2019 Private Fee-For-Service Plan

Reimbursement Guide

UnitedHealthcare®

Physicians and health care professionals can contact UnitedHealthcare® MedicareDirect for claims reimbursement questions and to check the status of a claim previously submitted for reimbursement by visiting our secured website, **UHCProvider.com**. Click the "New User" link to register or login with an existing User ID and Password. Or, call to speak with one of our representatives by calling us toll-free at **877-842-3210**, 7 a.m. to 7 p.m. Central Time, Monday through Friday.

Billing Instructions:

Please bill for this product utilizing the same claim forms, billing codes and coding methodology that is currently utilized for Medicare.

Service Category	Reimbursement Methodology
Acute Care Hospital – Inpatient Services	This payment system is referred to as the inpatient prospective payment system (IPPS). Under the IPPS, each case is categorized into a diagnosis-related group (DRG). Each DRG has a payment weight assigned to it, based on the average resources used to treat Medicare patients in that DRG. The base payment rate is divided into a labor-related and non-labor share. The labor-related share is adjusted by the wage index applicable to the area where the hospital is located, and if the hospital is located in Alaska or Hawaii, the non-labor share is adjusted by a cost of living adjustment factor. This base payment rate is multiplied by the DRG relative weight. If the hospital treats a high-percentage of low-income patients, it receives a percentage add-on payment applied to the DRG-adjusted base payment rate. This add-on, known as the disproportionate share hospital (DSH) adjustment, provides for a percentage increase in Medicare payment for hospitals that qualify under either of two statutory formulas designed to identify hospitals that serve a disproportionate share of low-income patients. For qualifying hospitals, the amount of this adjustment may vary based on the outcome of the statutory calculation. Also, if the hospital is an approved teaching hospital it receives a percentage add-on payment for each case paid through IPPS. This add-on known as the indirect medical education (IME) adjustment varies depending on the ratio of residents-to-beds under the IPPS for operating costs, and according to the ratio of residents-to-average daily census under the IPPS for capital costs. Finally, for particular cases that are unusually costly, known as outlier cases, the IPPS payment is increased. This additional payment is designed to protect the hospital from large financial losses due to unusually expensive cases. Any outlier payment due is added to the DRG-adjusted base payment rate, plus any DSH or IME adjustments. https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/index.html

Service Category	Reimbursement Methodology
Acute Care Hospital – Inpatient Outliers	The actual determination of whether a case qualifies for an outlier payment takes into account both operating and capital costs and DRG payments. That is, the combined operating and capital costs of a case must exceed the fixed loss outlier threshold to qualify for an outlier payment. The operating and capital costs are computed separately by multiplying the total covered charges by the operating and capital cost-to-charge ratios. The estimated operating and capital costs are compared with the fixed-loss threshold after dividing that threshold into an operating portion and a capital portion (by first summing the operating and capital ratios and then determining the proportion of that total comprised by the operating and capital ratios and applying these percentages to the fixed-loss threshold). The thresholds are also adjusted by the area wage index (and capital geographic adjustment factor) before being compared to the operating and capital costs of the case. Finally, the outlier payment is based on a marginal cost factor equal to 80 percent of the combined operating and capital costs in excess of the fixed-loss threshold (90 percent for burn DRGs). https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/outlier.html
Acute Care Hospital – Value Based Purchasing (VBP)	The Hospital VBP Program is funded by reducing participating hospitals' base FY 2018 operating Medicare severity diagnosis-related group (MS-DRG) payments by 2%. Any leftover funds are redistributed to hospitals based on their Total Performance Scores (TPS). What hospitals earn depends on the range and distribution of all eligible/participating hospitals' TPS scores for a FY. It's possible for a hospital to earn back a value-based incentive payment percentage that is less than, equal to, or more than the applicable reduction for that FY. https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HospitalQualityInits/Hospital-Value-Based-Purchasing-.html
Acute Care Hospital – Outpatient Services	The Outpatient Prospective Payment System (OPPS) applies to all hospital outpatient departments except for hospitals that provide Part B only services to their inpatients; Critical Access Hospitals (CAHs); Indian Health Service hospitals; hospitals located in American Samoa, Guam, and Saipan; hospitals located in the Virgin Islands; The OPPS also applies to partial hospitalization services furnished by Community Mental Health Centers (CMHCs). Certain hospitals in Maryland that are paid under Maryland waiver provisions are also excluded from payment under OPPS but not from reporting Healthcare Common Procedure Coding System (HCPCS) and line item dates of service. https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c04.pdf

