

USA CareSM

Reimbursement Grid Contract H6806

Service Category	Reimbursement Methodology
Acute Care Hospital – Inpatient Services	Reimbursement for inpatient services is made under the Prospective Payment System (PPS) using the Medicare Severity Diagnostic Related Group (MS-DRG) methodology. All payment rates and calculations including outliers will follow CMS guidelines.
Acute Care Hospital – Outpatient Services	Reimbursement for outpatient services is based on the Outpatient Prospective Payment System (OPPS) using the Ambulatory Payment Classification (APC) methodology. All payment rates and calculations including outliers will follow CMS guidelines.
Ambulance	Reimbursement is 100% of the Medicare Ambulance Fee Schedule.
Ambulatory Surgery Center	Reimbursement is based on the Medicare ASC fee schedule. Services should be billed using a UB04 claim form.
Anesthesia/Physician Performed	Reimbursement is based on the Medicare anesthesia conversion factor by locality, times the sum of uniform base units, plus time units.
Assistant at Surgery – Physicians	For covered assistant at surgery services, the allowed amount is 16% of the amount for the global surgery under the Medicare fee schedule. Payment is made at the lesser of billed charges or the Medicare Fee Schedule.
Bad Debt	Medicare Advantage Organizations (MAO) are not required to cover Bad Debt. USA Care will not pay Bad Debt.
Blood	For hospital outpatient services, blood is reimbursed under the Outpatient Prospective Payment System (OPPS). For hospital inpatient services, all covered blood and blood processing expenses are included in the DRG payment.
Cancer Hospitals – Inpatient	Cancer Hospitals are excluded from IPPS. The Cancer Hospital must submit a copy of their most recent interim rate letter from their Medicare fiscal intermediary (FI). Payment for covered inpatient services will be at 102% of the rate noted in the FI interim rate letter supplied by the Cancer Hospital.
Cancer Hospitals – Outpatient	Payment for covered outpatient cancer hospital services are based upon the Outpatient Prospective Payment

	System (OPPS). Services excluded from OPPS will be reimbursed according to the applicable Medicare fee schedule.
Children's Hospital – Inpatient	Services are excluded from IPPS and reimbursement is made on a cost basis. Children's Hospitals will be requested to submit a copy of their recent interim rate from their Medicare Fiscal Intermediary (FI).
Children's Hospital – Outpatient	Reimbursement for outpatient services is based on the Outpatient Prospective Payment System (OPPS) using the Ambulatory Payment Classification (APC) methodology. All payment rates and calculations will follow CMS guidelines.
Clinical Psychologist	Reimbursement is at 100% of the Medicare Physician Fee Schedule.
Clinical Social Worker	Reimbursement is at 75% of the Medicare Physician Fee Schedule.
Community Mental Health Centers	Payment for covered outpatient services is based upon the Outpatient Prospective Payment System (OPPS).
Comprehensive Outpatient Rehabilitation Facility (CORF)	Payment for covered services will be based on the Medicare Physician Fee Schedule. Payment is made at the lesser of billed charges or the Medicare Fee Schedule.
Critical Access Hospital (CAH)	Critical Access Hospitals are excluded from the Inpatient Prospective Payment System (IPPS) and the Outpatient Prospective Payment System (OPPS). Payment is made on a reasonable cost basis, so Critical Access Hospitals must submit a copy of their most recent interim rate letter received from their Medicare fiscal intermediary (FI). Payment for covered inpatient services will be made at 102% of the inpatient rate noted in the FI interim rate letter. Outpatient services will be reimbursed at 102% of billed charges.
Diabetic Shoes	Payment will be based on the Durable Medical Equipment, Prosthetic, Orthotics, and Supplies (DMEPOS) fee schedule.
Drugs	Payment is based on 106% of the "average sales price" (ASP) for most drugs. Exceptions include blood, drugs delivered through DME, influenza, pneumococcal and hepatitis B vaccines, and certain new drugs which are all still paid based on 95% Average Wholesale Price (AWP).
Durable Medical Equipment	Reimbursement is 100% of the Medicare DMEPOS Fee Schedule.

