating hospital. Please see http://www.cms.gov/MLNMattersArticles/downloads/MM7141.pdf for more details. Payment system changes needed to accommodate this change (transfers to CAHs) are scheduled for April 2011.

Post-acute care transfers – a transfer from an acute care hospital to a SNF or HHA with certain DRG's: the payment of certain DRG's is reduced for the acute care hospital when the patient is discharged to a Skilled Nursing Facility or Home Health Agency.

Wrap around payments:
Medicare may 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. However, they are required to pay the full Medicare allowed 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 pass-throughs 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.gov/PCPricer/

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

Hospital Cost Report Master File (HCRIS): The hospital cost report file is updated quarterly and can be found on http://www.cms.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.gov/transmittals/downloads/R1311CP.pdf

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

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

Medicare prohibits payments for never events and certain hospital acquired conditions (HAC). Medicare will eliminate the diagnosis codes identified as never events or HACs when calculating DRGs. To the extent an MAO does not pay a non-contracting PPS hospital for never events and HACs, the Medicare certified hospital cannot bill the member.

MAOs (and hospitals) have asked whether an MAO must withhold payment to a **contracting** hospital for never events and HACs. CMS is considering how we can best extend the statutory requirements to the MA program context. Until CMS releases guidance on this issue, we consider reimbursement for never event/HACs an issue between MAOs and their contracting providers.

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 were made in the past to those hospitals that were 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. A limited number of 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.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.gov/center/hha.asp . This page has links to detailed information on how home health payments are determined.

Master Cost Report File: See http://www.cms.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.gov/SNFPPS/ This page also has a link to the quarterly Pricer. Further information is on: www.cms.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.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.

Under the optional method 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 if under the optional method.

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 (optional method). 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.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 was payable until 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.gov/HPSAPSAPhysicianBonuses/ and

http://www.cms.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 services in a non-hospital setting had an effective 50% coinsurance calculated as 80% of 62.5% of the allowed charge. This coinsurance is being phased down to 20% to be consistent with the coinsurance for most other Part B services. The coinsurance will be 45% in 2010 and 2011, 40% in 2012, 35% in 2013, and 20% in 2014 and later.

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.

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: changed from 65% MFS to 100% effect 1/1/11

Physicians and other qualified professionals are eligible to receive incentive payments that are contingent on the reporting of quality measures. This is called the **PQRI bonus**.

PQRI 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.gov/PQRI/

MIPPA (the Medicare Improvements for Patients and Providers Act of 2008) initiated an **e-prescribing bonus** for physicians who electronically prescribe prescription drugs to Medicare beneficiaries. The first reporting year is CY 2009. The payments are made in a lump sum based on claims data submitted within 2 months after the end of the year. The last reporting year for e-prescribing bonus payment purposes is 2013. The bonus is applied to physician allowed charges and is 2% for 2009 and 2010; 1% for 2011 and 2012; and 0.5% for 2013.

In addition, penalties will be applied to payments of physicians who are unsuccessful e-prescribers. The penalties are 1% for 2012; 1.5% for 2013; and 2% for 2014 and thereafter. For more information see
http://www.cms.gov/pqri/downloads/pqrieprescribingfactsheet.pdf

A **primary care incentive payment** (PCIP) is applicable for claims starting on 1/1/11. Details can be found on
http://www.cms.gov/MLNMattersArticles/downloads/MM7060.pdf
The payment is equal to 10 percent of the amount paid each calendar quarter, in other words the amount net of Medicare's Part B deductible and coinsurance (4 payments annually), for CPT codes 99201 through 99215, and 99304 though 99350, for each qualifying NPI listed on the **Primary Care Incentive Payment Program Eligibility File**. Once again, the incentive payment is based on the amount paid, and not the Medicare approved amount. Original Medicare contractors will pay the primary care incentive payment at the same time and on the same check as the HPSA physician bonus. This new incentive is paid in addition to any HPSA bonus otherwise due.

