MA Payment Guide
for Out of Network Payments
6/15/06 Update

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

This payment guide is updated periodically, and a link to it can be found on http://www.cms.hhs.gov/MedicareAdvtgSpecRateStats/downloads/oon-payments.pdf
Please direct questions, comments, or suspected inaccuracies in this guide to Bill London of CMS's Office of the Actuary: William.London@cms.hhs.gov .

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

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

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

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

Medicare cost report information is on: **http://www.cms.hhs.gov/CostReports/**

The CMS online manual system can be found on
http://www.cms.hhs.gov/Manuals/01_Overview.asp#TopOfPage
The manuals and transmittals contain detailed payment information.

Coverage decisions can be found on http://www.cms.hhs.gov/coverage/default.asp

Another important resource for payment policies is
http://www.cms.hhs.gov/MedlearnMattersArticles/

The Medicare Guide to Rural Health Services is on
http://www.cms.hhs.gov/MedlearnProducts/downloads/MedRuralGuide.pdf

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Acute Care Hospital - Inpatient Services

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

DRG based payments paid for a discharge consist of operating and capital costs which include IME, DSH, outliers, and the new technology add on. An amount for hemophilia clotting factors is also included.

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
3) Organ acquisition costs (excludes bone marrow transplants)
4) CRNA's- for small rural hospitals
5) Nursing and allied health education costs

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

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

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

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

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

MA plans do not need to pay the organ acquisition cost pass-through; but would instead pay for an organ acquisition for their own members. Please note that if one runs the Pricer with HMO=yes, on the passthroughs, organ acq is lumped in. We plan to take org acq out for HMO=yes in the next update to the internet Pricer so that plans do not have to necessarily look at the hospital’s cost report to identify this amount.

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 www.cms.hhs.gov/providers/pricer/

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

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

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

For the DSH formula, the provider specific file has the SSI ratio in file position 111-114, and the Medicaid fraction in file position: 115-118.

Hospital 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.

Payment rates for APC's, passthroughs, and coinsurance are on
http://www.cms.hhs.gov/providers/hopps/default.asp

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

Outlier payments:
For 2006, the outlier thresholds are 1.75 times the payment of the APC and $1,250 over the APC payment rate. When the estimated cost of an APC hospital outpatient service exceeds these thresholds, CMS will make an outlier payment of 50% of the amount by which the cost of furnishing the service exceeds 1.75 times the APC payment rate.

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. Go to http://www.cms.hhs.gov/providers/hopps/ .

Coinsurance: The same link referred to above has a table showing coinsurance amounts for each APC. Providers are allowed to waive coinsurance in excess of 20% of each APC.

Payment information for MA plans: OPD Pricer details are on:
http://www.cms.hhs.gov/providers/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. These DME "pass-through" codes may be found on:
http://www.cms.hhs.gov/providers/hhapps/ Go to the 5th bullet point under "coding and billing".

The CMS home health page is http://www.cms.hhs.gov/providers/hha/ . This page has links to detailed information on how home health payments are determined. The HIPPS groups used in home health bills are explained on:
http://www.cms.hhs.gov/providers/hippscodes/ .

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

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 M+C plans: The SNF internet page is:
http://www.cms.hhs.gov/SNFPPS/
The Provider Specific Files (PSF) and PRICERS for SNF are available through the Internet on http://www.cms.hhs.gov/providers/pricer/ . These are updated quarterly. The Internet version of the PSF's have the hospital specific data bundled into the PRICER.

Master Cost Report File: The SNF cost report file is on
http://www.cms.hhs.gov/data/cost_reports/default.asp .

Swing Beds

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.

Critical Access Hospitals

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

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

If a physician elects to reassign their claims to the CAH (election of method II), the CAH is paid an extra 15% of Medicare's portion of the physician fee schedule amount.

