

MA Payment Guide for Out of Network Payments

4/15/2015 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/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/OONPayments.pdf>

Please direct questions, comments, or suspected inaccuracies in this guide to MAGuide@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.

In situations when plans must pay the Medicare amount, plans must accept from providers the same billing forms used to bill original Medicare.

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, 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/Medicare/Medicare.html> This site has links for most services covered by Medicare.

The Medicare manuals and transmittals link is:

<http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/index.html>

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/Regulations-and-Guidance/Guidance/Transmittals/index.html>

Fee schedules can be found on: <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/FeeScheduleGenInfo/index.html> or on <https://www.cms.gov/Center/Provider-Type/All-Fee-For-Service-Providers-Center.html>

Medicare Internet Pricers are on: <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PCPricer/index.html> They are generally updated quarterly.

Medicare cost report information (HCRIS) is on: <http://www.cms.gov/Research-Statistics-Data-and-Systems/Files-for-Order/CostReports/index.html>

Coverage decisions can be found on <http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx> , then clicking on “Medicare coverage”. The Medicare National Coverage Determinations Manual can be directly accessed by clicking: <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS014961.html>

Another important resource for payment policies is <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/index.html> . 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/Provider-Type/Rural-Health-Clinics-Center.html>

Another very helpful link for a description of original Medicare payments is <http://www.medpac.gov/> Click on “documents”, then “Medicare background”, then “payment basics”.

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Acute Care Hospital - Inpatient Services

General acute care hospitals are paid using the Medicare inpatient prospective payment system (IPPS) in all states except Maryland. Payment is based on diagnosis related groups (DRG). 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 indirect medical education (IME), disproportionate share (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 IPPS amount even if the submitted charge is lower.

Non- PPS payments include:

- 1) Direct graduate medical education payment (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) Certified Register Nurse Anesthetist (CRNA)- for small rural hospitals
- 5) Nursing and allied health education costs
- 6) Bad debt

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 DRGs, 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/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM7141.pdf> for more details.

Post-acute care transfers – a transfer from an acute care hospital to a skilled nursing facility (SNF) or Home Health Agency (HHA) for certain DRGs: the payment of certain DRGs is reduced for the acute care hospital when the patient is discharged to a SNF or HHA.

Regional PPO essential hospitals:

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.

Value Based Purchasing (VBP):

Medicare began withholding a percentage of base operating payments (includes new technology add-on but excludes IME, DSH, and outliers) for PPS hospitals starting 10/1/12. The current schedule calls for a 1% withhold in FY 2013, gradually increasing each year until it gets to 2% in 2017. Hospitals can recover all or part of the withheld payments based on their performance on certain quality measures. The best performing hospitals will recover more than the amount that was withheld from them. The net payment adjustment is, or will soon be, included in the Pricer. The VBP adjustment is applicable to plans that are required to pay at least Medicare rates. This might require a retroactive payment adjustment if the plan payment was based on a version of the Pricer that did not yet include the full adjustment factor.

Readmission adjustment:

Starting 10/1/12, base DRG payments (includes new technology add-on but excludes IME, DSH, and outliers) for certain DRGs are subject to a reduction based on a comparison of actual to expected readmissions for each PPS hospital. Under the current schedule, the maximum reduction starts at 1%, and increases each year until it becomes 3%. The factors are included in the Pricer. This reduction is applicable to MA plans that are required to pay at least the Medicare amount.

VBP and the readmissions adjustments apply to PPS hospitals, but not critical access hospitals. For sole community hospitals, the adjustments are calculated based on the PPS operating amount, not the HSP amount. But the adjustments apply even if the claim is paid based on HSP.

Changes to the Medicare DSH Payment: Effective for discharges occurring on or after FY 2014, hospitals will receive 25 percent of the amount they previously would have received under the current statutory formula for Medicare DSH.

Additional Payment for Uncompensated Care: The remainder, equal to 75 percent of what otherwise would have been paid as Medicare DSH will become available for an uncompensated care payment after the amount is reduced for changes in the percentage of individuals that are uninsured, and an additional subtraction which in FY 2014 is 0.1%. In FY 2015 through 2017, the additional subtraction is 0.2%. Each Medicare DSH hospital will receive an uncompensated care payment based on its share of insured low income days.

Payment information for MA plans:

Capital for new hospitals: For new hospitals that do not elect to be paid based on the capital IPPS rate, the new hospital capital amount may show as zero on the Pricer, but plans must pay the amount that the FIs determine to be a best estimate (i.e. the interim rate). This amount might not be available at the time that the claim is submitted. New hospitals should generally bill plans upon discharge. If interim amounts are not yet available, the hospital should bring the fact to the plan's attention that it qualifies for new capital cost-based payments on its initial bill. The plan should process the claim as if it were not from a new hospital. The hospital should then bill the plan for the additional capital amount as soon as the MAC determines an interim amount.

Since operating IME and DGME for inpatients are paid by MACs 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 MACs 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 57 and 58. Item #2 is on line 53 that says "Nursing and Allied Health Managed Care."

