

# Chapter 4

## Payment Methodology

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## Payment by Provider Type

In general, claims will be paid per Medicare reimbursement methodology, less any applicable member cost sharing amount. **It is the provider's responsibility to collect any applicable member cost-sharing.**

Specifics regarding the contract payment amounts are outlined in each provider contract, amendment or payment exhibit.

### Dual Eligibility and MedicareBlue PPO

Individuals who qualify for both Medicare and Medicaid (dual eligibility), are not liable for Medicare Part A and B cost-sharing when the state is responsible for paying those amounts. You should either accept the MedicareBlue PPO payment as payment in full, or bill the appropriate state Medicaid office for the Part A and B cost-sharing rather than billing the dually-eligible Medicare member.

### Payments for Medicare Incentive Programs

MedicareBlue PPO does not pay contracted providers for incentive programs that may be available under Medicare. Examples of this include, but are not limited to, the Physician Quality Reporting Initiative (PQRI), the E-Prescribing Incentive (eRx) and the Electronic Health Record Incentive (EHR).

Refer to your provider agreement for bonus payment information for Health Professional Shortage Areas (HPSAs).

In accordance with Medicare Advantage requirements, all providers (facilities, clinics, practitioners, etc.) must be Medicare-certified and eligible to provide services.

### General Claims Submission Guidelines

- Claims should be submitted to MedicareBlue PPO in the same billing format (CMS-1500 or UB-04, or their electronic equivalent) used for an Original Medicare claim of the same type. In some states there are exceptions to this policy for specific provider types. For these exceptions, see the Payment by Provider Type table on the next page.
- Submit claims using National Provider Identifier (NPI).
- Each Blue Cross and Blue Shield plan within Region 19 will collect and store Medicare-issued facility IDs with its Blue Cross and Blue Shield proprietary IDs. Medicare-issued facility IDs are required to process facility claims through the various CMS intermediaries.

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## Payment by Provider Type for MedicareBlue PPO Covered Services

### PPS Acute Care Hospital or Indian Health Services (IHS)

Inpatient services payment is based on the Prospective Payment System (PPS) using diagnosis-related group (DRG) methodology.

- Our reimbursement will include any applicable capital, disproportionate share hospital (DSH) and/or capital indirect medical expense (IME) payments.
- Our reimbursement will NOT include any operating IME costs, graduate medical education (GME) or nursing/allied education reimbursement expenses. Reimbursements for these expenses can be recovered from the Original Medicare Fiscal Intermediary via submission of a shadow bill for the rendered services. This information will be accumulated by the Fiscal Intermediary for reimbursement consideration at Medicare Cost Report settlement time.
- Bad debt (beneficiary deductible, coinsurance and copay amounts) is not reimbursable.

**Inpatient outliers** will be paid per Medicare guidelines.

**Inpatient transfers** payment is based on Medicare guidelines (transferring hospitals are reimbursed a calculated per diem rate based on length of stay).

**Swing beds** are payable for PPS hospitals per Skilled Nursing Facility (SNF) reimbursement and for CAH hospitals via per diem (refer below for details).

**Outpatient services** are payable based on Medicare Ambulatory Payment Classification (including Medicare coinsurance) or fee schedule if excluded from Outpatient Prospective Payment System.

**Outpatient Outliers** payment is based on Medicare guidelines.

**Organ acquisition** will be reimbursed according to Medicare PPS reimbursement guidelines. The facility should include the cost of the organ acquisition on the claim submission. Reimbursement will be based upon actual cost of the organ acquisition.

### Acute Long-Term Care Hospital

Payment based upon LTC-DRG reimbursement.

## Ambulance

Payment based on Medicare ambulance fee schedule. Point of pick-up ZIP code is required on claim submission to appropriately reimburse according to fee schedule.

## Ambulatory Surgical Center (ASC)

Providers in Iowa, Montana and South Dakota submit electronically using 837 Institutional format or UB-04 claim form for paper.