The primary care incentive 10% payment also applies to practitioners who reassign their claims to critical access hospitals (known as the "optional method"). The payment is 10% of physician payment after adding the additional optional method 15%. Details can be found on: https://www.cms.gov/transmittals/downloads/R2169CP.pdf

A HPSA **surgical incentive payment (HSIP)** is payable starting 1/1/11 for procedures performed in a zip code listed in:
http://www.cms.gov/HPSAPSAPhysicianBonuses/01_overview.asp
Details can be found on:
http://www.cms.gov/MLNMattersArticles/downloads/MM7063.pdf
The incentive payment applies to major surgical procedures, defined as 10-day and 90-day global procedures, under the Physician Fee Schedule (PFS) and furnished on or after January 1, 2011, and before January 1, 2016, by a general surgeon with a primary specialty code of 02 (General Surgery) in an area designated under section 332(a)(1)(A) of the Public Health Service Act as a HPSA. A general surgeon may receive both a HPSA physician bonus payment under the established program and an HSIP payment under the new program beginning in CY 2011.

Modifier AQ is to be used to denote claims that were furnished in HPSAs approved by December 31 of the preceding calendar year, but that are not recognized for automatic payment. In other words, where the zip codes are not yet in the HPSA zip code file, providers will use the AQ modifier to claim HPSA and HSIP bonuses, where applicable. The

modifier must be appended to the surgical procedure for the service to be eligible for the 10 percent additional HSIP payment, unless the services are provided in a ZIP code on the list of HPSA ZIP codes where automatic incentive payments are made.

The HSIP bonus is 10 percent of the Medicare allowed amount net of the Part B coinsurance.

The *Medicare Physician Fee Schedule Fact Sheet* provides information about MPFS payment rates and the MPFS payment rates formula and is available in downloadable format from the Centers for Medicare & Medicaid Services **Medicare Learning Network** at
http://www.cms.gov/MLNProducts/downloads/MedcrePhysFeeSchedfctsht.pdf

Payment information for MA plans:

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

As is the case with Original Medicare, plan types other than PFFS must make balanced billing payments, if billed, up to the 15% limit to physicians who do not participate with Original Medicare. PFFS plans can prohibit balanced billing if stipulated in their terms and conditions of payment.

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

Note that the HPSA 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 HPSA 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 **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. The 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.

Because it is not known whether a physician will be entitled to the PQRI bonus until the end of the calendar year, an MA organization should wait until the next year to pay the bonus. The plan would then make a lump sum payment to each physician based on that physician’s percentage.

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 12/08/10.

MA plans must pay the **e-prescribing bonus** in situations where they must pay the same as Medicare. As is the case with the PQRI bonus, CMS will have a link to show which providers will be entitled to the e-prescribing bonus. As described above, e-prescribing penalties will also apply beginning in 2012. Plans may lower their payments to the applicable physicians to account for the penalties beginning in 2012.

Starting with services performed on or after 1/1/2010, Medicare will no longer pay for services that are billed using **consultation codes** (CPT codes 99241-99245 and 99251-99255). These services should instead be billed using the most appropriate visit code based on the content of the visit. When Medicare pays secondary to other coverage, although the primary payer may be billed for and pay a consultation code, the service must be billed to Medicare using a visit code and must show how much the primary payer paid. An exception to the elimination of consultation codes is that Medicare will continue to pay for the G-codes that represent telehealth consultations. MA plans can choose, but are not required, to pay non-contracting physicians based on the eliminated consultation codes if the amount is not less than what Original Medicare would have paid for the same service.

Note that when original Medicare fee schedules are updated, MAOs must also update their rates of payment when reimbursing non-contracting and deemed (PFFS only) providers in order to meet their responsibility for paying at least the amount that original Medicare would have paid.

More detailed information on the elimination of consultation codes may be found on http://www.cms.gov/MLNMattersArticles/downloads/MM6740.pdf

A file with the NPI of each provider who qualifies for the **PCIP bonus** will be made available through HPMS. As mentioned above, CPT codes 99201 through 99215, and 99304 through 99350 are eligible for the 10% bonus and the bonus is paid net of Medicare's 20% coinsurance. Plans would therefore pay 10% of 80% of the Medicare allowed charge for these codes. The PCIP bonus is paid in addition to the HPSA physician bonus, if any is due. This bonus is paid to eligible providers regardless of whether the service is performed in a HPSA. The bonus is not paid on the all inclusive rates of FQHCs and RHCs, nor is it paid on ASC charges.