The DRG is determined by the GROUPER program based on patient information on the hospital claim. The payment is determined using the PRICER program. Hospital specific data is contained on the Provider Specific Files. The PRICERs on the Internet already contains the provider specific files and can be found on

<http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PCPricer/inpatient.html>

Hospital payment details are on: <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/index.html>

Hospital Cost Report Master File (HCRIS): The hospital cost report file is updated quarterly and can be found on <http://www.cms.gov/Research-Statistics-Data-and-Systems/Files-for-Order/CostReports/index.html>

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 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>

Hospital acquired conditions

Medicare prohibits payments for **certain hospital acquired conditions (HAC)** and certain other serious adverse events that are usually preventable. Medicare will eliminate the diagnosis codes identified with these conditions when calculating DRGs. To the extent an MAO does not pay a non-contracting PPS hospital for these conditions, the Medicare certified hospital cannot bill the member.

MAOs (and hospitals) have asked whether an MAO must withhold payment to a **contracting** hospital for 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 HACs an issue between MAOs and their contracting providers.

Section 1886(p) of the Act, as added under section 3008(a) of the Affordable Care Act, establishes an adjustment to hospital payments for HACs under which payments to

applicable hospitals are adjusted to provide an incentive to reduce HACs, effective for discharges beginning on October 1, 2014 and for subsequent program years. This 1-percent payment reduction applies to a hospital whose ranking is in the top quartile (25 percent) of all applicable hospitals, relative to the national average, of conditions acquired during the applicable period and on all of the hospital's discharges for the specified fiscal year.

Uncompensated Care Payment

As mentioned above, a new "uncompensated care payment" (UCP) is paid to DSH hospitals starting in FY 2014. The CMS policy for the methodology of plan payments for UCP to non-network hospitals is being determined and should be available soon.

Hospital Outpatient

Services subject to outpatient prospective payment system (OPPS) are paid by the Ambulatory Patient Classification (APC) methodology. Hospitals exempt from OPPS include those in Maryland, Indian Health Service, and Critical Access Hospitals. OPPS 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.

In addition to outpatient OPPS, Outpatient Departments (OPD) can be paid pass-through payments for new technologies such as drugs and devices. Alternatively, some new technologies are paid using separate APCs. Outlier payments are also paid in addition to APCs.

Inexpensive drugs and biologicals are packaged and not separate paid. More expensive drugs above a cost threshold are paid at average sales price (ASP) plus 6%.

The 3 day payment rule prohibits separate billing for all diagnostic services and therapeutic services that are related to an inpatient admission and rendered in the OPD within 3 days of the admission when the OPD wholly owned and operated by the hospital. Instead, these services are considered to be part of the inpatient stay.

Medicare reduces payments for OPPS services rendered by hospitals that fail to report quality measures under the Hospital Outpatient Quality Data Reporting Program (HOP QDRP). This reduction is automatically reflected in the Pricer output.

TOPS payments:

Transitional outpatient payments (TOPs) 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 were payable through the end of 2003 for most hospitals.

Some sole community hospitals (SCHs), cancer hospitals, and rural hospitals continue to be eligible for TOPS payments, or other extra OPD payments not classified as TOPS, subject to changes in legislation. The TOPS formula for these types of hospitals is subject to change and, for example, changed in 2012.

For SCHs and cancer hospitals that receive both a percentage add-on payment and TOPS, the TOPS amount is determined using the payment amount after applying the add-on amount.

Extra payments may also be made to certain cancer hospitals and children's hospitals.

Outlier payments:

If the cost of a visit compared to the APC payment amount 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 for the primary service.

Coinsurance:

Coinsurance amounts vary for each APC of each provider. Providers are allowed to waive coinsurance in excess of 20% for any given APC.

Partial hospitalizations:

Although OPSS pays on a per service basis, partial hospitalizations are paid per diem to an OPD or community mental health center.

Payment information for MA plans:

OPD details are on: <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/index.html> The hyperlink in the left hand margin that says "Addendum A and Addendum B updates" shows APC and procedure codes.

As mentioned above, certain payment adjustments related to quality are reflected in the OPSS Pricer. MA plans required to pay the Medicare amount are to include those adjustments.

Home Health

If a patient receives less than 5 visits (nurse, PT, speech therapist) in a 60 day period, Medicare pays per visit. For 5 or more visits in a 60 day period, the patient is assigned to one of 153 (as of this writing) home health resource groups (HHRGs). These payments

cover episodes of care up to 60 days. Adjustments are made for outliers. Durable medical equipment is excluded from HHRG payments and is instead paid on a fee schedule basis.

The CMS home health page is <http://www.cms.gov/Center/Provider-Type/Home-Health-Agency-HHA-Center.html> . This page has links to detailed information on how home health payments are determined.

Master Cost Report File: See <http://www.cms.gov/Research-Statistics-Data-and-Systems/Files-for-Order/CostReports/index.html>

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 (payment per visit) applies. Otherwise, payments must be computed using HHRGs and 60-day episodes of care.

Skilled Nursing Facilities

SNF is paid on PPS and generally paid by original Medicare only after a hospital stay of at least 3 consecutive days. In addition, the beneficiary must have been transferred to a participating SNF within 30 days after discharge from the hospital, unless the patient's condition makes it medically inappropriate to begin an active course of treatment in an SNF within 30 days after hospital discharge, and it is medically predictable at the time of the hospital discharge that the beneficiary will require covered care within a predetermined time period.

A case-mix adjusted payment for varying numbers of days of SNF care is made using one of roughly 66 or so Resource Utilization Groups, Version III (RUG-III). The RUG is identified in the first 3 positions of the HIPPS code. Payments vary by factors including intensity of care, and urban/rural.

