Payment Methodology Grid

Medi-Pak Advantage generally reimburses deemed providers the amount they would have received under Original Medicare for Medicare covered services, minus any amounts paid directly by Original Medicare (such as for direct graduate medical education) and minus any member required cost sharing, for all medically necessary services covered by Medicare. Payment for certain providers will be based on the estimated Medicare amount and calculated using a proxy method developed by CMS. Medi-Pak Advantage does not do cost settlements. For providers paid on a cost basis, Medi-Pak Advantage makes payment based on the interim rate letter from the fiscal intermediary or Medicare contractor. Medi-Pak Advantage does not pay for hospice services or clinical trials. Hospice and clinical trial providers should continue to file claims with Original Medicare using their current process.

Provider	Payment Methodology
Acute Care Hospital - Inpatient Services	Payment for covered inpatient services are based upon the inpatient Prospective Payment System (IPPS). Acute care hospitals are paid a DRG amount using the Medicare prospective payment system (PPS) in all states except Maryland. The DRG payments include amounts for capital indirect medical education (IME) and capital disproportionate share hospital (DSH). Organ acquisitions for members are reimbursed on a cost basis at an approved transplant facility. The following items are excluded from our payment, but are paid directly to the hospital by original Medicare: 1) DGME 2) Operating IME Acute care hospitals should submit a “no pay” bill to their Medicare contractor for stays by Medicare Advantage members.
Acute Care Hospital - Inpatient Services Outliers	Payment is 80% of the excess of the cost of an admission over the sum of the DRG payment (including capital IME and DSH) and a threshold amount determined by CMS. The cost of an admission is determined by multiplying the hospital’s cost to charge ratio by its charge.
Acute Care Hospital – Outpatient Services.	Services subject to the Outpatient Prospective Payment System (OPPS) are paid using the Ambulatory Payment Classification (APC) methodology. When processing an APC claim, components that comprise the total reimbursement amount (e.g., accounting for outlier, drugs and devices paid as pass through) will be included. Services excluded from OPPS are reimbursed based on their respective fee schedule. Hospitals exempt from OPPS include those in Maryland, Indian Health Service, and Critical Access Hospitals.
Ambulance	Total reimbursement will equal 100% of the ambulance fee schedule with extra payments made for ground transportation exceeding 50 miles, and for providers in certain rural areas, as provided under Original Medicare payment methodology.
Ambulatory Surgical Centers	ASCs are paid based on the CMS fee schedule. Payments are area wage adjusted.
Anesthesiologists – Personally Performed	Payment will be calculated using the Medicare methodology: the sum of uniform base units and time units multiplied by the anesthesia conversion factor specific to the locality.

Provider	Payment Methodology
Anesthesiologists – Direction of two or more nurse anesthetists concurrently	Payment will be on the basis of 50 percent of the allowance for the service performed by the physician alone.
Assistant at Surgery - Physician	For assistant at surgery services performed by physicians, the fee schedule amount equals 16 percent of the amount otherwise applicable for the global surgery.
Assistant at Surgery – Physician Assistant	For assistant at surgery services performed by physician assistants, the fee schedule amount equals 85 percent x 16 percent of the amount otherwise applicable for the global surgery.
Audiologists	Audiologists are paid the lesser of the actual charge for services or 100% of the Medicare physician fee schedule.
Cancer Hospitals – Inpatient Services	The Medicare IPPS methodology will be used as described for Acute Care Hospital Inpatient Services for Cancer Hospitals that are subject to IPPS. For PPS-exempt hospitals, reimbursement is based on the lesser of their actual costs or their TEFRA limited costs. Payment adjustments are then made depending on the difference between these two costs. Facilities are required to supply a copy of their most recent annual FI rate letter to show the interim per diems for inpatient services.
Cancer Hospitals – Outpatient Services	The Medicare OPPS methodology will be used to group/price APC claims for any Medicare approved provider subject to OPPS. For PPS-exempt hospitals, costs are reimbursed using a payment to charge ratio. Facilities are required to supply a copy of their annual FI rate letter to show the cost-to-charge ratios for outpatient services.
Certified Registered Nurse Anesthetists	CRNAs are paid the Medicare anesthesia conversion factor by locality x the sum of uniform base units + time units. Payment is made on an assignment basis only. The above allowance is divided between the anesthesiologist and the anesthetist for directed services.
Chiropractors	Chiropractors are paid the lesser of the actual charge for services or 100% of the Medicare physician fee schedule for Medicare covered services.
Children's Hospitals	The Medicare IPPS methodology will be used as described for Acute Care Hospital Inpatient Services for Children's Hospitals that are subject to IPPS. For PPS-exempt hospitals, reimbursement is based on the lesser of their actual costs or their TEFRA limited costs. Payment adjustments are then made depending on the difference between these two costs. Facilities are required to supply a copy of their annual FI rate letter to show the interim per diems for inpatient services.
Children's Hospitals – Outpatient Services	The Medicare OPPS methodology will be used to group/price APC claims for any Medicare approved provider subject to OPPS. For PPS-exempt hospitals, costs are reimbursed using a payment to charge ratio. Facilities are required to supply a copy of their annual FI rate letter to show the cost-to-charge ratios for outpatient services.
Clinical Nurse Specialist	Clinical Nurse Specialists are paid the lesser of the actual charge for services or 85% of the Medicare physician fee schedule.
Clinical Psychologist	Clinical Psychologists are paid the lesser of the actual charge for services or 100% of the Medicare physician fee schedule.