Service Category	Reimbursement Methodology
Ambulance	These services are reimbursed at the lesser of billed charges or 100 percent of the Medicare Ambulance Fee Schedule.
Ambulatory Surgery Center (ASC)	Beginning January 1, 2008, with implementation of the revised ASC payment system, the payment rates for most covered ASC surgical procedures and covered ancillary services are established prospectively based on a percentage of the OPPS payment rates. For more information on where to locate these prospective payment rates, see §30.1. https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c14.pdf
Anesthesia – Physician Performed	Reimbursement for these services is based on the Medicare anesthesia dollar conversion factor by locality, times the sum of uniform base units, plus time units.
Anesthesia – Physician Medical Direction of Two or More Nurse Anesthetists Concurrently	Reimbursement for these services is based on the Medicare anesthesia conversion factor by locality, times the sum of uniform base units, plus time units, reduced by 50 percent of the allowance for the service performed by the physician.
Assistant Surgeon (Physician)	Reimbursement for these services is based on the lesser of the billed charge or 16 percent of the amount applicable for global surgery under the Medicare Fee Schedule.
Assistant Surgeon (Physician Assistant)	Reimbursement for these services is based on the lesser of the billed charge or 85 percent times 16 percent of the amount paid to a physician who serves as an assistant at surgery.
Bad Debts (Facilities)	The Plan will only pay for bad debt on copayments and coinsurance that the member is directly responsible to pay. Bad debt reimbursement will only occur after a facility has made reasonable attempts to collect from the member. Bad debt reimbursement will occur if 120 days have elapsed since the date of service without collection of the member's copayment or coinsurance. No less than 120 days from the date the member received the first bill for the claim in question, and up to 12 months after that, the facility may submit a copy of a bill demonstrating an outstanding balance and 120 days delinquency. Hospitals receive 70 percent of bad debt; other facilities receive 100 percent of bad debt, including Skilled Nursing Facilities (SNFs), Rural Health Clinics (RHCs), Federally Qualified Health Centers (FQHCs), Community Mental Health Clinics and End Stage Renal Disease (ESRD) facilities: bad debts are capped so that the reimbursement does not exceed the facility's costs.

Service Category	Reimbursement Methodology
Blood	Billing and Payment for Blood, Blood Products, and Stem Cells and Related Services Under the Hospital Outpatient Prospective Payment System (OPPS) Section 6011 of Public Law (P.L.) 101-239 amended §1886(a)(4) of the Social Security Act (the Act) to provide that prospective payment system (PPS) hospitals receive an additional payment for the costs of administering blood clotting factor to Medicare hemophiliacs who are hospital inpatients. https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c03.pdf https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c04.pdf https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c17.pdf
Braces	Braces are covered when furnished incident to physicians' services or on a physicians' order. Reimbursement is at the Medicare Allowable Charge on the Medicare Durable Medical Equipment, Prosthetic, Orthotic and Supplies (DMEPOS) Fee Schedule.
Cancer Hospitals – Inpatient	These services are exempt from the inpatient Prospective Payment System (PPS). Cost-based Tax Equity and Fiscal Responsibility Act (TEFRA) reimbursement is paid on a per-day basis for routine and ancillary services and based on the most recent cost report data. Payment is applicable to Medicare approved services only.
Cancer Hospitals – Outpatient	Reimbursement for these services is based on the Outpatient Prospective Payment System (OPPS), under Ambulatory Payment Classifications (APCs).Payment for outpatient services rendered by a Cancer Hospital are based on the higher of the OPPS or the cost to charge ratio (as provided in the interim rate letter).
Children's Hospitals – Inpatient	These services are exempt from the inpatient Prospective Payment System (PPS), and reimbursement is cost-based. Routine services and ancillary services are reimbursed on a per diem basis. Ancillary services' reimbursement is based on the most recent cost-report data.
Children's Hospitals – Outpatient	Reimbursements for these services are based on the Outpatient Prospective Payment System (OPPS) under Ambulatory Payment Classifications (APCs).
Clinical Nurse Specialist	Reimbursement is at 80 percent of the lesser charge or 85 percent of the Medicare Allowable Charge on the Medicare Physician Fee Schedule for comparable services.