Original Medicare covers up to 100 SNF days per spell of illness. A new spell of illness starts 60 days after the last hospital or SNF discharge.

SNF services in CAHs that are not provided in distinct units (generally in swing beds) are paid based on their costs.

There is an add-on for AIDS patients until the RUGs are adjusted appropriately to account for the higher costs of AIDS patients.

SNF- consolidated billing - SNFs bill for most Part A services; and also certain Part B services including physical and occupational therapists, and speech pathologists.

Payment information for MA plans:

The SNF internet page is: <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/index.html> This page also has a link to the quarterly Pricer. Further

information is on: <http://www.cms.gov/Medicare/Billing/SNFConsolidatedBilling/index.html>

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 bed SNF services 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 at 101% of costs. Ambulance is also paid costs if it is the only supplier within a certain number of miles.

CAHs may have distinct units that are SNFs, small psychiatric units, small rehab units, or HHAs, but these units are paid PPS instead of costs.

Under the optional method of assigning physician claims, 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.

Also, for CAH OPDs, the original Medicare patient coinsurance is 20% of the submitted charge.

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:

MACs determine the interim payment amounts for each hospital based on their costs. For outpatient services, the payment amount is calculated by the MACs 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 MAC. The CAH internet site is <http://www.cms.gov/Center/Provider-Type/Critical-Access-Hospitals-Center.html> . 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". As is the case with other hospitals, plans are not required to cost settle with CAHs.

Physician Services

Physicians and other professionals paid on the physician fee schedule, are paid using the lesser of billed charges, or the Medicare Physician Fee Schedule (MPFS). A 10% bonus could be paid if these services are furnished in a primary medical care health professional shortage area (HPSA). Mental health HPSAs are used for psychiatrists. 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/Medicare/Medicare-Fee-for-Service-Payment/HPSAPSAPhysicianBonuses/index.html> and

<http://www.cms.gov/MLN MattersArticles/downloads/MM5698.pdf>

The fee schedule for physicians that do not participate (e.g. do not accept assignment on all services provided to Medicare beneficiaries) in Medicare is 95% of the participating physician 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 was phased down to 20% to be consistent with the coinsurance for most other Part B services. The coinsurance was 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 CRNAs. For more information, see <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c12.pdf>.

Payments for **physical therapy, speech, language, and occupational therapy** have different rules, and some years are subject to annual payment limits per beneficiary. There is generally one limit that applies to both physical therapy and speech therapy combined and a 2nd limit for occupational therapy. Some years, there is also an exceptions process to enable spending to go above the limits. Both the limits and the availability of the exceptions process are subject to change at any time. They are oftentimes changed on a year by year basis.

Outpatient therapy is provided as per a written treatment plan and must be recertified every 90 days.

A payment reduction may apply to multiple therapy procedures rendered on the same patient on the same day by the same provider.

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 the **PQRI/PQRS bonus**.

PQRI/PQRS bonus payments for claims incurred in a given year were payable the following year in a lump sum. For example, bonuses earned for claims incurred in 2008 were payable early in 2009. More information on the PQRI/PQRS bonus payment is available at <http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/index.html>. The first reporting year was CY 2007. The payments were made in a lump sum based on claims data submitted within 2 months after the end of the year. The last reporting year for PQRI/PQRS bonus payment purposes was 2014. The bonus was applied to physician allowed charges and was 1.5% for 2007 and 2008; 2% for 2009 and 2010; 1% for 2011; and 0.5% for 2012 - 2014. An additional bonus could be earned by successfully participating in a Maintenance of Certification Program.

Starting in 2015, payment penalties based on 2013 quality reporting will begin. Those physicians who elect not to participate or do not successfully participate in PQRI/PQRS during 2013 will receive a 1.5% penalty in 2015, which increases to 2% thereafter.

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 were applied to payments of physicians who were unsuccessful e-prescribers. The penalties were 1% for 2012; 1.5% for 2013; and 2% for 2014. For more information see <http://www.cms.gov/pqri/downloads/pqrieprescribingfactsheet.pdf>

Both the PQRI/PQRS and e-RX are due on 100% of the physician fee schedule, before deducting patient cost sharing. These incentives are not applicable for fee schedule services billed as technical components.

PQRS can be applied on an individual physician or a group basis. Furthermore, individual physicians can bill under more than one tax ID number (TIN). The rendering physician has an NPI. And the PQRS adjustment is on an NPI/TIN combination basis. Therefore a physician can get a payment adjustment on one TIN, but not necessarily when billing under a different TIN.

The Affordable Care Act established a **Value Modifier** that provides for differential payment to a physician or group of physicians under the Medicare Physician Fee Schedule based upon the quality of care furnished to Medicare FFS beneficiaries as well as the cost of that care during a performance period. Further, the statute requires that we begin applying the Value Modifier on January 1, 2015, with respect to items and services furnished by specific physicians and groups of physicians (depending on how many physicians are in a group) and to apply it to all physicians and groups of physicians beginning not later than January 1, 2017. CMS is planning to apply the Value Modifier to nonphysician practitioners beginning in CY 2018.