Providers in Minnesota, Nebraska, North Dakota and Wyoming submit electronically using 837 Professional format or CMS 1500 claim form for paper.

Payment made in accordance with Medicare rates.

## Anesthesia

Physician payment is based on Medicare methodology (Medicare anesthesia conversion factor by locality x sum of code designated base units + time units).

For Physician Medical Direction of two or more Nurse Anesthetists concurrently, reimbursement is 50 percent of the allowance for the service performed by the physician.

MedicareBlue PPO acknowledges concurrence with CMS billing protocol:

- Time Units: 15 minute increments; payment for less than 15 minute increments prorated per CMS guidelines.
- Base units: CPT accepted American Society of Anesthesiologist (ASA) codes.
- Physical status modifiers (complexity of anesthesia service provided): no additional reimbursement for submission of service billing modifiers, e.g., P1–P6.
- Qualifying circumstances (submission of risk codes): no additional reimbursement, e.g., 99100\*, 99116, 99135, 99140.

## Clinical Trials

Routine services associated with clinical trials are generally not payable under MedicareBlue PPO. These claims should be submitted to Original Medicare.

## Community Mental Health Centers (CHMC's)

CHMC services provided by Medicare-eligible mental health practitioners are separately billable and payable based on the Medicare Fee Schedule or a negotiated local Blue Cross and Blue Shield plan specific amount.

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CMHC outpatient facility services are payable under Medicare APC methodology (including Medicare coinsurance).

### Critical Access Hospital

Reimbursement is established by each Blue Cross and Blue Shield plan in conjunction with each facility.

Reimbursement is based on Medicare methodology to emulate the Original Medicare payment for the service.

Reimbursement rates are based on the facility's most recent intermediary rate letter(s) and finalized cost reports obtained by each Blue Cross and Blue Shield plan directly from the CAH.

To expedite claims payment, the facility's reimbursement for acute care, swing bed and outpatient hospital services should be established and agreed upon by the CAH and Blue Cross and Blue Shield plan prior to submission of claims. Each time the payment rates are adjusted by the Fiscal Intermediary, CAHs are encouraged to provide the most recent copy of their intermediary letter(s) to their local Blue Cross and Blue Shield plan.

MedicareBlue PPO recognizes:

- Acute care and swing bed reimbursed via per diems
- Outpatient hospital reimbursed at percent of charge
  - Method 1 and Method 2 billing by CAHs
  - CAHs using Method 2 billing should provide copies of affected MDs/CRNAs attestations to their local Plan.
  - CAHs using Method 2 to include MD/CRNA services are reimbursed at 115 percent on eligible professional services. In addition, if applicable, MDs are eligible for additional health professional shortage area (HPSA) reimbursement (10 percent). Physician scarcity area (PSA) reimbursement expired on June 30, 2008.
  - Ambulance service, owned and operated by CAHs, reimbursement is percent of charge. Ambulance services should be billed separately from the hospital bill.
  - Lab work performed at a Critical Access Hospital and billed within the inpatient and/or outpatient hospital bill will be paid per CAH methodology above.

### Clinic/Office Administered Drugs

Payable under Medicare methodology.

The payment allowance limits for Medicare Part B drugs and biologicals are reimbursed at the Original Medicare Average Sales Price (ASP) rate with the following exceptions.

Medicare calculates these services using the following payment allowance limits:

- **Blood and blood products** are 95 percent of the average wholesale price (AWP).
- **Infusion drugs** furnished through covered durable medical equipment are 95 percent of the AWP regardless of whether or not the DME is implanted.
- **Influenza, pneumococcal and Hepatitis B vaccines** are 95 percent of the AWP.
- **Drugs**, other than new drugs, not included in the ASP Pricing File or Not Otherwise Classified (NOC) Pricing File are 100 percent of the published wholesale acquisition cost (WAC) for the lesser of the lowest brand or median generic. If a payment limit is available from CMS, those limits will apply.
- The payment allowance limits for new drugs and biologicals not included in the ASP Medicare Part B Drug Pricing File or NOC Pricing File are based on 106 percent of the WAC.

