

2009 Private Fee-for-Service Proxy Payment Grid

Provider Type	Medicare Based Reimbursement Methodology Summary
Ambulance Services	Reimbursement is based on the Medicare Ambulance Fee Schedule unless otherwise specified by CMS. <i>www.cms.hhs.gov/AmbulanceFeeSchedule/</i>
Ambulatory Surgical Center (ASC)	Reimbursement is based on the Medicare Ambulatory Surgical Center (ASC) Payment System unless otherwise specified by CMS. The ASC Payment System is a fee schedule comprised of wage adjusted payment groups. <i>www.cms.hhs.gov/ASCPayment/</i>
Hospital-Outpatient Services	Reimbursement is based on the Outpatient Prospective Payment System (OPPS), under Ambulatory Payment Classifications (APC) methodology unless specified otherwise by CMS. <i>www.cms.hhs.gov/HospitalOutpatientPPS/</i>
Clinical Laboratory	Reimbursement is based on the Medicare Clinical Laboratory Fee Schedule unless specified otherwise by CMS. Outpatient clinical laboratory services are paid based on a fee schedule in accordance with Section 1833(h) of the Social Security Act. Payment is the lesser of the amount billed, the local fee for a geographic area, or a national limit. <i>www.cms.hhs.gov/ClinicalLabFeeSched/</i>
Durable Medical Equipment (DME), Prosthetics, Orthotics, Parenteral and Enteral Nutrition (PEN), Surgical Dressings, Therapeutic Shoes and Supplies (DMEPOS)	Reimbursement is based on the Medicare Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Fee Schedule unless otherwise specified by CMS. Payment is the lesser of the amount billed or the fee schedule amount calculated for the item. <i>www.cms.hhs.gov/DMEPOSFeeSched/</i>

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End Stage Renal Disease (ESRD) Center	<p>Reimbursement is based on a composite rate for hospital based ESRD facilities, independent ESRD facilities, and home dialysis services for beneficiaries who select Method I for home dialysis payments. A drug add-on, the percentage of which is subject to change each year, is applied to the composite rate. Reimbursement for Method II home dialysis is based on reasonable charges limited to a monthly cap. Epoetin has different payments depending on whether or not it is billed by an ESRD facility.</p> <p>Today's Options covers all Medicare covered dialysis services and nutrition therapy for renal disease.</p> <p>www.cms.hhs.gov/center/esrd.asp</p>
Federally Qualified Health Centers (FQHC)	<p>Reimbursement 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. There is a separate national limit for urban and for rural facilities, and these limits are subject to change each year.</p> <p>www.cms.hhs.gov/center/fqhc.asp</p>
Home Health Care	<p>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.</p> <p>http://www.cms.hhs.gov/center/hha.asp</p>

INPATIENT HOSPITAL SERVICES

www.cms.hhs.gov/center/hospital.asp

Acute Inpatient Services	<p>Reimbursement is based on the Inpatient Prospective Payment System (IPPS), under Diagnosis Related Groups (DRGs) and effective for discharges after October 1, 2007 Medicare Severity DRGs (MS-DRG's) methodology unless specified otherwise by CMS.</p> <p>Operating IME and DGME for inpatients are paid by Fiscal Intermediaries' (MACs/FI's) on behalf of Medicare Advantage members. Operating IME and DGME is not paid by Today's Options. However, "capital IME" is paid by Today's Options since it is part of the capital payment, not the IME cost.</p> <p>www.cms.hhs.gov/AcuteInpatientPPS</p>
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Critical Access Hospitals	<p>Critical Access Hospitals (CAHs) are exempt from the Inpatient and Outpatient Prospective Payment Systems (PPS).</p> <p>Medicare pays CAHs for most inpatient and outpatient services to Medicare beneficiaries on the basis of 101 percent of their allowable and reasonable costs. CAHs on a cost based optional elective payment method are reimbursed:</p> <ul style="list-style-type: none"> • For facility services, the lesser of 80 percent of 101 percent of the reasonable cost of the CAH in furnishing CAH services <i>OR</i> 101 percent of the outpatient CAH services less applicable Medicare Part B deductible and coinsurance amounts; and • For physician professional services, 115 percent of the allowable amount, after applicable deductions, under the MPFS. Payment for non-physician practitioner professional services is 115 percent of the amount that otherwise would be paid for the practitioner's professional services under the MPFS. <p>CAHs are paid reasonable cost for ambulance services if the CAH is the only ambulance supplier within 35 miles unless otherwise specified by CMS.</p> <p>www.cms.hhs.gov/center/cah.asp</p>
Inpatient Rehabilitation Facility (IRF)	<p>Reimbursement is based on the Inpatient Rehabilitation Facility Prospective Payment System (IRF-PPS) unless otherwise specified by CMS.</p> <p>www.cms.hhs.gov/InpatientRehabFacPPS</p>
Inpatient Psychiatric Facility (IPF)	<p>Reimbursement is based on the Inpatient Psychiatric Facility Prospective Payment System (IPF-PPS) for both freestanding psychiatric hospitals and certified psychiatric units of general acute care hospitals, unless specified otherwise by CMS.</p> <p>www.cms.hhs.gov/InpatientPsychFacilPPS/</p>
Long-Term Care Hospital	<p>Reimbursement is based on the Long Term Care Hospital Prospective Payment System (LTCHPPS), under Long Term Care Diagnosis Related Groups (LTC-DRGs/MS-LTC-DRGs).</p> <p>www.cms.hhs.gov/LongTermCareHospitalPPS/</p>
SNF	<p>Reimbursement based on the Skilled Nursing Facility (SNF) Prospective Payment System (PPS) unless otherwise specified by CMS. The PPS payment rate utilizes Resource Utilization Groups (RUG III) is adjusted for case mix and geographic variation in wages and covers all costs of furnishing covered SNF services (routine, ancillary, and capital-related costs).</p> <p>www.cms.hhs.gov/SNFPPS/</p>