Implementation of the VM is based in part on participation in Physician Quality Reporting System (PQRS). However for the 2015 reporting year/2017 payment adjustment year, solo providers and groups with 2-9 providers will not receive a VM penalty under quality tiering, but may have a VM penalty if not reporting PQRS. Groups with 10 or more providers may receive an upward, neutral or downward adjustment under quality tiering.

The value modifier is summarized on: <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/ValueBasedPaymentModifier.html> Click on the 1st hyperlink under “Downloads” for a summary.

Primary Care Incentive Payment

Section 5501(a) of the Affordable Care Act authorized a quarterly incentive payment program to augment the Medicare payment for primary care services furnished on or after January 1, 2011, and before January 1, 2016, by a primary care practitioner.. Primary care practitioners with a Medicare specialty designation of family medicine, geriatric medicine, pediatric medicine, internal medicine, nurse practitioner, clinical nurse specialist, or physician assistant are eligible for the incentive payment if primary care services (CPT codes 99201 through 99215 and 99304 through 99350) accounted for at least 60 percent of the practitioner’s total allowed charges under the physician fee schedule in the qualifying calendar year. Details can be found in the following article:

<http://www.cms.gov/MLN Matters Articles/downloads/MM7060.pdf>

The incentive payment is equal to 10 percent of Medicare’s payment for primary care services each calendar quarter (4 payments annually), for each qualifying NPI listed on the **Primary Care Incentive Payment Program Eligibility File**. This new incentive is paid in addition to any HPSA bonus otherwise due.

The primary care incentive payment also applies to practitioners who reassign their claims to critical access hospitals under the “optional method”. The incentive payment is paid based on 10% of the 115% of the Medicare Physician Fee Schedule amount paid to the CAH for qualifying primary care services. 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/Medicare/Medicare-Fee-for-Service-Payment/HPSAPSAPhysicianBonuses/index.html>

Details can be found on:

<http://www.cms.gov/MLN MattersArticles/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.

As noted above, the HSIP and PCIP could expire at the end of CY 2015 unless extended by law.

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.cms.gov/Center/Provider-Type/Physician-Center.html> . Further information on HCPCS codes can be found on, or accessed from: <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PFSlookup/index.html> A direct link to the complete PFS is on <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/index.html> For example, file RVU12M has the March update to the 2012 PFS.

As is the case with Original Medicare, plans must make balanced billing payments, if billed, up to the 15% limit to physicians who do not participate with Original Medicare.

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.

Because it is not known whether a physician will be entitled to the PQRS 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 claims and the applicable percentage.

A registered HPMS user can access the list of providers who are entitled to the PQRS incentive payment by visiting the Data Extract Facility. A link is available on the right-hand side of the Home Page of HPMS. On the Data Extract facility page, there will be a link entitled “Incentive Payments” on the left navigation bar. The filename for the list of providers is “**PQRS File.**”.

As is the case with the PQRS bonus, CMS has a file to show which providers will be entitled to the **e-prescribing bonus**. The filename for the list of providers is “PQRI File.” 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. However, this fee cut is not mandatory for plans.

Computation of Bonus Due

Generally, for the TIN/NPI (must be an exact match on both numbers) for non-contracting providers, the MAO is to pay an additional e-Rx incentive of the applicable amount of the total amount paid to the provider for Part B physician fee schedule services its MA plan members received with dates of service between January 1 and December 31 of the applicable year. The e-Rx incentive is due on 100% of the physician fee schedule amount, including member cost sharing, not just the plan’s portion of the payment.

Consultation Codes

Starting with services performed on or after 1/1/2010, Medicare no longer pays 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/MLNMMattersArticles/downloads/MM6740.pdf>

PCIP

A **Primary Care Incentive Payment Program (PCIP) Eligibility File** with the NPI of each eligible provider who qualifies for the **PCIP bonus** is available through HPMS. Look for the PCIP Eligibility File on the Data Extract Start Page, under the Incentive Payments module. Excel 2007 or newer versions can be used when extracting the file.

As mentioned above, CPT codes 99201 through 99215, and 99304 through 99350 are eligible for a 10% bonus calculated on Medicare's payment for primary care services. Medicare pays 80% of the MPFS allowed charges for qualifying primary care services. Plans should 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.

HSIP

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 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/Medicare/Coding/NationalCorrectCodInitEd/index.html> 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/MLN MattersArticles/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 Services

Under the ambulance fee schedule (AFS), Medicare Part B will cover ambulance services furnished to a Medicare beneficiary that meet the following requirements: there is medically necessary transportation of the beneficiary to the nearest appropriate facility that can treat the patient's condition and any other methods of transportation are contraindicated meaning that traveling to the destination by any other means would endanger the health of the beneficiary. The beneficiary's condition must require both the ambulance transportation itself and the level of service provided in order for the billing service to be considered medically necessary. As of this writing, there are 9 levels of service covering ground (land and water transportation is included) and air transports (called the “base payment”) that are paid in addition to a mileage component. The fees cover both the transport and all items and services associated with the transport.

The AFS also incorporates two permanent add-on payments and three temporary add-on payments to the base rate and/or mileage rate. The two permanent add-ons include: a 50 percent increase in the standard mileage rate for ground ambulance transports that originate in rural areas where the travel distance is between 1 and 17 miles, and a 50 percent increase to both the base and mileage rate for rural air ambulance transports.