### Durable Medical Equipment (DME), Prosthetics, Orthotics, Medical Supplies

These are payable under CMS' Medicare Durable Medical Equipment, Prosthetic, Orthotic and Supplies (DMEPOS) payment methodology. There are three DMEPOS payment methodologies:

- **Fee Schedules** – Applies to the allowed amount for expendable supplies, those items that require frequent and substantial servicing, other prosthetic and orthotic devices, capped rental items, and oxygen and oxygen supplies and parenteral and enteral nutrition (PEN).
- **Reasonable Charge** – Applies to the allowed amount for certain dialysis equipment and supplies, and therapeutic shoes claims.
- **Average Wholesale Pricing (AWP)** – Applies to the allowed amount for immunotherapy, bronchodilator and other DMEPOS drugs.

**Note:** The beneficiary's permanent address, rather than the location of the DMEPOS supplier, will determine the amount allowed by Medicare for a supplier service on mail order services.

### ESRD Facility (independent and provider-based)

Payment is based on the Medicare composite rate following Medicare methodology or a local Blue Cross and Blue Shield plan-established specific amount.

Non-routine services (not included in the composite rate) are paid based on a fee schedule. Non-routine drugs are paid according to the drug methodology outlined above.

### Federally Qualified Health Center (FQHC)

#### Rural Health Clinic (RHC) (independent and provider-based)

Payment is based on either the Medicare “all inclusive” rate or the Medicare national per-visit limit for FQHC (urban or rural) or RHC facility type. Providers may collect the applicable cost sharing from the enrollee above the Medicare “all inclusive” rate or national per-visit limit.

If your local Plan reimburses based upon the Medicare all inclusive rate, FQHCs and RHCs should provide a copy of their most recent intermediary rate letter to their local plan to establish an agreed upon rate prior to the submission of claims. To ensure ongoing appropriate and current payment, submit a copy of your intermediary rate letter to your local plan each time the rate is adjusted by the fiscal intermediary.

MedicareBlue PPO acknowledges Medicare reimbursing RHCs and FQHCs separately for specific immunizations. These immunizations are not included in RHCs or FQHCs all inclusive rate, e.g., per diem. MedicareBlue PPO suggests billing these services at the point of service using a UB claim form. Reimbursement for immunizations and the administration of them are payable based on the Medicare Fee Schedule.

When billing immunizations with an encounter rate, only the immunization should be billed separately. The administration for the vaccine is considered part of the all inclusive rate, e.g., per diem (revenue code 052x). To submit the immunization on a UB, use revenue code 0636 (do not use revenue code 0250) with the following HCPCS codes:

- Influenza vaccine – 90656\*, 90658, 90660
- Pneumococcal – 90732
- Hepatitis A – 90632
- Hepatitis A/Hepatitis B – 90636
- Hepatitis B – 90740, 90746, 90747
- Hepatitis B/Hib – 90748

When billing immunization services only via a UB (e.g., an encounter rate is not being billed [revenue code 052x]), Region 19 provides separate reimbursement for the administration and immunization via the Medicare Fee Schedule. In addition to billing the appropriate immunization revenue code and HCPCS, **administration services** may also be billed using **revenue code 0771** and HCPCS codes:

- Administration influenza virus vaccine – G0008
- Administration pneumococcal vaccine – G0009
- Administration Hepatitis B vaccine – G0010
- Immunization administration, one vaccine – 90471
- Immunization administration, each additional vaccine – 90472

### Home Health Agencies

Home Health Services payment is based on Medicare PPS home health resource group (HHRG) payment methodology and use of CMS' OASIS patient assessment software.

Payment for covered services will follow the standard CMS episode-based reimbursement methodology.