There is no need for a list of providers who qualify for the **HSIP bonus**. This bonus is paid if the service is performed in a physician HPSA (the dental and mental health HPSAs are not relevant for this bonus). The bonus is payable only for physicians who have a specialty of "general surgery" (specialty code 02) and for procedures that have a 10 or 90 day global period. The amount is 10% of 80% of the Medicare allowed charge for the procedure.

Although Medicare pays the PCIP and HSIP bonuses quarterly, along with the regular HPSA bonus, plans may pay them quarterly, or with each qualifying claim.

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.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.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 in certain circumstances including 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.gov/AmbulanceFeeSchedule/ .

Ambulatory Surgical Centers

ASC's are paid on a fee schedule comprised of wage adjusted payment groups. ASC payments have limits based on the hospital OPD rates.

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

End Stage Renal Disease Facilities

ESRD facilities are paid a composite rate for routine services including the dialysis treatment, certain routinely furnished ESRD drugs, lab tests and supplies. Composite rates are geographically adjusted and also adjusted for patient specific parameters.

Certain other drugs, tests, and supplies may be billed separately. Epoetin has different payments depending on whether or not it is billed by an ESRD facility. Some facilities receive "exception" payments instead of the composite rate.

Starting 1/1/2011, the composite rate increases since it now includes additional lab tests, drugs and biological that previously were billed separately. The new rate is phased in over a 4 year period, but facilities can make a one time election to skip the blended rates and get paid entirely under the new system starting 1/1/2011. Rates will be based on patient and facility characteristics, and also on the extent to which facilities meet measures established under a quality incentive program (QIP). There is also an outlier payment adjustment. The newer larger composite rate is also referred to as the "ESRD PPS rate".

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.gov/ESRDPayment . The ESRD PC Pricer is on http://www.cms.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.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.

Starting with 1/1/11, DMEPOS supplies paid on the new competitive bidding schedule in one of the competitive bidding areas (CBAs) will be paid by original Medicare only to competitive bid suppliers. The web site: http://www.dmecompetitivebid.com/palmetto/cbic.nsf/DocsCat/Home has the zip codes for each competitive bidding area. It also shows the bid price for each HCPPCS code in each CBA. In original Medicare, the bid prices apply if a beneficiary resides in a CBA.

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.gov/DMEPOSFeeSched/ . Plans required to pay non-network suppliers the Medicare rates may take advantage of the lower fees that original Medicare pays for members residing in competitive bidding areas when paying DME suppliers that accept those rates for original Medicare claims.

Additionally, MAOs and Cost HMOs/CMPs need to tell plan members how the DMEPOS competitive bidding program will affect them, including what members should do if they need to change suppliers.

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.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 is 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.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.

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

The all-inclusive methodology, as well as the Part B deductible exemption, applies only to "FQHC services", not to other services performed 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.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 an allowed charge which is 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 performed 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.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 and are paid 100% PPS.

Outliers:
The inpatient 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.gov/LongTermCareHospitalPPS/01_overview.asp

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

The Pricer is on http://www.cms.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.gov/InpatientRehabFacPPS/ The Pricer is on
http://www.cms.gov/PCPricer/06_IRF.asp#TopOfPage

Psychiatric Hospitals

There is a relatively 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.

The new PPS system uses a federal per diem base amount which is then adjusted for factors such as DRG's, co-morbidities, 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 initial 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.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. In addition, in some years, these hospitals may or may not have a cap on their DSH payments. Payments can also include an additional amount for new technology.

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. For OPD services, Medicare makes an add on payment for some services of certain qualifying SCH's. SCHs should submit "no pay" bills to their FIs on behalf of MA patients to ensure they get credit for qualification standards based on the percentage of Medicare patients admitted to the hospital.