The three temporary policies, which are set to expire after March 31, 2015, include (1) a 3 percent increase to the base and mileage rate for ground ambulance transports that originate in rural areas, and a 2 percent increase to the base and mileage rate for ground ambulance transports that originate in urban areas; and (2) a 22.6 percent increase in the base rate for ground ambulance transports that originate in “super rural” areas.

For services furnished on or after October 1, 2013, the AFS also includes a 10 percent reduction in payments for certain non-emergency basic life support transports of beneficiaries with end-stage renal disease (ESRD) for renal dialysis services.

Payment information for MA plans:

The ambulance fee schedule, and other detailed information, is on <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AmbulanceFeeSchedule/index.html> .

Ambulatory Surgical Centers

ASC's are paid on a fee schedule comprised of wage adjusted payment groups called APCs. ASCs and OPDs both use ambulatory payment classifications (APCs) as the unit of payment. The payment for most APCs in an ASC is lower than the payment for the same APC when rendered in an OPD. In addition, ASC payments have limits based on the hospital OPD rates. Other limits, based on the practice expense portion of the physician fee schedule, are applied to services that are usually performed in a doctor's office.

Payment information for MA plans:

The ASC fee schedule, including geographic adjustments and other detailed information, is on <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ASCPayment/index.html>

End Stage Renal Disease Facilities

The ESRD prospective payment system (PPS) provides ESRD facilities a case-mix adjusted bundled payment for renal dialysis services provided in an ESRD facility or in a patient's home on or after 1/1/2011. The ESRD PPS rate replaced the prior case-mix adjusted composite rate. The new rate was phased in over a 4 year period, but facilities could make a one time election to skip the blended rates and get paid entirely under the new system starting 1/1/2011. About 90% of ESRD facilities elected to skip the transition. Effective 1/1/2014, all ESRD payments are made under the ESRD PPS.

ESRD PPS rates are adjusted for 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 as well as a self-dialysis training add-on payment. Certain "low volume" facilities receive extra payments. Medicare applies an "onset of dialysis" adjustment to the composite rate when the date of ESRD onset is within 120 days of a line item's date of service.

Under the ESRD PPS, routinely furnished ESRD drugs, lab tests, and supplies (including some that were formerly separately billable) are now subject to consolidated billing. 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.

Payment information for MA plans:

The ESRD PPS 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/Medicare/Medicare-Fee-for-Service-Payment/ESRDpayment/index.html> . The ESRD PC Pricer is on http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PCPricer/ESRD_Pricer.html

Master Cost Report File – The renal facility cost report file is accessible by a hyperlink called “Renal Facility” found on: <http://www.cms.gov/Research-Statistics-Data-and-Systems/Files-for-Order/CostReports/index.html>

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. Each state has a different fee schedule.

Unlike other services, DME is paid according to the patient’s place of residence rather than the location of the DME provider.

Starting 1/1/2011, due to the new DMEPOS competitive bidding fee schedule and program, in one of the competitive bidding areas (CBAs) only competitive bid suppliers are paid by original Medicare for competitive bid supplies. Other suppliers are either excluded from the market for bid items, or not allowed to serve new clients with bid items. But certain exceptions apply. For example, non-competitive bid hospitals or doctors may be able to supply walkers (which are a competitive bid item) to their own patients.

The web site: <http://www.dmecompetitivebid.com/palmetto/cbicrd1recompete.nsf/DocsCat/Competitive%20Bidding%20Areas> has the zip codes for each competitive bidding area. It also shows the bid price for each HCPCS code in each CBA. In original Medicare, the bid prices apply if a beneficiary resides in a CBA.

Drugs and oxygen administered through DME are paid under different fee schedules.

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. Further payment details are on <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/DMEPOSFeeSched/index.html>. 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 based on the lab fee schedule which varies by geographic region. There are 56 regions. In addition, there is a national payment limit for each test and most lab services are paid at this “national limitation amount”.

Certain small hospitals, including critical access hospitals, are paid a higher rate, or based on their costs instead of the fee schedule. Pap smear tests have a national minimum payment that is subject to change each year.

The Medicare payment is the lesser of the submitted charge, the fee schedule, or the national limitation for each lab HCPCS code.

Beginning in CY 2014, payment for most laboratory tests (except for molecular pathology tests) in the OPD will be packaged under the OPPI instead of paid separately. However if a lab test is the only service, it will be paid on the lab fee schedule.

Starting on January 1, 2017, most rates on the lab fee schedule will be determined based on rates from private payers.

Payment information for MA plans:

The lab payment details are on <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ClinicalLabFeeSched/index.html>

Part B Drugs

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

When the outpatient department of a hospital bills for drugs, payment is included in the APC payment if the cost per day is below a threshold amount. Above the threshold amount, payment is at ASP plus 6%. Payment for certain new drugs is also payable for the first 2 or 3 years at ASP plus 6%.

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/Medicare/Medicare-Fee-for-Service-Part-B-Drugs/McrPartBDrugAvgSalesPrice/index.html>

Federally Qualified Health Centers

FQHCs are paid an all-inclusive rate (AIR) for primary health services and qualified preventive health services. Beginning on or after October 1, 2014, FQHCs will transition to the FQHC prospective payment system (PPS) as required by Section 10501(i)(3)(B) of the Affordable Care Act.