CMS' billing protocol should be followed when filing as initial notification claim and when the episode treatment plan is commenced. It should be followed by an appropriate final claim at the termination of the treatment episode.

All standard Medicare billing protocols and claim elements should be used for claim assessment.

Reimbursement follows the standard Medicare plan process for a prorated reimbursement:

1. Initial reimbursement will occur at the commencement (initial date of service) of the plan of care.
2. The balance of reimbursement for the episode follows at the termination of a fully completed treatment episode.
3. The proration of a fully completed episode payment will follow the standard Medicare plan methodology of 60 percent of the episode payment upon the initial claim and the remaining 40 percent at the initial episode completion. The RAP payment for the second and subsequent episodes of care is 50 percent with the other 50 percent payable on the final claim.
4. Payment for low utilization treatment plans (typically four visits or less) or materially modified treatment plans which would not require or permit the full episode of treatment: a prorated reimbursement would be applied per day of care based on standard Medicare payment methodology.

MedicareBlue PPO does permit home health agencies to bill their nursing services and applicable DME/medical supplies on the same claim rather than perform split billing.

Covered services not included in per visit rates reimbursed under DME POS fee schedule.

Home Health services RAP billing:

- Bill type 322 or 332
- First and only revenue code should be equal to:
  - Revenue code: 0023
  - Charges: \$0.00
  - HIPPS code: OASIS determined HIPPS code
  - Units: should be zero or one
- Treatment Authorization Code (TAC) required
- Core Based Statistical Area (CBSA) required with Value Code 61

Home Health services Final Claim billing:

- Bill type – 329 or 339
- First revenue code should be equal to:
  - Revenue code: 0023
  - Charges: \$0.00
  - HIPPS code: OASIS determined HIPPS code
  - Units: should be zero or one
- Remaining revenue codes lines should include actual services provided
- Treatment Authorization Code (TAC) required
- Core Based Statistical Area (CBSA) required with Value Code 61

## Home Infusion

Covered services are limited to Medicare eligible services only and Medicare compliant billing. Nursing services billed on a UB-04 claim form, or electronic equivalent, by the home health agency providing the 60-day episode of care. DME/supplies/drugs billed on a CMS-1500 or electronic equivalent.

MedicareBlue PPO does permit home health agencies to bill their nursing services and applicable DME/medical supplies on the same claim rather than performing split billing.

Eligible home infusion providers should follow the protocol for home health billing as applicable.

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## Hospice

All claims for hospice services should be directed to Original Medicare.

## Clinic Based or Independent Laboratory and Radiology/Imaging Services

Payment is based on the Medicare Fee Schedule.

MedicareBlue PPO allows lab services to either be billed by the independent laboratory or by the clinic/physician office, with the exception of services only eligible for Medicare reimbursement when billed by an independent laboratory.

Lab work performed at a Critical Access Hospital and billed within the inpatient and/or outpatient hospital bill will be paid per CAH methodology above.

## Chiropractors (for Medicare-covered services)

Chiropractor services are payable based on the Medicare Fee Schedule.

Chiropractors, per Medicare, are not eligible for HPSA.

## Other Health Care Professionals

Reimbursement is based on the Medicare Fee Schedule (MFS) applicable for physicians.

85% of MFS:

- Advanced nurse practitioners
- Physician assistants
- Clinical nurse specialists
- Registered dietitians
- Medical nutrition therapists

100% MFS

- Clinical psychologist
- Physical therapists
- Occupational therapist
- Speech therapist

75% of MFS

- Clinical social worker

65% of MFS

- Nurse Midwives

### Psychiatric Hospital or CMS Designated Mental Health Unit of Acute Care Hospital

Inpatient payment is based on the Inpatient Psychiatric Facility (IPF) Prospective Payment System (PPS) using psychiatric DRGs.

MedicareBlue PPO reimbursement is based in full on the PPS methodology.

### Rehabilitation Hospital

Inpatient payment based on Medicare PPS, using case-mix group (CMG) methodology for inpatient rehabilitation services.