Provider	Payment Methodology
Clinical Social Worker	Clinical Social Workers are paid the lesser of the actual charge for services or 75% of the Medicare physician fee schedule.
Comprehensive Outpatient Rehabilitation Facility (CORF)	Reimbursement is based on the Medicare physician fee schedule.
Co-Surgeons	For each co-surgeon, the allowed amount is 62.5% of the global surgery allowed amount under the Medicare fee schedule.
Critical Access Hospitals	Reimbursement for inpatient and outpatient services will be based on the critical access hospital's most recent interim rate letter from their Medicare fiscal intermediary or contractor. In order to ensure appropriate reimbursement we request that you provide that letter to us.
Durable Medical Equipment (DME)	Reimbursement is calculated using DMEPOS Fee Schedules.
Drugs (Part B)	Reimbursement is based on the drug fee schedule which is 106% of the "average sales price" (ASP). Exceptions include blood drugs delivered through durable medical equipment (DME), influenza, pneumococcal and hepatitis B vaccines and certain new drugs which are still paid based on 95% of the average wholesale price (AWP). Epoetin (EPO)- Reimbursement 95% of median average price in Drug Topics Red Book if administered by a physician to a home patient. If furnished by end stage renal disease (ESRD) facility, payment is made at the rate of $10 per 1,000 units rounded to the nearest 10 units. Hemophilia Clotting Factors Billed by Provider (ex. Hospital, Skilled Nursing Facility, Home Health Agency)- Reimbursement for patient care is an ad-on payment to the Medicare PPS. In an outpatient setting, reimbursement is on a cost basis. All other setting [skilled nursing facility (SNF), home health agency (HHA)] are paid 95% of Drug Topics Red Book average wholesale prices. Hemophilia Clotting Factors billed by Suppliers- Reimbursed 95% average wholesale price in Drug Topics Red Book. Immunosuppressive Drugs Transplant- Reimbursement is based on the Medicare OPPS if the beneficiary is in the OP department of a Medicare participating hospital. In all other setting, reimbursement is 85% of the average wholesale price (AWP). Injections-Specific services are reimbursed separately if the physician doesn't render other service at the time of the injection. Chemotherapy injections are paid in the addition to the office visit for the same date of service. Reimbursement is based on the applicable fee schedule. Oral Anti- Cancer and Oral Anti-Nausea Drugs- Reimbursement is based on the appropriate Medicare national fee schedule.
ESRD Facility	Payment is based on the CMS Composite Rate methodology, this includes geographic and patient case-mix adjustments.
Federally Qualified Health Centers	Facilities are required to supply a copy of their most recent annual FI rate letter to show the interim per diems for inpatient services and a valid Medicare billing number. For FQHC services, reimbursement is at 80% of the lesser of the all- inclusive rate or the national limit, plus 20% of the actual charge. Medicare services not covered under the FQHC "all–inclusive rate" are paid at the same rate that the FQHC would receive