Service Category	Reimbursement Methodology
Clinical Psychologist	Reimbursement is at the Medicare Allowable Charge on the Medicare physician Fee Schedule or actual charge, whichever is less, for comparable services for administering diagnostic psychological tests and supervising the administration of these tests.
Clinical Social Worker	Reimbursement is at 75 percent of the Medicare Allowable Charge on the Medicare Physician Fee Schedule for comparable services.
Clinical Trial Services	For clinical trials covered under the Clinical Trials National Coverage Determination 310.1 (NCD) (NCD manual, Pub. 100-03, Part 4, section 310), original Medicare covers the routine costs of qualifying clinical trials for all Medicare enrollees, including those enrolled in MA plans, as well as reasonable and necessary items and services used to diagnose and treat complications arising from participating in qualifying clinical trials. All other original Medicare rules apply. https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/mc86c04.pdf
Community Mental Health Centers	Reimbursement for these services is based on the Outpatient Prospective Payment System (OPPS), under Ambulatory Payment Classifications (APCs).
Comprehensive Outpatient Rehabilitation Facility (CORF)	Reimbursement is at the Medicare Allowable Charge on the Medicare Physician Fee Schedule. Vaccines are reimbursed at 95 percent ASP (average sale price) drug payment system.
Correct Coding Initiative	UnitedHealthcare MedicareDirect applies CMS Correct Coding Initiative edits to physician claims. This allows claims to be processed according to Medicare's correct coding guidelines using Medicare's Column 1/Column 2 and Mutually Exclusive edits. Information regarding Medicare's Correct Coding Initiative can be found on the CMS website here: http://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html
Co-Surgeons	Reimbursement for each co-surgeon is 62.5 percent of the global surgery rate under the Medicare Physician Fee Schedule.
Critical Access Hospitals (CAH)	Reimbursement is at 100 percent of the rate payable under Medicare (101 percent of billed charges based on a calculated cost to charge ratio on the facility's most recent interim rate letter). The facility should send a copy of its most recent interim rate letter from the Medicare Administrative Contractor (MAC) by sending a fax to UnitedHealthcare MedicareDirect Reimbursement Services at: Fax 866-943-9811.

Service Category	Reimbursement Methodology
Diabetic Shoe	The reimbursement rate is at the Medicare Allowable Charge on the Medicare DMEPOS Fee Schedule.
Drugs	Drugs not paid on a cost or prospective payment basis will be paid under the ASP (average sale price) drug payment system. For drug Gap-Fill, RJ Health is used.
Durable Medical Equipment (DME)	These services are reimbursed at the Medicare Allowable Charge on the Medicare DMEPOS Fee Schedule for those DME suppliers who are not considered a participating supplier in the Medicare competitive bidding area (CBA) Program. For those participating suppliers in the CBA Program, reimbursement is made at the rate published for the CBA Program for the particular area.
Epoetin (EPO)	Drugs not paid on a cost or prospective payment basis will be paid under the ASP (average sale price) drug payment system. For drug Gap-Fill, RJ Health is used.
End Stage Renal Disease (ESRD) Facility	Effective January 1, 2011 Section 153b of the Medicare Improvements for Patients and Providers Act (MIPPA) requires the implementation of an ESRD bundled prospective payment system (ESRD PPS). The ESRD PPS provides a single payment to ESRD facilities that will cover all of the resources used in furnishing an outpatient dialysis treatment, including supplies and equipment used to administer dialysis (in the ESRD facility or at a patient's home), drugs, biologicals, laboratory tests, training, and support services. https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c08.pdf
Federally Qualified Health Centers (FQHC)	FQHCs are paid under the PPS, Medicare payment is based on the lesser of the FQHC's actual charge or the PPS rate, as determined by the MAC. The FQHC PPS rate will be updated annually beginning January 1, 2016. https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c09.pdf
Health Professional Shortage Area (HPSA)	Reimbursement is at the Medicare Physician Fee Schedule (MPFS) plus a 10 percent bonus for health professional in a designated HPSA area based on the physician's ZIP Code. Bonus will be paid on a quarterly settlement basis.