Payment information for MA plans:
The Pricer has recently been changed for sole community hospitals (SCH) when coded HMO=YES. The field "MA-HSP" will show the hospital specific rate (i.e. hospital specific payment) for each discharge. This is the formula for MA plans (coded HMO=YES) to use when they need to pay the same as Medicare:

MA payment to SCHs = the greater of (MA_HSP + TOT_CAPI_AMT), or TOTAL_AMT

The fields "total amt" and "total capi amt" are in the lower left corner of the Pricer output on the internet Pricer. The "MA-HSP" amount is in the bottom middle part of the Pricer output. Note from the above formula that the MA payment to non-network providers is not necessarily the "TOTAL AMT" on the Pricer output page.

The PPS hospital transfer payment reduction to the first hospital only applies to the PPS rate. It does not apply to the HSP rate since this rate is already reduced to reflect the lower cost of patients who are transferred out of the hospital.

Low Volume Hospitals

CMS makes additional payments to hospitals with a low volume of Medicare patients and if the hospital is at least a given number of miles from another hospital. The TOTAL AMT field in the PC Pricer includes the additional low-volume payment even though this amount is not displayed separately. The low-volume payment amounts are reflected in the difference between the TOTAL AMT and the sum of TOT OPER AMT + TOT CAPI AMT.

Sections 3125 and 10314 of the ACA provide for a temporary change in the low-volume adjustment for FYs 2011 and 2012. Further details are in the regs at 412.101(c)(2).

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.

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

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.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.gov/ClinicalTrialPolicies/

Payment information for MA plans:
Medicare will reimburse qualifying clinical trial claims on behalf of MA members and will waive the Part A and the Part B deductibles. Plans are responsible for the remaining original Medicare coinsurance minus the plan's normal member copays for the incurred types of service. 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. Special rules apply if the patient is on Medicaid. ESRD can also be eligible for a limited amount of bad debt reimbursement.

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.

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.

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.

Health Information Technology bonuses:

A new bonus system was created by the ARRA (the American Recovery and Reinvestment Act of 2009) to pay **health information technology (HIT) bonuses** to qualifying eligible professionals (EPs) and hospitals. Hospital based physicians are not eligible. Other EPs will be eligible for either a Medicare or a Medicaid bonus beginning with services provided in 2011.

Hospitals can earn bonuses under both Medicare and Medicaid. If eligible physicians or hospitals do not comply with the meaningful usage requirements of HIT by 2014, they would be subject to payment reduction penalties.

Payment information for MA plans:
The HIT bonuses and penalties paid by FFS Medicare do not apply to payments from MA plans to either physicians or hospitals. CMS's monthly payments to MA plans will not include an adjustment to account for the HIT bonuses and penalties.

However, there is a separate HIT bonus that will be payable by CMS to qualifying MAOs – see CMS-0033-P, http://edocket.access.gpo.gov/2010/pdf/E9-31217.pdf

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.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 or a PACE provider:

In general, an MAO is required to pay non-contracting providers in combined plan payment and member cost sharing at least the amount the provider would have received in combined Original Medicare payment, beneficiary cost sharing and permitted balance billing. 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 when reimbursing for emergency, urgently needed, out-of-area dialysis and post stabilization services. However, when a provider indicates to an MA organization that it is submitting a bill for services for which payment is made under a PPS system under Original Medicare, this should be considered a bill for the PPS amount (and not the "billed" or "charge" amount from the claim) that Medicare would pay in the case of a similar submission. The MAO would then need to pay based on the PPS amount.

When a PACE plan receives a claim from a provider that indicates it is submitting a bill for services for which payment is made under a PPS system under Original Medicare, the PACE provider should consider the bill to be a request for payment of the PPS amount (and not the

"billed" or "charge" amount from the claim) that Medicare would pay in the case of a similar submission. The PACE provider would then need to pay based on the PPS amount.