On May 2, 2014, CMS published a final rule that establishes methodology and payment rates for a PPS for FQHC services under Medicare Part B beginning on October 1, 2014, in compliance with the statutory requirements of Section 10501 of the Patient Protection

and Affordable Care Act of 2010. Medicare will pay FQHCs a national encounter-based rate per beneficiary per day, with some adjustments. Payment will be 80 percent of either the PPS rate, or the total charges for services furnished, whichever is less. FQHCs will be able to bill for separate visits when a mental health visit occurs on the same day as a medical visit. The FQHC PPS rate will be adjusted for geographic differences in the cost of services. In addition, the rate will be increased by 34 percent when a FQHC furnishes care to a patient that is new to the FQHC or to a beneficiary receiving a comprehensive initial Medicare visit or an annual wellness visit. FQHCs will transition into the PPS beginning October 1, 2014, based on their cost reporting periods.

The five specific payment codes to be used by FQHCs submitting claims under the PPS are:

1. G0466 – FQHC visit, new patient: A medically-necessary medical, or a qualified preventive health, face-to-face encounter (one-on-one) between a new patient (as defined in section 70.2), and a FQHC practitioner during which time one or more FQHC services are rendered and includes a typical bundle of Medicare-covered services that would be furnished per diem to a patient receiving a FQHC visit.
2. G0467 – FQHC visit, established patient: A medically-necessary medical, or a qualifying preventive health, face-to-face encounter (one-on-one) between an established patient and a FQHC practitioner during which time one or more FQHC services are rendered and includes a typical bundle of Medicare-covered services that would be furnished per diem to a patient receiving a FQHC visit.
3. G0468 – FQHC visit, IPPE or AWV: A FQHC visit that includes an IPPE or AWV and includes a typical bundle of Medicare-covered services that would be furnished per diem to a patient receiving an IPPE or AWV.
4. G0469– FQHC visit, mental health, new patient: A medically-necessary, face-to-face mental health encounter (one-on-one) between a new patient (as defined in section 70.2),and a FQHC practitioner during which time one or more FQHC services are rendered and includes a typical bundle of Medicare-covered services that would be furnished per diem to a patient receiving a mental health visit.
5. G0470 – FQHC visit, mental health, established patient: A medically-necessary, face-to-face mental health encounter (one-on-one) between an established patient and a FQHC practitioner during which time one or more FQHC services are rendered and includes a typical bundle of Medicare-covered services that would be furnished per diem to a patient receiving a mental health visit.

Under the AIR methodology, the FQHC allowed charge is the lesser of an “all inclusive rate” or a national per-visit limit. The all inclusive rate (AIR) 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 updated each year based on the Medicare Economic Index (MEI).

Generally, for FQHCs billing under the AIR, Medicare pays FQHC’s 80% of the allowed charge, and the beneficiary pays 20% of the actual charge. Coinsurance is 20% of total charges, not the allowed charge. FQHC services are not subject to the Part B deductible. However, for FQHCs billing under the PPS, the coinsurance is 20 percent of the lesser of the FQHC’s charge for the specific payment code or the PPS rate.

The FQHC 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 supplemental payments to FQHC’s that have written contracts with MA plans for rates below the lesser of the FQHC’s AIR 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 supplemental payments only apply to services which qualify as “FQHC services”.

For FQHCs paid under the FQHC PPS, the wrap around payment is based on the difference between the MA contracted rate, subject to the above conditions, and the PPS rate (not the charges).

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 when paying based on AIR. When paying based on PPS, the full amount is the lesser of the PPS amount or the actual charge. Also, certain preventive services have no cost sharing. The plan may request a copy of the approved rate letter from the FQHC or from the FQHC’s MAC.

The internet site is: <http://www.cms.gov/Center/Provider-Type/Federally-Qualified-Health-Centers-FQHC-Center.html>

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.

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 provided by an FQHC but not covered under the FQHC benefit are to be paid at the same rate that they would be paid under original Medicare.

PFFS Plans that use a “network model”

For in-network providers:

Plans negotiate terms 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 MA 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 FQHC benefit 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:

An 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 to receive the supplemental wrap-around payment – 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 AIR or a national per-visit limit. The AIR 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 is 20% of charges, not the all-inclusive payment. The national per visit limit is updated each year based on the MEI. 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 non-RHC services 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/Provider-Type/Rural-Health-Clinics-Center.html>

Long Term Care Hospitals

Hospitals can qualify under Medicare as a Long Term Care Hospital (LTCH) if their average length of stay is at least a given number of days. As of the time of this writing, the average was a minimum of 25 days for its Medicare patients.

The payments are PPS based on DRGs. Hospitals that do not submit adequate quality data are subject to payment reductions.

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. OPD has different outlier rules.

There are also short stay outlier payment adjustments. These fall into one of 2 categories depending on the length of stay. OPD has different outlier rules.

LTCHs also have a single payment for interrupted stays. This is when patients are transferred to an inpatient acute care or rehab hospital, or a SNF; then back to the same LTCH. This policy is invoked depending on the length of stay at the non-LTCH. Also, any discharge followed by a re-admission within 3 days may be subject to the interrupted stay policy.

LTCHs are also subject to payment reductions if a certain percentage of their patients are transferred from the same hospital. This is known as the “25% rule”. The rules vary according to whether the transfer is to a LTCH that is a hospital within a hospital, or the LTCH is freestanding. The rules also vary according to whether the LTCH is in a rural area. Certain LTCHs are exempt.