Service Category	Reimbursement Methodology
Hemophilia Clotting Factors Billed by Provider (e.g., Hospital, Skilled Nursing Facility, Home Health Agency)	Blood clotting factors not paid on a cost or prospective payment system basis are priced as a drug/biological under the drug pricing fee schedule effective for the specific date of service. If a beneficiary is in a covered part A stay in a PPS hospital, the clotting factors are paid in addition to the DRG/HIPPS payment. https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c17.pdf
Hemophilia Clotting Factors Billed by Supplier (e.g., Durable Medical Equipment Supplier, Independent Pharmacy, Red Cross)	A Part B blood clotting factor claim from a Part B supplier is processed by the A/B MAC (B). https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c17.pdf
Home Dialysis Supplies and Equipment	Reimbursement is according to Method I or Method II per Medicare Fee Schedules. https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c08.pdf
Home Health	Under prospective payment, Medicare pays home health agencies (HHAs) a predetermined base payment. The payment is adjusted for the health condition and care needs of the beneficiary. The payment is also adjusted for the geographic differences in wages for HHAs across the country. The adjustment for the health condition, or clinical characteristics, and service needs of the beneficiary is referred to as the case-mix adjustment. The home health PPS will provide HHAs with payments for each 60-day episode of care for each beneficiary. https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HomeHealthPPS/index.html
Home Infusion	Reimbursement is based on the Medicare DMEPOS Fee Schedule for applicable services. https://www.cms.gov/medicare/prescription-drug-coverage/prescriptiondrugcovcontra/downloads/partsbdcoveragesummarytable_041806.pdf
Hospice	Claims for Medicare-covered hospice services and Medicare-covered non-hospice services must be submitted directly to the appropriate Medicare Administrative Contractor (MAC). Claims for services covered by non-Medicare, supplemental or value-added benefits should be submitted to the Plan.

Service Category	Reimbursement Methodology
Hospital Transfer – Acute to Acute	For transfers between IPPS hospitals, the transferring hospital is paid based upon a per diem rate. The transferring hospital may be paid a cost outlier payment. The outlier threshold for the transferring hospital is equal to the outlier threshold for non-transfer cases, divided by the geometric mean length of stay for the DRG, multiplied by a number equal to the length of stay for the case plus one day. The payment to the final discharging hospital is made at the full prospective payment rate. The outlier threshold and payment are calculated the same as any other discharge without a transfer. https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c03.pdf
Hospital Transfer – Acute to Post-Acute	For transfers from an IPPS hospital to a hospital or unit excluded from IPPS with a DRG that is subject to the post-acute care transfer policy, the transferring hospital is paid based upon a per diem rate. The transferring hospital may be paid a cost outlier payment. In general, the outlier threshold for the transferring hospital is equal to the outlier threshold for non-transfer cases, divided by the geometric mean length of stay for the DRG, multiplied by a number equal to the length of stay for the case plus one day. https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c03.pdf
Immunosuppressive Drugs, Transplant	Reimbursement is according to the Outpatient Prospective Payment System (OPPS) if the member is in the outpatient department of a Medicare participating hospital. In all other settings, reimbursement is at 85 percent of ASP (average sale price) drug payment system. For drug Gap-Fill, RJ Health is used.
Indian Health Service Facility (IHS) – Inpatient Services	Reimbursement to IHS or Tribal CAHs for covered inpatient services is based on a facility specific per diem rate that is established on a yearly basis from the most recently filed cost report information. Payment for inpatient IHS or Tribal CAH services is at 100% of the facility specific per diem rate less applicable deductible and coinsurance. Inpatient services should be billed on an 11X type of bill. Beginning January 1, 2004, IHS or Tribal CAHs are paid 101% of the facility specific per diem rate. https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c03.pdf
Indian Health Service Facility (IHS) – Outpatient Services	Reimbursement is excluded from the Outpatient Prospective Payment System (OPPS) and is based on an all-inclusive rate. Outpatient professional services are reimbursed based on their respective fee schedules.

