



**Private Fee-For-Service
Reimbursement Grid**

The ConnectiCare Medicare VIP Private Fee For Services (PFFS) Reimbursement Grid describes how ConnectiCare will calculate claims for covered items and services rendered to the ConnectiCare Medicare VIP PFFS members enrolled in ConnectiCare’s CHOICE Plans.

Please note that all clean claims must be submitted to ConnectiCare within 365 days of the date of service. A clean claim is one that has no defect, impropriety, lack of any required substantiating documentation - including the substantiating documentation needed to meet the requirements for encounter data - or particular circumstance requiring special treatment that prevents timely payment; and a claim that otherwise conforms to the clean claim requirements for equivalent claims under original Medicare.

Service Category	<u>Service Sub-category or Payment Component</u>	Payment Methodology
Acute Care Hospital	<u>Inpatient Services</u>	<p>Payment for covered inpatient services are based upon the Inpatient Prospective Payment System (IPPS), and includes payments for capital, DSH, capital Indirect Medical Education (IME), clotting factors and other pass-through payments as applicable under this payment methodology.</p> <p>Operating IME and DME costs are fully carved out of the DRG payment per 42 CFR 422.216(a) (4).</p> <p>Organ acquisitions are reimbursed based upon full hospital costs and in accordance with applicable Medicare guidelines.</p> <p>Maryland hospitals are excluded from IPPS; see section on Maryland hospitals below.</p>

	<p style="text-align: center;"><u>Inpatient Outliers</u></p>	<p>Payment is 80% of the excess of the cost of an admission over the sum of the DRG payment (including IME, DSH and any add-ons for new technology) and a threshold amount.</p> <p>The threshold amount changes each year and is \$24,485 for FY2007.</p> <p>The cost of an admission is generally determined by multiplying the hospital's cost-to-charge ratio by its charges.</p>
	<p style="text-align: center;"><u>Inpatient Transfers (Acute to Acute)</u></p>	<p>Discharging acute care hospitals receive the full DRG payment.</p> <p>Payment to the transferring hospital is based upon a per diem rate (i.e., the prospective payment rate divided by the geometric mean length of stay for the specific DRG into which the case falls and multiplied by the patient's length of stay at the transferring hospital). Twice the per diem is paid on the first day and the per diem for every following day up to the transfer date or the full DRG amount. If less than 1 day, 1 day per diem is paid.</p> <p>A hospital that transfers a patient classified into DRG 385 or 456 will be paid the full amount of the PPS rate associated with the DRG rather than the per diem rate, plus any cost outlier payment, if applicable.</p>
	<p style="text-align: center;"><u>Inpatient Transfers (Acute to Post Acute)</u></p>	<p>A qualified discharge from one of 29 DRGs to a post acute care provider will be treated as a transfer case and reimbursed the per diem methodology stated above, with the following exception; DRGs 209, 210 and 211 are paid at 50% of the DRG amount for the first day plus, for each subsequent day, 50% of the per diem is paid, up to the full DRG amount.</p>

	<u>Outpatient Services</u>	<p>Payment for covered outpatient hospital services are based upon the Outpatient Prospective Payment System (OPPS). Services excluded from OPPS are reimbursed according to the applicable fee schedule.</p> <p>Transitional outpatient payments (TOPS) will be made as appropriate to Rural Hospitals with 100 or less beds and Sole Community Hospitals. Maryland hospitals are excluded from OPPS; see section on Maryland hospitals below.</p>
	<u>Outpatient Outliers</u>	<p>For CY2006, when the cost of a hospital outpatient service exceeds 1.75 times the APC payment rate and the cost exceeds \$1,250 over the APC payment rate, the hospital will receive an outlier payment of 50% of the difference between 1.75 times the payment amount and the cost of furnishing the service.</p>
Acute LTC	<u>Inpatient Services</u>	<p>Effective for cost reporting periods beginning on or after 10/01/02, Long Term Care Hospitals were subject to payment under the Long Term Care PPS. A 5-year transition period was implemented to phase-in the PPS for LTC hospitals from cost-based reimbursement to 100% PPS, unless the LTC hospital hospitals elected to go immediately to 100% PPS.</p>
	<u>Inpatient Outliers</u>	<p>Payment is 80% of the excess of the cost of an admission over the sum of the DRG payment and the \$17,864 threshold. Outlier payments for certain short stays will be made in accordance with CMS guidelines.</p>
	<u>Outpatient Services</u>	<p>Payment for covered outpatient hospital services are based upon the Outpatient Prospective Payment System (OPPS). Services excluded from OPPS are reimbursed according to the applicable fee schedule.</p>