Payment information for MA plans: FI's determine the interim payment amounts for each hospital based on their costs. For outpatient services, the payment amount is calculated by the FI's by multiplying the billed charges by the cost to charge ratio (ccr) for each hospital. Inpatient services are paid a per diem cost. The MA plan may ask the billing hospital to submit a copy of their most recent interim rate letter from their Medicare fiscal intermediary (FI). The CAH internet site is http://www.cms.hhs.gov/center/cah.asp

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% bonus is payable in 2005, 2006, and 2007 in areas designated by CMS as "physician scarcity areas". More details, including qualifying zip codes, can be found on http://www.cms.hhs.gov/HPSAPSAPhysicianBonuses/

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

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

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

Payments for physical therapy and occupational therapy have different rules, and some years are subject to annual payment limits per beneficiary.

Medicare 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.

The recently passed DRA gives physician services an increase for 2006 which is retroactive to 1/1/06.

Payment information for MA plans:
The physician fee schedule details are on: http://www.cs.hhs.gov/center/physician.asp . Further information on HCPCS codes can be found on http://www.cms.hhs.gov/medicare/hcpcs/

There is also a lookup application on http://www.cms.hhs.gov/apps/pfslookup/

Plans must pay the same as Medicare using the same rules, including the DRA fee increase.

Ambulance

These services were paid on a blend of "reasonable charges" and a fee schedule. Beginning 1/1/06, they will be paid at 100% of the ambulance fee schedule. Extra payments are made for ground transportation exceeding 50 miles, and for providers in certain rural areas.

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

Ambulatory Surgical Centers

ASC's are paid on a fee schedule. There are about 9 payment groups depending on the service, and the payments are area wage adjusted.

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

End Stage Renal Disease Facilities (this section will be updated soon)

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. Some facilities receive additional payments to their ESRD composite rates that are called "exception" payments. Beginning 4/1/05, a new case mix adjusted PPS payment system was established. Epoetin has different payments depending on whether or not it is billed by an ESRD facility

Payment information for MA plans:

The composite rates are on the internet. Payments are described in chapter 8 of the Medicare Claims Processing Manual (see internet link above). Detailed information on ESRD can be found on: http://www.cms.hhs.gov/providers/esrd.asp .

Master Cost Report File – The renal cost report file is on http://www.cms.hhs.gov/CostReports/

Durable Medical Equipment

Payments are on the DMEPOS fee schedule.

Payment information for MA plans:

DMEPOS (durable medical equipment, prosthetics, orthotics, and supplies) payment details are on http://www.cms.hhs.gov/DMEPOSFeeSched/

Clinical Lab

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

Payment information for MA plans:

The lab payment details are on http://www.cms.hhs.gov/ClinicalLabFeeSched/

Part B Drugs

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

When the outpatient department of a hospital bills for drugs, the cost is generally included in the APC payment. However an extra payment for certain new drugs are payable for the first 2 or 3 years. Also, during the transition to APC's, other drugs may have extra payments. Changes were made to drugs payments in 2004 and 2005 as follows:

Non-hospital outpatient drugs:

Effective 1/1/05, payment is based on 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.

Payment information for MA plans:

This is from the CMS web site:

Section 303(c) of the Medicare Modernization Act of 2003 (MMA) revised the payment methodology for Part B covered drugs that are not paid on a cost or prospective payment basis. In particular, section 303(c) of the MMA amended Title XVIII of the Act by adding section 1847A, which established a new average sales price (ASP) drug payment system. Beginning January 1, 2005, drugs and biologicals not paid on a cost or prospective payment basis will be paid based on the ASP methodology, and payment to the providers will be 106 percent of the ASP. There are exceptions to this general rule which are listed in the latest ASP quarterly change request (CR) document. The ASP methodology uses quarterly drug pricing data submitted to the CMS by drug manufacturers. CMS will supply contractors with the ASP drug pricing files for Medicare Part B drugs on a quarterly basis.

Please read the following link for more information:
http://www.cms.hhs.gov/transmittals/downloads/R876CP.pdf

The drug fee schedule can be found on
http://www.cms.hhs.gov/McrPartBDrugAvgSalesPrice/

Federally Qualified Health Centers

The FQHC allowed charge is the lesser of an "all inclusive rate" or a national per-visit limit. The all inclusive rate is determined for each center based on historical costs. The 2006 limit is $112.96 for urban centers, and $97.13 for rural centers.

