

Medi-CareFirst BlueCross BlueShield Reimbursement Grid for AdvantageBlue Private-Fee-For-Service Plan

PROVIDER TYPE	MEDICARE PAYMENT METHOD	OUR PAYMENT
Acute Care - Inpatient	These are all paid a DRG payment consisting of operating and capital costs which include IME, DSH, outliers, and the new technology add on. An amount for hemophilia clotting factors is also included. Payment is calculated using software similar to the pricer on the CMS website. Hospitals in the state of Maryland are excluded and are paid at 94% of charge.	Same as Medicare. Claims route through HSS pricer
Acute Care - Outpatient	Services subject to outpatient PPS are paid by the APC methodology. Other services, such as lab, are 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.	Same as Medicare. Claims route through HSS pricer
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.	Home Health payments will be based on episodes of care as per original Medicare. For FQHC and RHC, we will contact the clinic for an FI rate letter if it is not obtainable from the FI.
Skilled Nursing Facility	SNF is paid on PPS. A case-mix adjusted payment for varying numbers of days of SNF care is made using one of 53 Resource Utilization Groups, Version III (RUG-III). The RUG is identified in the first 3 positions of the HIPPS code. These are priced using the SNF pricer on the CMS website	Same as Medicare. Claims are manually priced using CMS SNF pricer.
Swing Bed	Swing beds are paid on 100% skilled nursing facility PPS for hospital fiscal years that begin on or after 7/1/02. Critical Access Hospital swing beds are exempt from PPS and are paid 101% of reasonable costs.	Same as Medicare. Claims are manually priced using CMS SNF pricer.
Critical Access Hospitals	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 based on a copy of the facility's most recent interim rate letter from their Medicare fiscal intermediary (FI).	We contact the provider to see if they will send us their interim rate letter, and if not, we will contact the FI. Once we obtain the information, we will pay the same as Medicare.
Physician Services	Physicians are paid using the lesser of billed charges, or the Medicare Physician Fee Schedule (MFS). The fee schedule for physicians that do not participate in Medicare is 95% of the par fee schedule. The limiting charge we can pay the provider is 115% of this amount.	Same as Medicare. The Medicare fee schedule is loaded to our system, and all claims price off of it. We pay the limiting charge in non-par situations, so there is no balance billing. If there is no Medicare fee for a code that we would like to pay, we try to obtain a fee from HGSA. If they do not have a fee, we try to equate the code to another code that has a Medicare fee. If that is not possible, we pay the code at the KHPW rate.

Ambulance	Before 2006, these services were paid on a blend of "reasonable charges" and a fee schedule. Beginning 1/1/06, they are paid at 100% of the ambulance fee schedule.	Same as Medicare. The Medicare fee schedule is loaded to our system, and all claims price off of it.
Ambulatory Surgical Centers	All procedures are classified into one of nine ASC groups which have a base payment rate. This rate is then adjusted for the wage index of the facility.	Same as Medicare. Claims are manually priced using the base rates and adjusting for wage index.
ESRD 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.	Same as Medicare. Composite rate is obtained using CMS ESRD calculator. Other services are paid on a line basis, based upon Medicare rules.
DME	Payments are on the DMEPOS fee schedule.	Same as Medicare. Wright and Filippis handles pricing for these claims.
Clinical Lab Services	Payments are based on the lab fee schedule, with sole community hospitals eligible for a slightly higher payment.	Same as Medicare. The HSS pricer incorporates the clinical lab fee schedule, as does our professional pricing program.
Part B Drugs	Most drugs are not paid separately for inpatient or outpatient since they are already included in the DRG or APC rate, but those that are paid are paid at 106% of the "average sales price" for most drugs. Exceptions include blood, drugs delivered through DME (durable medical equipment), influenza, pneumococcal and hepatitis B vaccines, and certain new drugs which are all still paid based on 95% AWP. There are also some other exceptions which are paid based on the wholesale acquisition costs.	Same as Medicare. Pricing is incorporated into all pricers that we use. ESRD drug charges are paid manually based on 106% ASP.
Federally Qualified Health Centers	The MA plan must pay 80% of the allowed charge, plus 20% of the actual charge, minus any copay. The plan may request the FI approved rate from the billing RHC.	We will contact the FI to get the approved rate, and will then price the claims just as Medicare would.
Rural Health Clinics	The MA plan must pay 80% of the allowed charge, plus 20% of the actual charge, minus any copay. The plan may request the FI approved rate from the billing RHC.	We will contact the FI to get the approved rate, and will then price the claims just as Medicare would.
Long Term Care Hospitals	These are paid on a DRG basis and also incorporate certain outlier payments. Pricing is obtained from the pricer located on the CMS website.	Same as Medicare. Claims are manually priced using the LTAC pricer on the CMS website
Inpatient Rehab Hospitals	These hospitals are paid using the Inpatient Rehabilitation Facility Prospective Payment System (IRF PPS). A case-mix adjusted payment for varying numbers of days of IRF care is made using one of 100 Case Mix Groups (CMG). These CMGs are represented as HIPPS codes.	Same as Medicare. Claims are manually priced using the Rehab pricer on the CMS website
Psychiatric Hospitals	These are paid as a blend of a new PPS system and the old TEFRA rate. The PPS portion of the payment is a national rate adjusted for DRG, comorbidities, geographical location, age, outliers, and certain add-ons.	We pay a little higher than Medicare. We pay the PPS portion the same, but can't calculate the TEFRA portion, so we pay that at charge.
Medicare Dependent Hospitals	These are paid on a PPS basis.	Claims are paid on a PPS basis.

Sole Community Hospitals	These hospitals are paid the greater of PPS or the hospital specific rate for a full year.	There is no specific Medicare number range for this type of facility, so they are paid PPS originally, and adjustments will be made if we find that they fall into this facility category and if an underpayment was made.
Low Volume Hospitals	If a hospital has under 800 discharges per year, and is more than 25 miles from the closest acute care hospital, we make an additional payment not to exceed 25% in addition to the regular PPS payment.	There is no specific Medicare number range for this type of facility, so they are paid PPS originally, and adjustments will be made if we find that they fall into this facility category and if an underpayment was made.
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.	There is no specific Medicare number range for this type of facility, so they are paid PPS originally, and adjustments will be made if we find that they fall into this facility category and if an underpayment was made.
Children's 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.	There is no specific Medicare number range for this type of facility, so they are paid PPS originally, and adjustments will be made if we find that they fall into this facility category and if an underpayment was made.