Note that a PFFS plan must always pay a non-contracting provider at least 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.gov/HealthPlansGenInfo/

Provides mailing addresses for the MA claims processing contacts.
http://www.cms.gov/MCRAdvPartDEnrolData/MACPC/list.asp#TopOfPage

Payment Dispute Resolution Process for Non-contracted and Deemed Providers:

If you are a non-contracted or a "deemed" provider and believe that an MAO reached an incorrect decision regarding your payment dispute, you have the right to request an independent decision from CMS' Payment Dispute Resolution Contractor, C2C Solutions, Inc (C2C) within 180 days of the MAO's decision. In addition, if the organization fails to make a decision in response to a non-contracted or deemed provider's dispute within 30 days from the date the dispute was received by the organization, the provider may request a Payment Dispute Decision (PDD) without having received an initial internal dispute decision by providing evidence to C2C of the dispute it filed with the organization. Network provider disputes may not be handled under this resolution process. C2C is an independent entity contracted by CMS to act as the Payment Dispute Resolution Contractor (PDRC). C2C can receive payment dispute decision requests via the following media:

E-mail. If the submission and associated documents do not contain any personally identifiable health information (PHI), or all PHI has been redacted, the payment dispute decision request can be submitted to a dedicated email box at PDRC@C2Cinc.com. Otherwise, you may submit payment dispute decision requests (including associated documents such as claims forms that may contain PHI) via the methods outlined below.

Fax. Fax electronic requests for payment dispute decisions to (904) 361-0551.

OR

Mail. Providers can mail hard copy requests for payment dispute decisions to the following address:

C2C Solutions, Inc.
Payment Dispute Resolution Contractor
P.O. Box 44017, 532 Riverside Ave.
Jacksonville, Florida 32231-4017

Before submitting a request with C2C, please review their webpage for additional information and a copy of the request form: www.C2Cinc.com |QIC PDRC. Submit all required documentation with your request to avoid having your request dismissed or delayed.

Note that denials subject to the beneficiary appeals process should not be directed to C2C.

Provider payment disputes subject to CMS' independent review process include any decisions where a non-contracted or "deemed" provider contends that the amount paid by the organization for a covered service is less than the amount that would have been paid under original Medicare.

Provider Identification Numbers:

The identification number for facilities have six digits. The first two digits identify the State in which the provider is located. The last four digits identify the type of facility such as short stay hospital, critical access hospital, rural health clinic, etc. Further details can be found on https://www.cms.gov/transmittals/downloads/R26SOM.pdf

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. The program requires hospitals paid under the LTCH PPS to submit informational-only Medicare Advantage data which are used to determine payment adjustments under the short-stay outlier (SSO) policy as well as for the calculation of the greater than 25-day average length of stay 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.

5) **Q:** Medicare pays ambulance claims based on fractions of a mile. An MA plan might find it easier, due to payment system limitations, to first round up to the nearest mile before calculating the total miles for payment purposes. If an MA plan intentionally pays a higher amount for any type of service in order to facilitate their payment processes, such as working around their payment system limitations, can the plan recoup the overpayments at a later time?

   A: No.

6) Q. Medicare is reprocessing claims for certain types of service on a retroactive basis back to 1/1/2010 due to changes resulting from the Affordable Care Act (ACA). Some providers will receive additional amounts from CMs and others will owe money back to CMS. Also, not all affected claims will be automatically reprocessed. For example, physician and ambulance claims for which the submitted charge is less than the revised fee schedule amount will not be automatically reprocessed. Providers will have the option to ask Medicare payment contractors to manually reprocess those claims. Will MA plans be required to automatically reprocess all claims due to ACA retroactive provisions?

   A. We expect that the effect of such adjustments will be small for most providers and will therefore not require MA plans to automatically reprocess all non-network claims and make the extra payments to some providers, while demanding the resulting refunds from other providers. But if large sums of money are involved for a given provider, retroactive adjustments (payments or refunds) may be appropriate if well documented and addressed in a timely manner. Also, a provider requesting the re-processing of claims must recalculate all claims including those that resulted in overpayments. The plan will be allowed to net out underpayments for some services with any overpayments for other services.