Ambulance		Beginning 1/1/06, these services will be paid at 100% of the ambulance fee schedule. Extra payments are made to for ground transportation exceeding 50 miles, and for providers in certain rural areas.
Anesthesia	<u>Physician Performed</u>	Anesthesia services are paid using a system of base and time units. The base and time units are summed and multiplied by the anesthesia conversion factor.
	<u>Physician Medical Direction of 2, 3, or 4 CRNAs, AA, residents or interns concurrently</u>	Anesthesia services are paid using a system of base and time units. The base and time units are summed and multiplied by the anesthesia conversion factor. Payment rate is on the basis of 50% of the allowance for the service performed by the physician alone.
Ambulatory Surgery Centers		Ambulatory Surgical Centers are paid on a fee schedule. There are 9 payment categories depending on the service, and the payments are adjusted by the relevant wage index.
Assistant at Surgery	<u>Physicians</u>	For covered assistant at surgery services, the allowed amount is 16% of the amount for the global surgery under the Medicare Fee Schedule.
	<u>Physician Assistant</u>	For covered assistant at surgery services, the allowed amount is 85% times 16% of the Medicare Fee Schedule.
Blood		For hospital outpatient services, blood is reimbursed under OPPS. For hospital inpatient services, all covered blood and blood processing expenses are included in the DRG payment.

Cancer Hospitals	<u>Inpatient Services</u>	Cancer Hospitals are excluded from IPPS. These hospitals are paid based on the lesser of their actual costs or their TEFRA limited costs.
	<u>Outpatient Services</u>	Payment for covered outpatient cancer hospital services are based upon the Outpatient Prospective Payment System (OPPS). Services excluded from OPPS are reimbursed according to the applicable fee schedule.
Certified Registered Nurse Anesthetist (CRNA)		Anesthesia services are paid using a system of base and time units. The base and time units are summed and multiplied by the CRNA anesthesia conversion factor.
Children's Hospitals	<u>Inpatient Services</u>	Children's hospitals are excluded from IPPS. Payment is made on a cost basis.
	<u>Outpatient Services</u>	Payment for covered outpatient hospital services are based upon the Outpatient Prospective Payment System (OPPS). Children's hospitals are held "harmless," under OPPS, meaning that they cannot be paid less in aggregate under OPPS than they were paid under the prior system. Services excluded from OPPS are reimbursed according to the applicable fee schedule.
Clinical Nurse Specialist		Payment for covered services at 85% of the Medicare Physician Fee Schedule amount.
Clinical Psychologist		Payment for covered services at 100% of the Medicare Physician Fee Schedule amount.
Clinical Social Workers		Payment for covered services at 75% of the Medicare Physician Fee Schedule amount.

Clinical Trial Services		Payment for covered services provided to a Medicare Advantage enrollee enrolled in an eligible Clinical Trial is made by the applicable Original Medicare FFS contractor.
Community Mental Health Centers		Payment for covered outpatient services is based upon the Outpatient Prospective Payment System (OPPS).
Comprehensive Outpatient Rehabilitation Facility (CORF)		Payment for covered services will be based on the Medicare Physician Fee Schedule.
Co-Surgeons		The Medicare Fee Schedule is increased by 25% then split between the 2 surgeons. Each is then paid 62.5% of the Medicare Fee Schedule. Team surgery (e.g. modifier 66) is paid for on a “by report” basis.
Critical Access Hospital (CAH)		CAHs are excluded from IPPS and OPSS. Payment is made on a reasonable cost basis (101% of costs). CAHs will be requested to submit a copy of their recent interim rate letter from their Medicare Fiscal Intermediary (FI).
Diabetic Shoes		Payment will be based on the Durable Medical Equipment, Prosthetic, Orthotics, and Supplies (DMEPOS) Fee Schedule.
Drugs		Effective 1/1/05, payment is based on 106% of the "Average Sales Price" (ASP) for most drugs. Exceptions include blood, drugs delivered through DME, influenza, pneumococcal and hepatitis B vaccines, and certain new drugs which are all still paid based on 95% Average Wholesale Price (AWP).