Changes to LTCH payments starting 10/1/2015

Starting 10/1/2015 LTCHs will begin to transition to a “site neutral” payment method which pays the lesser of the PPS amount, or 100% of the cost of the hospital stay. This is under the Pathway for SGR Reform Act of 2013.

Not all LTCH stays will be affected by this new payment method. Criteria for exclusion from the site neutral payment rate are: (1) the discharge from the LTCH does not have “a principal diagnosis relating to a psychiatric diagnosis or to rehabilitation”; (2) admission to the LTCH was “immediately preceded” by discharge from a subsection (d) hospital; and (3) the immediately preceding stay in a subsection (d) hospital included at least 3 days in an intensive care unit (ICU) (“the ICU criterion”) or the discharge from the LTCH is assigned to a MS-LTC-DRG based on the patient’s receipt of ventilator services of at least 96 hours (“the ventilator criterion”).

The new PPS payment involves a per diem amount determined using the average length of stay for each DRG with a cap of the full DRG payment. Then, the lesser of the PPS amount or the cost of the stay is paid.

The transition period for the new payment is FY 2016 and FY 2017 with blended rates. Full implementation begins in FY 2018.

The internet site is: <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/LongTermCareHospitalPPS/index.html>

The following site has additional information including an updated list of all long term care hospitals: <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/LongTermCareHospitalPPS/download.html>

The Pricer is on <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PCPricer/LTCH.html> .

Inpatient Rehabilitation Hospitals

These hospitals are paid using the Inpatient Rehabilitation Facility Prospective Payment System (IRF PPS). A hospital qualifies as an IRF if at least a certain percentage of their

patients have at least one condition on a list of qualifying conditions. As of the time of this writing, there were 13 qualifying conditions, and the percentage was 60%.

A case-mix adjusted payment is made using case mix groups (CMGs) for varying numbers of days of IRF care. At the time of this writing there were 92 CMGs.

The IRF web site is: <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientRehabFacPPS/index.html> The Pricer is on http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PCPricer/IRF_Archive.html

Psychiatric Hospitals

There is also a 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. In contrast, psychiatric patients in regular beds in acute care hospitals are paid under the acute care hospital PPS.

The PPS system uses a federal per diem base amount which is then adjusted for factors such as DRGs, 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.

Original Medicare's lifetime limit for freestanding psychiatric hospitals, as opposed to psychiatric units of general hospitals or regular beds in general hospitals, is 190 days.

Beginning in FY 2015, the annual update to the base payment amount will be reduced by 2 percentage points if a facility fails to submit required quality data.

Detailed information on payments for psychiatric hospitals may be found on <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientPsychFacilPPS/index.html> .

Medicare Dependent Hospitals

This program is in effect according to a schedule determined by Congress. When in effect, 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) for operating costs, the hospital is paid a certain percentage of the difference which may change over time. As of this writing, the percent used is 75%. 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 and a low volume hospital payment adjustment.

Here is an example of the calculations a plan should make to pay a non-network MDH using output from the Pricer as of September, 2012. The formula is subject to change by statute. This formula should be used for a non-network MA patient - instead of paying the "total amt" shown on the Pricer output.

Code HMO=YES

If the MA-HSP exceeds the sum of the operating FSP, OUTLR, and DSH, use 75% of the difference as shown below. Otherwise, use the PPS amounts and not the MA-HSP (do not use the O-HSP in either case for an MA non-network claim).

Assume O-OUTLR = 0:

O-FSP= 20,000

O-DSH= 1,000

C-FSP= 2,000

MA-HSP= 50,000

O-FSP + O-DSH = 21,000

Operating payment= $21,000 + 0.75 (50,000 - 21,000) = 42,750$

Note: In the above step, if the difference is negative, use 0% instead of 75%.

If the hospital is a sole community hospital instead of a MDH and the difference is positive, use 100% instead of 75%. If the difference is negative, use 0%.

Then apply the VBP adjustment, the readmit adjustment, and the low volume add on payment if any.

Then, for both SCH and MDH, add the low volume adjustment and capital:

Total payment = $42,750 + 2,000 = 44,750$

In the above example, the outlier is zero. However if there is an outlier payment, add it to the 21,000.

Sole Community Hospitals

These hospitals are generally paid the greater of PPS or the hospital specific rate (HSR) for a full year. SCHs should submit “no pay” bills to their MACs 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.

To calculate the payment, enter HMO=YES on the Pricer. Then use the greater of the operating PPS based amount or the MA-HSP. Then add the capital amount. For an example, see the formula in this document under “Medicare Dependent Hospitals”. It will indicate which step changes for an SCH.

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.

See the OPD section for the potential for extra OPD payments to certain SCHs.

Low Volume Hospitals

When this program is in effect, 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.

When the Pricer is run as “HMO=YES”, IME is omitted since it is paid by FFS Medicare on behalf of MA patients. But the portion of the low volume add-on payment attributable to IME is included in the Pricer amount since it is not paid by FFS Medicare on behalf of MA patients. So the low volume payment, when in effect, on the Pricer should be paid by plans to non-network hospitals. The low volume amount is included, but not separately identified, on the Pricer.

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 and can result in a higher payment than regular acute care hospitals. In

addition, these hospitals have an OPD payment to cost ratio adjustment that started in 2012.