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Laboratory	Reimbursement is at the lesser of billed charges or the Medicare Allowable Charge on the Medicare Clinical Laboratory Fee Schedule.
Local Coverage Determinations	UnitedHealthcare MedicareDirect's claim adjudication system allows claims to be processed according to Medicare Local Coverage Determinations (LCDs). There are currently thousands of Medicare LCD policies across all states that contain detailed Medicare coverage guidelines specific to each locality. Our claim adjudication system will look at the submitted claim and apply the appropriate LCD policy specific to the provider's locality. This process is in effect for all physician claims. Providers can view the Local Coverage Determinations on their Medicare Fee-For-Service Medicare Administrative Contractor's (MAC) website. This information is also housed on the CMS website at www.cms.hhs.gov; however, MAC websites may have more detailed or up-to-date information.
Long-Term Care Hospitals (LTCHs)	The Medicare prospective payment system (PPS) for LTCHs applies to hospitals described in section 1886(d)(1)(B)(iv) of the Social Security Act (the Act), effective for cost reporting periods beginning on or after October 1, 2002. Section 1886(d)(1)(B)(iv)(I) of the Act defines a LTCH as "a hospital which has an average inpatient length of stay (as determined by the Secretary of Health and Human Services (the Secretary)) of greater than 25 days. https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/LongTermCareHospitalPPS/index.html
Mammography Screening	Reimbursement is at the Medicare Allowable Charge on the Medicare Physician Fee Schedule.
Maryland Hospitals	Reimbursement is at 94 percent of approved charges for inpatient and outpatient services.
Medical Nutrition Therapy (Registered Dietician)	Reimbursement is at the lesser of billed charges or 85 percent of the Medicare Allowable Charge on the Medicare Physician Fee Schedule.
National Coverage Determinations	A number of processes are in place that allow UnitedHealthcare MedicareDirect to process claims according to Medicare National Coverage Determinations (NCDs) for both facility and physician claims. The NCDs are administered systematically and/or through manual review processes. Documentation may be requested for review in effort to process some claims according to the national coverage guidelines. Medicare NCDs can be viewed on the CMS website at www.cms.hhs.gov or the direct link to the Medicare Coverage Database located here: http://www.cms.hhs.gov/mcd/overview.asp.

Service Category	Reimbursement Methodology
Nurse Practitioner	Reimbursement is at 80 percent of the lesser charge or 85 percent of the Medicare Allowable Charge on the Medicare Physician Fee Schedule.
Oral Anti-Cancer Drugs	Drugs not paid on a cost or prospective payment basis will be paid under the ASP (average sale price) drug payment system. For drug Gap-Fill, RJ Health is used.
Oral Anti-Nausea Drugs	Drugs not paid on a cost or prospective payment basis will be paid under the ASP (average sale price) drug payment system. For drug Gap-Fill, RJ Health is used.
Parenteral and Enteral Nutrition (PEN)	Reimbursement is based on the PEN Fee Schedule.
Physical, Occupational, Speech Therapist	Reimbursement is at the lesser of billed charges or Medicare Allowable Charge on the Medicare Physician Fee Schedule.
Physician Assistant	Reimbursement is at 80 percent of the lesser charge or 85 percent of the Medicare Allowable Charge on the Medicare Physician Fee Schedule.
Physician Services – All Categories	Reimbursement is paid using the lesser of billed charges and the Medicare Physician Fee Schedule (MPFS), geographically adjusted. The fee schedule for physicians that do not participate in Medicare is 95 percent of the MPFS; however, UnitedHealthcare MedicareDirect reimburses all providers at 100 percent of the MPFS.
Physician Services (Audiologist)	Reimbursement is paid using the lesser of billed charges and the Medicare Allowable Charge on the Medicare Physician Fee Schedule.
Physician Services (Chiropractor)	Reimbursement is paid using the lesser of billed charges and the Medicare Allowable Charge on the Medicare Physician Fee Schedule.
Physician Services (Dentist)	Reimbursement is paid using the lesser of billed charges and the Medicare Allowable Charge on the Medicare Physician Fee Schedule.
Physician Services (DO)	Reimbursement is paid using the lesser of billed charges and the Medicare Allowable Charge on the Medicare Physician Fee Schedule.
Physician Services (MD)	Reimbursement is paid using the lesser of billed charges and the Medicare Allowable Charge on the Medicare Physician Fee Schedule.
Physician Services (Optometrist)	Reimbursement is paid using the lesser of billed charges and the Medicare Allowable Charge on the Medicare Physician Fee Schedule.
Physician Services (Oral and Maxillofacial Surgeon)	Reimbursement is paid using the lesser of billed charges and the Medicare Allowable Charge on the Medicare Physician Fee Schedule.