<p>Durable Medical Equipment</p>		<p>Payment based on 100% of the Medicare DMEPOS Fee Schedule.</p>
<p>End Stage Renal Disease (ESRD) Facility</p> <p>Independent and Hospital Based</p>		<p>Payment for ESRD services from independent and hospital-based ESRD facilities will be based upon the composite rate, with additional payments made to those facilities that have received an approved exception from their Fiscal Intermediary. In general, the composite rate is payment for the complete dialysis treatment, except for physicians' professional services, separately billable laboratory services, and separately billable drugs. Effective January 1, 2005, EPO will be paid based on the ASP Pricing File.</p>
<p>Federally Qualified Health Center (FQHC)</p> <p>Independent and Provider Based</p>		<p>Payment is based on the FQHC allowed charge, which 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. For 2006, the limits are \$112.96 for urban centers and \$97.13 for rural centers. FQHCs will be requested to provide the FI approved all-inclusive-rate prior to payment. Payment will be based upon 80% of the above amount, plus coinsurance of 20% of the actual charge, not the all-inclusive payment.</p>
<p>Hemophilia clotting factors</p>		<p>For inpatient care, payment is an add-on to the DRG rate, as noted above. For outpatient services, payment is made according to OPPS guidelines.</p>
<p>Home Health Agencies Independent and Provider Based</p>		<p>Payment is made based upon the Home Health PPS (HHRGs). Payments cover episodes of care up to 60 days. Adjustments are made for short stays and for outliers. DME paid in accordance with the DMEPOS.</p>

Indian Health Service Facility (IHS)	<u>Inpatient Services</u>	Payment for covered inpatient services are based upon the Inpatient Prospective Payment System (IPPS).
	<u>Outpatient Services</u>	Payment is based upon an all-inclusive rate. Excluded from OPSS. Professional services are based upon the applicable fee schedule.
Laboratory		Payment is based upon 100% of the Medicare laboratory fee schedule.
Mammography Screening/ Diagnostic		Payment is based upon 100% of Medicare Physician Fee Schedule amount.
Maryland Hospitals		Maryland Hospitals are paid at rates set by the HSCRC in accordance with Medicare waiver. Discounts for Medicare Advantage, prompt payment and working capital are applied as appropriate.
Medical Nutrition Therapy		Payment is based upon 85% of Medicare Physician Fee Schedule amount.
Nurse Practitioner		Payment is based upon 85% of Medicare Physician Fee Schedule amount.
Parenteral and Enteral Nutrition (PEN)		Payment is based upon the PEN Fee Schedule.
Physical, Occupational, and Speech Therapy		Payment is based upon 100% of Medicare Physician Fee Schedule.

Physician	<u>MD, DO, Chiropractor, Dentist, Optometrist, Oral and Maxillofacial Surgeon, Podiatrist</u>	Physicians are paid using the lesser of billed charges, or 100% of Medicare Physician Fee Schedule. A 10% bonus is paid if these services are furnished in a health professional service area (HPSA). An Additional 5% bonus is payable in areas designated by CMS as “physician scarcity areas”.
Physician Assistant		Payment is based upon 85% of Medicare Physician Fee Schedule amount.
Prosthetic Devices		Payment based on 100% of the Medicare DMEPOS (Durable Medical Equipment, Prosthetic, Orthotics, and Supplies) Fee Schedule.
Psychiatric Hospital	<u>Inpatient Services</u>	Payment for covered inpatient psychiatric services are based upon the Inpatient Psychiatric Facility Prospective Payment System (IPF PPS), with blended TEFRA/PPS payments through the 3-year transition period and outlier payments made as applicable.
	<u>Outpatient Services</u>	Payment for covered outpatient hospital services are based upon the Outpatient Prospective Payment System (OPPS). Services excluded from OPPS are reimbursed according to the applicable fee schedule.
Registered Dietitian		Payment is based upon 85% of Medicare Physician Fee Schedule amount.
Rehabilitation Hospital	<u>Inpatient Services</u>	Payment for covered inpatient services are based upon the Inpatient Rehabilitation Facility Prospective Payment System (IRF PPS). Facility-level and case-level adjustment are applied to the payment amount as applicable. The facility-level adjustments include those that account for geographic variation in wages