Federally Qualified Health Centers (FQHC)	FQHCs are paid 80% of the allowed charge, plus 20% of the actual charge, minus the member's cost sharing amount. The billing hospital is asked to submit a copy of their most recent interim rate letter from their Medicare fiscal intermediary (FI).
Home Health	Reimbursement is based on the Medicare Home Health Resource Group (HHRGs). DME is paid at the DMEPOS Fee Schedule.
Home Infusion	Reimbursement is based on the Medicare DMEPOS Fee Schedule. May be subject to Part D benefits.
Indian Health Service Facility (IHS) – Inpatient Services	Payment for covered inpatient services are based upon the Inpatient Prospective Payment System (IPPS).
Indian Health Service Facility (IHS) – Outpatient Services	Payment is based upon an all-inclusive rate. Professional services are based upon the applicable fee schedule.
Laboratory	Reimbursement is at 100% of the CMS Laboratory Fee Schedule.
Long Term Care Hospitals (LTCH) - Inpatient	PPS reimbursement for LTCHs is based on a per discharge system with a diagnosis related group (DRG) based patient classification system.
Long Term Care Hospitals (LTCH) – Outpatient	Reimbursement for outpatient services is based on the Outpatient Prospective Payment System (OPPS) using the Ambulatory Payment Classification (APC) methodology. All payment rates and calculations will follow CMS guidelines.
Mammography Screening/Diagnostic	Reimbursement is at 100% of the Medicare Physician Fee Schedule.
Maryland Hospitals	Reimbursement is at 94% of billed charges.
Nurse Practitioner	Reimbursement is at 85% of the Medicare Physician Fee Schedule.
Outpatient Pharmaceuticals	Reimbursement is at 100% of the Medicare Drug fee schedule.
Physical, Occupational, Speech Therapist	Reimbursement is at 100% of the Medicare Physician Fee Schedule.
Physician Assistant	Reimbursement is at 85% of the Medicare Physician Fee Schedule.

Physician Services	Reimbursement is at 100% of the Medicare Physician Fee Schedule.
Prosthetics and Orthotics	Reimbursement is at 100% of the Medicare DMEPOS Fee Schedule.
Psychiatric Hospital – Inpatient	Reimbursement based on the Inpatient Psychiatric Facility Prospective Payment System (IPFPPS).
Psychiatric Hospital – Outpatient	Reimbursement for outpatient services is based on the Outpatient Prospective Payment System (OPPS) using the Ambulatory Payment Classification (APC) methodology. All payment rates and calculations will follow CMS guidelines.
Rehabilitation Hospital - Inpatient	Reimbursement is based on the Inpatient Rehabilitation Facility Prospective Payment System (IRFPPS).
Rehabilitation Hospital – Outpatient	Reimbursement for outpatient services is based on the Outpatient Prospective Payment System (OPPS) using the Ambulatory Payment Classification (APC) methodology. All payment rates and calculations will follow CMS guidelines.
Rural Health Clinics (RHC)	RHCs are paid 80% of the allowed charge, plus 20% of the actual charge, minus the member's cost sharing amount. The billing hospital is asked to submit a copy of their most recent interim rate letter from their Medicare fiscal intermediary (FI).
Skilled Nursing Facilities (SNF)	Reimbursement is based on PPS using Resource Utilization Group (RUG) methodology. SNFs must bill with Health Insurance Prospective Payment System (HIPPS) Resource Utilization Group (RUG) codes just as traditional Medicare requires.
Sole Community Hospital - Inpatient	Reimbursement is based on PPS using DRG methodology.
Sole Community Hospital – Outpatient	Reimbursement for outpatient services is based on the Outpatient Prospective Payment System (OPPS) using the Ambulatory Payment Classification (APC) methodology. All payment rates and calculations will follow CMS guidelines.

Balance Billing

Balance billing is prohibited by providers who provide services to USA Care members. Providers may collect only applicable copayment or coinsurance amounts from USA Care members and may not otherwise charge or bill the members. Copayments or coinsurance should be collected from the member at the time of service. If a provider (either deemed or

not deemed) mistakenly collects more from a member than the designated copayment or coinsurance amount, the provider must refund the difference to the member.

Cost Settlement

Original Medicare makes estimated (interim) payments to hospitals and clinics when claims are submitted. After the hospital's fiscal year ends, the fiscal intermediary settles with providers for the difference between interim payments and actual reasonable costs. CMS policy does not require Medicare Advantage plans to agree to settle with providers. Thus, USA Care/Preferred Care will not pay providers and providers will not pay USA Care/Preferred Care for the difference between interim payments and actual reasonable costs.