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Cancer Hospitals	Reimbursement is based on FI rate letters which show the interim per diems for inpatient and the cost to charge ratios for outpatient. A listing of Medicare PPS excluded cancer hospitals is available at www.cms.hhs.gov/AcuteInpatientPPS/10_PPS_Exc_Cancer_Hosp.asp

OTHER PROVIDERS AND SERVICES

Part B Drugs	<p>Part B drugs that are not applicable to PPS inpatient DRGs and APC outpatient payment groups, reimbursement is based on Average Sales Price (ASP) methodology unless otherwise specified by CMS.</p> <p>www.cms.hhs.gov/McrPartBDrugAvgSalesPrice/</p>
Physicians and other Healthcare Professionals	<p>Reimbursement is based on the lesser of charge or the Medicare Physician Fee Schedule (MFS) unless otherwise specified by CMS.</p> <p>http://www.cms.hhs.gov/PhysicianFeeSched/</p> <p>A 10% bonus is paid if these services are furnished in a health professional shortage area (HPSA). An additional 5% PSA bonus is payable through at least 6/30/08 in areas designated by CMS as “physician scarcity areas”. More details (including qualifying zip codes) can be found at http://www.cms.hhs.gov/HPSAPSAPhysicianBonuses/</p> <p>Reimbursement for non-physician practitioner independent billings:</p> <ul style="list-style-type: none"> • 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: 65% MFS <p>http://www.cms.hhs.gov/PhysicianFeeSched/</p>

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Anesthesia	<p>Reimbursement for personally performed, medically directed, and medically supervised services is calculated based on the following formula unless otherwise specified by CMS: Anesthesia conversion factor by locality x (sum of uniform base units + time units) x percentage based on anesthesia modifier.</p> <p>http://www.cms.hhs.gov/center/anesth.asp</p>
Rural Health Clinics	<p>Reimbursement for Rural Health Clinics (RHCs) is based on the lower of the provider specific rate or the per visit payment limit plus 20 percent of the RHC's actual charges unless otherwise specified by CMS. Note: Per visit limits do not apply to RHCs owned by rural hospitals with less than 50 beds and are paid on a cost basis.</p> <p>http://www.cms.hhs.gov/center/rural.asp</p>
Rehabilitation Occupational, Physical and Speech Therapy	<p>Reimbursement for outpatient rehabilitation services, including CORF services is lesser of charge or the allowed Medicare Physician Fee Schedule (MPFS) amount.</p> <p>Outpatient Rehabilitation Caps were implemented on January 1, 2006 and policies were modified to allow exceptions as directed by the Deficit Reduction Act only for calendar year 2006. The Tax Relief and Health Care Act of 2006 extended the cap exceptions process through calendar year 2007.</p> <p>For 2008, the annual limit on the allowed amount for outpatient physical therapy and speech-language pathology combined is \$1810; the limit for occupational therapy is \$1810.</p> <p>For 2009, the annual limit on the allowed amount for outpatient physical therapy and speech-language pathology combined is \$1,810; the limit for occupational therapy is \$1,810.</p>



A Healthy CollaborationSM

Today's Options® is a Medicare-approved Medicare Advantage plan offered through American Progressive Life & Health Insurance Company of New York and The Pyramid Life Insurance Company, members of the Universal American family of companies. Today's Options contracts with the Federal government.