Provider	Payment Methodology
	under original Medicare.
Home Health Agencies	Payments are made on a PPS basis, using CMS home health resource groups. Providers are reimbursed per 60-day episode of care via submission of a request for accelerated payment (RAP) and the claim. Reimbursement includes adjustments for low utilization (LUPA), significant change in condition (SCIC), partial episode payment (PEP), therapies and outliers. DME is reimbursed based on the DME POS fee schedule.
Laboratories	Payments are based on the CMS lab fee schedule.
Long term care hospitals	Payments are made on an inpatient PPS basis using Medicare Severity LTC–DRGs. Rates are adjusted for short stay outliers and high cost outliers.
Maryland Hospitals	Maryland hospitals are paid at rates set by the Health Services Cost Review Commission (HSCRV) in accordance with the Medicare waiver.
Nurse Practitioners	Nurse Practitioners are paid the lesser of the actual charge for services or at 85% of the Medicare physician fee schedule if a physician, facility, or other provider of services does not charge for the same service.
Optometrists	Optometrists are paid the lesser of the actual charge for services or 100% of the Medicare physician fee schedule for Medicare covered services.
Physical, Occupational or Speech Therapists	Physical, Occupational and Speech Therapists are paid the lesser of the actual charge for services or 100% of the Medicare physician fee schedule.
Physicians (MDs and DOs)	MDs and DOs are paid the lesser of the actual charge for the services or 100% of the Medicare physician fee schedule. A 10% bonus is paid if the services are furnished in a health professional shortage area. A 5% bonus is paid if they are furnished in a physician scarcity area (PSA).
Physicians (Podiatrists)	Podiatrists are paid the lesser of the actual charge for the services or 100% of the Medicare physician fee schedule. A 10% bonus is paid if the services are furnished in a health professional shortage area. A 5% bonus is paid if they are furnished in a physician scarcity area (PSA).
Physicians (Oral and Maxillofacial Surgeons)	Oral and Maxillofacial Surgeons are paid the lesser of the actual charge for services or 100% of the Medicare physician fee schedule. A 10% bonus is paid if these services are furnished in a health professional shortage area. A 5% bonus is paid if they are furnished in a physician scarcity area (PSA).
Physicians (Dentists)	Dentists are paid the lesser of the actual charge for the services or or 100% of the Medicare physician fee schedule. A 10% bonus is paid if these services are furnished in a health professional shortage area. A 5% bonus is paid if they are furnished in a physician scarcity area (PSA).
Physician Assistants	Physician Assistants are paid at the lesser of the actual charge for services or 85% of the Medicare physician fee schedule if a physician, facility, or other provider of services does not charge for the same service.
Psychiatric Hospitals – Inpatient	Payment is made based on the prospective payment system for inpatient psychiatric facility care (IPFPPS). An outlier payment is made when a psychiatric hospital's estimated total costs for a case exceed a threshold established by CMS plus the total payment amount for the case.

Provider	Payment Methodology
Psychiatric Hospitals – Outpatient	Payment is made based on the outpatient prospective payment system (OPPS). Including Community Mental Health Centers (CMHC).
Registered Dieticians	Registered Dieticians are paid the lesser of the actual charge for services or 85% of the Medicare physician fee schedule.
Rehab hospitals - Inpatient	Rehab 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.
Rehab hospitals - Outpatient	Payment is made based on the outpatient prospective payment system (OPPS).
Religious Non-Medical Health Care Institutions	Reimbursement is based on the Medicare cost basis for covered services.
Rural Health Clinics	Rural Health Clinics are reimbursed based on 80% of the per-visit payment limit plus 20% of the actual charges of covered services. 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. RHCs owned by rural hospitals (Critical Access Hospitals) with less that 50 beds are paid on a cost basis and are PPS exempt and paid on a reasonable cost basis. These RHCs are reimbursed based on a per diem rate for inpatient services and on a cost-to-charge ratio basis for outpatient services. To ensure appropriate payment, RHC's must provide a copy of their most recent interim letter from their Fiscal Intermediary or Medicare Contractor. Medicare services not covered under the RHC "all-inclusive rate" are paid at the same rate that the FQHC would receive under original Medicare.
Skilled Nursing Facilities	Payment is made based on the prospective payment system (PPS) for SNFs. A case-mix adjusted payment for varying numbers of days of SNF care is made using one of the Resource Utilization Groups (RUGs). The RUG is identified in the first 3 positions of the HIPPS code. There may be an add-on payment for AIDS patients.
Swing Beds	Covered swing bed facility services will be reimbursed based upon the Skilled Nursing Facility Prospective Payment System. Swing beds in a CAH facility are paid at a per diem based on the rate letter from the FI.
VA Hospitals	In general, federal providers are excluded from participation in the Medicare program. Like other non-participating hospitals. Federal Hospitals may be paid for emergency inpatient and outpatient hospital services at an applicable Medicare reimbursement.