		(wage index), percentage for low income patients (LIP) and location in a rural area. Case-level adjustments include those that apply for interrupted stays, transfer cases, short stays, cases in which patients expire and outlier cases.
	<u>Outpatient Services</u>	Payment for covered outpatient hospital services are based upon the Outpatient Prospective Payment System (OPPS). Services excluded from OPPS are reimbursed according to the applicable fee schedule.
Religious Non-Medical Health Care Institutions (RNHCI)		Payment for covered services is based upon a predetermined fixed amount per discharge. Payment to RNHCIs for DME items will be made based on the DMEPOS fee schedule. Payment to RNHCIs for nursing visits will be made at 80% of the national standard home health aide visit rate used under the HH PPS.
Routine Hearing		Routine hearing test will be reimbursed at ConnectiCare's Fee Schedule.
Routine Physical Exam		Medicare covered routine physical exam will be reimbursed according to the Medicare Allowable Charge. Non Medicare covered routine physical exam will be reimbursed at ConnectiCare's Fee Schedule.
Routine Vision		Routine eye exam will be reimbursed at ConnectiCare's Fee Schedule.
Rural Health Clinic (RHC) Independent and Provider Based		Payment to a RHC for covered services will be based upon the lesser of the provider specific "all inclusive rate" or a national per-visit limit. The limit does not apply to provider-based RHCs. The limit for 2006 is \$72.76. RHCs will be requested to provide the FI approved all-inclusive-rate prior to payment. Payment will be based upon 80% of the above amount,

		plus coinsurance of 20% of the actual charge, not the all-inclusive payment.
Skilled Nursing Facilities (SNF)		Payment for covered SNF services will be based upon the Skilled Nursing Facility Prospective Payment System (SNF PPS).
Sole Community Hospitals	<u>Inpatient Services</u>	Payment for covered inpatient services are based upon the Inpatient Prospective Payment System (IPPS). Sole Community Hospitals are paid the greater of PPS or the hospital specific rate.
	<u>Outpatient Services</u>	Payment for covered outpatient hospital services are based upon the Outpatient Prospective Payment System (OPPS). Services excluded from OPPS are reimbursed according to the applicable fee schedule.
Surgical Dressings		Payment for surgical dressings is based upon the Medicare DMEPOS fee schedule except when applied “incident to” a physician's professional services, furnished by an HHA and those applied while a patient is being treated in an outpatient hospital department or as an acute care inpatient.
Swing Beds		Payment for covered Swing Bed Facility services will be based upon the Skilled Nursing Facility Prospective Payment System (SNF PPS). Critical Access Hospital swing beds are exempt from PPS and are paid 101% of reasonable costs.
VA Hospitals		A Medicare Advantage Organization (MAO) may not use Medicare funds to pay the VA Healthcare System for VA-covered services rendered to veterans who are also MAO enrollees. However, payment for emergency services rendered to non-veteran enrollees may

		be made to the VA facility.
X-ray		Payment based upon the Medicare Fee Schedule or OPPS.

- Providers that agree to ConnectiCare’s Terms and Conditions of Payment must agree not to balance bill members above any applicable cost-sharing amounts, except for Providers that do not accept assignment. Providers that don't accept assignment may balance bill members up to the Medicare limiting charge (i.e., 15% over the Medicare allowable amount, unless the state has established a different amount). If a Provider collects more from a member than the amounts permitted under the Terms and Conditions of Payment, the Provider must refund the difference to the member.
- Providers that do not accept ConnectiCare’s Terms and Conditions of Payment and do not accept Medicare assignment, may balance bill members up to the Medicare limiting charge when rendering urgent or emergency services.
- Please note that deemed and non-deemed providers must agree that in no event, including but not limited to non-payment by ConnectiCare, insolvency of ConnectiCare or breach of ConnectiCare’s Terms and Conditions of Payment, shall the Provider or the Provider’s assignees and/or subcontractors bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against a ConnectiCare VIP Medicare PFFS Plan member or persons having authority to act on behalf of the member, for covered services provided by the Provider pursuant to these Terms and Conditions of Payment. This provision does not prohibit a Provider from collecting from a ConnectiCare VIP Medicare PFFS Plan member charges for non-covered services agreed to in advance in writing by the member or member cost-sharing amounts applicable under the ConnectiCare VIP Medicare PFFS Plan. Providers must further agree that (i.) this provision supersedes any oral or written agreement to the contrary now existing or hereafter entered into by a Provider and a ConnectiCare VIP Medicare PFFS Plan member or persons acting on a ConnectiCare VIP Medicare PFFS Plan member’s behalf; and (ii.) this provision shall apply to all of a Provider’s employees, agents, trustees, assignees and subcontractors, and Providers must obtain from such persons specific agreement to this provision.