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

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

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

Payment information for MA plans:

The MA plan must pay 80% of the allowed charge, plus 20% of the actual charge, minus the plan's copay. The plan may request the FI approved rate from the billing FQHC. The internet site is: http://www.cms.hhs.gov/providers/fqhc/.

More detailed information for Private Fee For Service Plans:

PFFS Plans that use a "non-network model"

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

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

PFFS Plans that use a "network model"

For in-network providers:

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

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

For out-of-network providers:

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

Rural Health Clinics

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

Coinsurance of 20% of charges, not the all-inclusive payment, applies to FQHC's as well as RHC's. The limit for 2006 is $72.76. RHC services are subject to the Part B deductible which is based on billed charges.

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

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

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. Until 10/1/03, they were paid 80% of the old payment plus 20% of the new payment (aka the federal rate). On 10/1/03, the weighted average became 60% old/ 40% new; and on 10/1/04 became 40% old/ 60% new. On 10/1/06, 100% PPS will be implemented. Instead of going through the 5 year transition, hospitals were allowed to elect to go immediately to 100% PPS. Rates are updated every July 1st.

Outliers for inpatient services: Payment is 80% of the excess of the cost of an admission over the sum of the DRG payment (including IME and DSH) and a threshold amount. The threshold amount for rate year 2006 is $10,501. There are also outlier adjustments for certain short stays. OPD has different outlier rules.

The internet site is: http://www.cms.hhs.gov/providers/longterm/
The Pricer is on http://www.cms.hhs.gov/providers/pricer/pricdnld.asp .

Inpatient Rehabilitation 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). On Medicare claims, these CMGs are represented as HIPPS codes.

The IRF web site is: http://www.cms.hhs.gov/InpatientRehabFacPPS/

Psychiatric Hospitals

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

Old system- TEFRA

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

New system – IPFPPS

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

The new PPS system uses a federal per diem base amount of $575.95 which is then adjusted for one of 15 DRG's, comorbidities, age, rural add-on, teaching add-on, outlier payments , wage index, the presence of an emergency department, and ECT treatment. There is also an extra payment which tapers down during the first 21 days of an admission. There are further rules concerning readmissions.

Outlier payments are effective after a loss of $5,700 (adjusted for wage index, rural, teaching, etc) per stay. The loss-sharing ratio is 80% for the first 9 days, and 60% thereafter. Each FI calculates cost to charge ratios for outlier purposes. There are further rules concerning readmissions. Different rules are used for Community Mental Health Center.

Detailed information on the development of the PPS system for psychiatric hospitals may be found on: http://www.cms.hhs.gov/providers/ipfpps/. Click on the link for the Nov. 15, 2004 final rule.

Medicare Dependent Hospitals

These are hospitals that:
1) are located in a rural area,
2) have less than 100 beds, and
3) at least 60% of their patients are on Medicare

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 50% of the difference. PRICER compares the PPS rate to the hospital specific rate for each service, but the final settlement compares the PPS payments to the hospital specific rate for the entire year.

Sole Community Hospitals

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

Low Volume Hospitals

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

Cancer Hospitals

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

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

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

Children's Hospitals

Same basic methodology as for Cancer Hospitals.

Clinical Trials:

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

- Overview
- Clinical Trials NCD

Payment information for MA plans:

FI's will reimburse qualifying clinical trial claims on behalf of MA members. Providers need to submit the bills to the carriers and intermediaries using the proper modifiers and ICD-9 codes.

Bad Debts

Most hospitals are paid 70% of bad debt by Medicare.

Certain other hospitals and facilities receive 100% bad debt reimbursement from Medicare including skilled nursing facilities (SNFs), rural health clinics, federally qualified health clinics, community mental health clinics.

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

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

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

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

Payment information for MA plans:
CMS policy is that MA plans are not required to pay their members' unpaid cost sharing. In any case, FI's 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%.

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 more than that of Medicare.

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:

This site http://www.cms.hhs.gov/mcd/search.asp? 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.

Plan Contact Information:

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

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

Provides mailing addresses for the MA claims processing contacts.
http://www.cms.hhs.gov/HealthPlansGenInfo/claims_processing_20060120.asp#TopOfPage