Cancer hospitals are subject to reporting quality data starting FY 2014.

Payment information for MA plans:

The MAC 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/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/PPS_Exc_Cancer_Hospasp.html

Children’s Hospitals

Same basic methodology as for Cancer Hospitals.

Clinical Trials

Medicare pays for qualified clinical trials. These claims are coded using a Q0 or Q1 modifier, and/or a diagnostic code of V70.7. There may be 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/Medicare/Coverage/ClinicalTrialPolicies/index.html> and on <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM6431.pdf>

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

Bad debt changed to 65% starting in FY 2015. Special rules apply if the patient is on Medicaid. ESRD can also be eligible for a limited amount of bad debt reimbursement under certain circumstances.

Provider	FY 2012	FY 2013	FY 2014	FY 2015 +
Hospitals	70%	65%	65%	65%
SNFs: Dual Eligibles	70%	65%	65%	65%
SB Hosp: Not Dual Eligible	100%	65%	65%	65%
SNFs: Dual Eligibles	100%	88%	76%	65%
SB Hosp: Dual Eligible	100%	88%	76%	65%
CAHs	100%	88%	76%	65%
ESRD Facilities	100%	88%	76%	65%
CMHCs	100%	88%	76%	65%
FQHCs	100%	88%	76%	65%
RHCs	100%	88%	76%	65%

Bad debts include deductible and coinsurance amounts for which a beneficiary is directly responsible. 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 to non-network providers. In any case, Medicare will not reimburse providers for bad debt payments incurred by MA plan 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 non-PAR suppliers of 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 that exceeds that of Medicare. They can choose to allow all types of providers to balance bill up to 15% more than the Medicare amount. 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 became eligible for either a Medicare or a Medicaid bonus beginning with services provided in 2011.

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>

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 future payment reduction penalties. The physician penalties started 1/1/15 and hospital penalties started 10/1/14.

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 therefore not include an amount to account for the HIT bonuses and penalties.

Therefore plans required to pay non-network providers at least the Medicare amount are not permitted to make a payment reduction for the HIT penalties.

Sequester

In general, Medicare FFS claims with dates-of-service or dates-of-discharge on or after April 1, 2013, will incur a 2 percent reduction in Medicare payment. Claims for durable medical equipment (DME), prosthetics, orthotics, and supplies, including claims under the DME Competitive Bidding Program, will be reduced by 2 percent based upon whether the date-of-service or the start date for rental equipment or multi-day supplies is on or after April 1, 2013.

The FFS Medicare payment cuts do not apply to beneficiary cost sharing.

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. Medicare Administrative Contractors (MAC) attempt to make the interim payments as accurate as possible. After the hospital's fiscal year ends, the MACs

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 MAC 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, MACs will not cost settle for the plans.

Medicare Coverage Database

The Medicare coverage database is on: <http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx> 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: http://comptroller.defense.gov/Portals/45/documents/rates/fy2014/2014_ia.pdf. Those rates are multiplied by the weighting factor that can be found on the TriCare website, at: <http://www.tricare.mil/drgrates/>

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 to the MAO in the same way it bills for services under the Original Medicare program, this should be considered a bill for the Original Medicare amount (and not the "billed" or "charged" 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 Original Medicare amount.

When a PACE plan receives a claim from a provider that indicates it is submitting a bill for services to the MAO in the same way it bills-under Original Medicare, the PACE plan should consider the bill to be a request for payment for the Original Medicare amount (and not the “billed” or “charge” amount from the claim) that Medicare would pay in the case of a similar submission. The PACE plan would then need to pay based on the Original Medicare 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. But keep in mind that for the physician fee schedule and some other fee schedules, the Medicare amount is the lesser of the fee schedule or the submitted charge.

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/Medicare/Health-Plans/HealthPlansGenInfo/index.html>

Provides mailing addresses for the MA claims processing contacts.

<http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MCRAdvPartDEnrolData/MA-Claims-Processing-Contacts.html>

Payment Dispute Resolution Process for Non-contracted and Deemed Providers

Changes to Payment Dispute Process between Non-Contracted Providers, MAOs and Other Payers after January 31, 2014

From 2009 until January 31, 2014, CMS contracted the services of C2C Solutions, Inc., an independent entity, to adjudicate payment disputes between non-contracted providers, MAOs and other payers. As of January 31, 2014, providers should contact the MAO or other payer directly to dispute payments. This applies to all non-contracted provider types that perform services for beneficiaries enrolled in MAOs, including PFFS, PACE organizations, Section 1876 Cost Plans, and Section 1833 Health Care Prepayment Plans.

If a provider has exhausted the plan’s internal dispute process and still maintains it has not been reimbursed fairly, it may file a complaint through 1-800-Medicare in addition to taking other actions it deems appropriate. CMS does not offer advice to providers on their potential rights in a payment dispute.

CMS is committed to ensuring that MAOs and other payers follow regulations at 42 C.F.R. §§ 422.214m, 417.559, and 422.520 when reimbursing non-contracted providers for services provided to Medicare beneficiaries. Non-contracted providers are required to accept as payment, in full, the amount that the provider could collect if the beneficiary was enrolled in 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 doctor is for a manual wheelchair, but the patient wants a power scooter instead, and if the doctor 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).

For 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 beneficiary, 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:** 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.

5) **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.