Service Category	Reimbursement Methodology
Physician Services (Podiatrist)	Reimbursement is paid using the lesser of billed charges and the Medicare Allowable Charge on the Medicare Physician Fee Schedule.
Prosthetic Devices	Reimbursement is at the Medicare Allowable Charge on the Medicare DMEPOS Fee Schedule.
Psychiatric Hospitals – Inpatient	Payments to IPFs under the IPF PPS are based on a single Federal per diem base rate computed from both the inpatient operating and capital-related costs of IPFs (including routine and ancillary services), but not certain pass-through costs (i.e., bad debts, direct graduate medical education, and nursing and allied health education). The Federal per diem payment under the IPF PPS is comprised of the Federal per diem base rate (which is broken into a labor-related share and a non-labor-related share) and applicable patient and facility adjustments that are described in §§190.5 and 190.6. https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c03.pdf https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientPsychFacilPPS/index.html
Psychiatric Hospitals – Outpatient	Reimbursement for these services is based on the Outpatient Prospective Payment System (OPPS), under Ambulatory Payment Classifications (APCs). https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c04.pdf
Radiology	The reimbursement rate is paid using the lesser of billed charges and the Medicare Allowable Charge on the Medicare Physician Fee Schedule (MPFS), professional and technical.
Registered Dietitian	Reimbursement is paid using the lesser of billed charges or 85 percent of the Medicare Allowable Charge on the Medicare Physician Fee Schedule (MPFS).
Rehab Hospital – Inpatient Services	The Inpatient Rehabilitation Facility (IRF) PPS will utilize information from a patient assessment instrument (IRF PAI) to classify patients into distinct groups based on clinical characteristics and expected resource needs. Separate payments are calculated for each group, including the application of case and facility level adjustments. https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientRehabFacPPS/index.html

Service Category	Reimbursement Methodology
Rehab Hospital – Outpatient Services	Section §1834(k)(5) to the Social Security Act (the Act), *requires* that all claims for outpatient rehabilitation services and comprehensive outpatient rehabilitation facility (CORF) services, be reported using a uniform coding system. The CMS chose HCPCS (Healthcare Common Procedure Coding System) as the coding system to be used for the reporting of these services. This coding requirement is effective for all claims for outpatient rehabilitation services and CORF services submitted on or after April 1, 1998. The Act also *requires* payment under a prospective payment system for outpatient rehabilitation services including CORF services. https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c05.pdf
Religious Non-Medical Health Care Institutions	Reimbursement is on a reasonable cost basis.
Rural Health Clinics (RHCs)	These facilities are reimbursed 105 percent of the sum of 80 percent of the lower of the provider specific interim rate or the per visit payment limit plus 20 percent of the RHC's billed charges. The 2019 per visit limit is $84.70. 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. UnitedHealthcare MedicareDirect pays the cumulative amount, less any patient cost-sharing (copayment or coinsurance), which is collected by the RHC at the point of service. Some services (e.g., flu vaccinations) are not part of the interim rate and are paid separately under Resource-Based Relative Value Scale (RBRVS). UnitedHealthcare MedicareDirect pays these claims at 100 percent of the RBRVS rate, less any patient cost-sharing (copayment or coinsurance). UnitedHealthcare MedicareDirect requires an interim rate letter on file for any date span for which services were rendered to a member. Please send a fax to UnitedHealthcare MedicareDirect Reimbursement Services at: Fax 866-943-9811.
Skilled Nursing Facilities (SNF)	SNFs are paid on the basis of a prospective payment system (PPS). The PPS payment rates are adjusted for case mix and geographic variation in wages and cover all costs of furnishing covered SNF services (routine, ancillary, and capital-related costs). https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/index.html