Rehabilitation Hospitals should use CMS inpatient rehabilitation facility (IRF) assessment tool to establish case mix group code. Follow CMS standard billing guidelines.

Inpatient billing:

- First revenue code line should be equal to:
  - Revenue code: 0024
  - Charges: \$0.00
  - CMG code: Appropriate software-determined CMG code(s) (5-position field) in the UB HCPCS/rates field(s) (UB-04 form locator 44)
  - Units should be equal to number of days
- Remaining revenue codes should indicate the following room and board and ancillary charges (i.e., medications, therapies and supplies) on remainder of claim:

Outpatient billing:

- Outpatient payment is based on Medicare APC or fee schedule if excluded from OPSS.

### Skilled Nursing Facility

Payment based on Medicare's (RUG) rate methodology. Follow CMS standard billing guidelines.

Inpatient billing:

- First revenue code line should be equal to:
  - Revenue code: 0022
  - Charges: \$0.00

- RUG code: Appropriate software-determined RUG categories in the UB HCPCS/rates field(s) (UB-04 form locator 44)
- Units: specific number of days/units
- Remaining revenue codes should indicate the following room and board and ancillary charges (i.e., medications, therapies, and supplies) on remainder of claim:

#### Outpatient or Inpatient Part B billing:

- Eligible outpatient services provided by a freestanding SNF are payable based on the Medicare Physician Fee Schedule
- Covered ancillary services provided to a SNF inpatient who is in a non-covered stay situation can be billed and will be reimbursed on the MPFS

Facilities will not be required to submit assessment paperwork at the point of claim for the purposes of claims processing.

Facilities are strongly encouraged to complete and file within their own facility assessment paperwork for federal and state audit purposes.

PPS hospitals with swing bed units are reimbursed via Medicare's (RUG) rate methodology.

### Medicare Dependent Hospital

UB-04 payment is based on Medicare PPS methodology.

In addition, if for any given full year the hospital specific rate (cost-based target rate) is greater than the federal rate (PPS), the hospital is paid 50 percent of the difference.

### Sole Community Hospital

UB-04 payment is based on Medicare methodology (the greater of PPS or the hospital-specific rate for a full year).

### Part B versus Part D Drugs and Vaccines

#### Part B

Drugs and vaccines administered in a clinic/physician's office for treatment of an injury or direct exposure to a disease or condition will continue to be reimbursed under "Part B." Claims should be submitted to MedicareBlue PPO.

## Part D

Drugs and vaccines administered for reasons other than injury or direct exposure to a disease or condition (preventive, routine or booster vaccinations) are reimbursed under “Part D.” Claims should be submitted to the Part D carrier (Prime Therapeutics). An example of a commonly administered Part D vaccine is Zostavax, the preventive vaccine for shingles.

TRHCA modified the definition of a Part D drug to include its administration. Beginning January 1, 2008, the Part D program covers vaccine administration costs associated with Part D vaccines. The coverage for administration that was available in 2007 under Part B ceased on or after January 1, 2008, and reimbursement is available solely under Part D.

MedicareBlue PPO made two options available for clinic/physician’s offices that do not have the ability to submit directly to the Part D carrier. Claims for Part D vaccines and vaccine administration can be submitted either electronically through the eDispense website or by using a CMS 1500 and following a paper claims process.

eDispense Part D Vaccine manager is a web portal that provides physicians with real-time claims processing, member eligibility, and copay determination for in-office administered vaccines. For more information on eDispense and how to sign up to use that system visit **[https://enroll.edispense.com/ws\\_enroll](https://enroll.edispense.com/ws_enroll)** or call DSI at **1-866-522-3386**.

If you decided not to enroll in eDispense, you can use a CMS 1500 to submit claims and include

- NDC for vaccine
- Quantity
- Days supply – use 1

Submit paper claims to:

MedicareBlue PPO  
P.O. Box 64813  
St. Paul, MN 55164