Service Category	Reimbursement Methodology
Sole Community Hospital (SCH)	These services are reimbursed according to the Prospective Payment System (PPS), under the DRG methodology. The PPS rate equals the greater of the federal rate or the applicable hospital specific rate (based on cost report data). https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c03.pdf
Surgical Dressings	The Medicare DMEPOS Fee Schedule applies to all surgical dressings except those applied incident to a physician's professional services, those furnished by a Home Health Agency (HHA) and those applied while a patient is being treated in an outpatient hospital department or as an acute care inpatient. Hospital outpatient services are reimbursed under Prospective Payment System (PPS) (Ambulatory Payment Classifications [APCs]). HHA's payment is bundled into PPS (home health resource groups [HHRGs]). If a physician, certified nurse midwife, physician assistant, nurse practitioner, or clinical nurse specialist applies surgical dressings as part of a professional service that is billed to Medicare, the surgical dressings are considered incident to the professional services of the health care practitioner.
Swing Beds	Critical Access Hospital (CAH) swing beds are exempt from SNF PPS. Section 4432(a) of the Balanced Budget Act (BBA) of 1997 specifies that swing bed facilities must be incorporated into Part A SNF PPS by the end of the statutory transition period. Effective with cost reporting periods beginning on or after July 1, 2002, swing bed bills are not paid on the cost-based method, but rather on the basis of the Part A SNF PPS. These payment rates cover all payment for furnishing covered swing bed extended care services (routine, ancillary, and capital-related costs) other than approved educational activities as defined in 42 CFR 413.85. https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c06.pdf
VA Hospitals	Federal providers are excluded from participation in the Medicare program. However, Federal Hospitals, like other non-participating hospitals, may be paid for emergency inpatient and outpatient hospital services. Hospital filed claims: inpatient services are reimbursed at the lower of actual charges or rates published for Federal Hospitals in the Federal Register under Office of Management & Budget – Cost of Hospital & Medical Care & Treatment. Outpatient services are reimbursed at 85 percent of the total covered charges.

Acronyms used in this document			
APC	Ambulatory Payment Classification	IPPS	Inpatient Prospective Payment System
ASC	Ambulatory Surgery Center	IRF	Inpatient Rehabilitation Facility
ASP	average sale price	LCD	Local Coverage Determination
CAH	Critical Access Hospitals	LTCH	Long-Term Care Hospital
CBA	competitive bidding area	MA	Medicare Advantage
CMHC	Community Mental Health Center	MAC	Medicare Administrative Contractor
CMS	Centers for Medicare & Medicaid Services	MIPPA	Medicare Improvements for Patients and Providers Act
CORF	Comprehensive Outpatient Rehabilitation Facility	MPFS	Medicare Physician Fee Schedule
DME	Durable Medical Equipment	MS-DRG	Medicare severity diagnosis-related group
DMEPOS	Durable Medical Equipment, Prosthetic, Orthotic and Supplies	NCD	National Coverage Determination
DRG	Diagnosis-related group	OPPS	Outpatient Prospective Payment System
DSH	disproportionate share hospital	PEN	Parenteral and Enteral Nutrition
EPO	Epoetin	PPS	Prospective Payment System
ESRD	End Stage Renal Disease	RBRVS	Resource-Based Relative Value Scale
FQHC	Federally Qualified Health Center	RHC	Rural Health Clinic
HCPCS	Healthcare Common Procedure Coding System	SCH	Sole Community Hospital
HHA	Home Health Agency	SNF	Skilled Nursing Facility
HHRG	home health resource group	TEFRA	Tax Equity and Fiscal Responsibility Act
HPSA	Health Professional Shortage Area	TPS	Total Performance Scores
IHS	Indian Health Service Facility	VBP	Value Based Purchasing
IME	indirect medical education		

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