

Medica Advantage Solution Reimbursement Methodology

Medica Health Plans and Medica Insurance Company

Effective January 25, 2008

Category	Payment Methodology
Acute Care Hospital <ul style="list-style-type: none"> • Inpatient services • Inpatient outliers • Inpatient transfers 	<p>Services are payable under the PPS using diagnosis related group methodology. Reimbursement will be at 102% of the DRG, including any application capital, disproportionate share hospital (DSH) and/or capital indirect medical expense (IME) payments. Operating IME costs and graduate medical education (GME) expenses are paid by CMS or the Fiscal Intermediary. Payments for nursing school, allied health education costs and capital exceptions are reimbursed, if applicable. Organ acquisition paid on cost basis case-by-case. Bad debt is reimbursed on a case-by-case basis.</p> <p>Paid per Medicare guidelines: Payment is 80% of the excess of the cost of an admission over the sum of the DRG payment (IME and DSH) and the threshold amount established by CMS</p> <p><u>Acute-to-Acute and Acute to Post acute:</u> Transferring hospitals are reimbursed at a prorated amount per Medicare guidelines.</p>
Outpatient services	102% of Medicare APC (including Medicare coinsurance) or 102% of fee schedule if excluded from OPPS.
Outpatient Outliers	For 2006 the outlier thresholds are 1.75 times the payment of the APC and \$1,250 over the APC Payment Rate. When the estimated cost of an APC Hospital outpatient service exceeds these thresholds, CMS will make an outlier payment of 50% of the amount by which the cost of furnishing the service exceeds 1.75 times the APC payment rate.
Acute Long Term Care	<p>Inpatient: As of 10/01/02 CMS began a 5-year transition to the PPS. Some facilities may elect to go immediately to 100% PPS. We will reimburse 102% of the Medicare payment under the methodology chosen by the provider. Short stay and high cost outliers apply.</p> <p>Outpatient: 102% of Medicare APC (including Medicare coinsurance) or 102% of fee schedule if excluded from OPPS. Outliers paid per Medicare guidelines with documentation.</p>
Ambulance	Paid 102% of the Medicare ambulance fee schedule. Additional payments are made for longer distance trips and for providers in certain rural areas per Medicare guidelines.
Ambulatory Surgical Center (ASC)	102% ASC fee schedule wage adjusted when appropriate.
Anesthesia	<p>Physician: 102% of Medicare payment (Medicare anesthesia conversion factor by locality x sum of uniform base units + time units.)</p> <p>For Physician Medical Direction of 2 or more Nurse Anesthetists concurrently, 50% of the allowance for the service performed by the physician.</p>
Assistant at Surgery	102% of the amount that would be paid under Medicare. If physician is assistant, payment is 16% Medicare Fee Schedule; if physician assistant is assistant, payment is 85% times 16% Medicare Fee Schedule.
Blood	For outpatient services, 102% of Medicare APC (including Medicare coinsurance).
Cancer Hospital	Inpatient services: 102% of the rate payable under Medicare (billed charges based on a calculated cost to charge ratio.) CCRs are obtained from the most recently filed cost report data provided by the facility or a copy of the facility's most recently filed interim rate letter from their FI. Payment is applicable to Medicare approved facilities only.

Enrollee cost sharing (co-payments and/or coinsurance) will be deducted from a physician or provider's payment. Each physician or other provider is responsible to collect any applicable cost sharing from the member. Physicians and other health care providers who agree to our plans terms and conditions agree not to balance bill enrollees above any applicable co-payments and/or coinsurance.

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	Outpatient services: 102% of the rate payable under Medicare OPPS services excluded from OPPS are reimbursed at the respective fee schedule.
Clinical Trials	Not reimbursable under Medica Advantage Solution. Claims for clinical trial services should be submitted directly to Medicare for reimbursement.
Community Mental Health Centers	Paid at 102% of Medicare PPS (APC) (including Medicare coinsurance). Outliers are reimbursed when appropriate.
Critical Access Hospital (CAH)	Paid at 102% of the rate payable under Medicare (101% of billed charges based on a calculated cost to charge ratio). CCRs are obtained from the most recently filed cost report data provided by the facility or a copy of the facility's most recently filed interim rate letter from their FI. To expedite claims payment, the CAH should submit the cost report or interim rate letter prior to or with the claim.
Durable Medical Equipment (DME), Braces, Prosthetics, Orthotics, Medical Supplies, Diabetic Shoes, Home Dialysis Supplies, Home Dialysis Equipment, Surgical Dressings	102% of the Medicare Durable Medical Equipment Prosthetic, Orthotic and Supplies (DMEPOS) Fee Schedule. Payment for equipment rental follows Medicare guidelines.
Medicare Covered Drugs	Paid at 102% of the Medicare rate of Average Sales Price Fee Schedule plus 6%. If there is no Fee Schedule rate, reimbursed 102% of 95% of the AWP (Average Wholesale Price.)
ESRD Facility	Paid at 102% of Medicare composite rate. Non-routine services (not included in the composite rate) are paid based on 102% of fee schedule. Non-routine drugs are paid according to the Drug methodology outlined above.
Federally Qualified Health Centers (FQHC): Independent and Provider based	Paid 102% of the lesser of the "Medicare "all inclusive rate or the national per-visit rate. Providers will be reimbursed 80% of the allowed charge; plus 20% of the FQHC's actual charge. <i>Urban FQHC limit:</i> \$112.96 for CY 2006 <i>Rural FQHC limit:</i> \$97.13 for CY 2006
Home Health Agencies	Home Health services will be paid at 102% of Medicare PPS using home health resource group (HHRGs) methodology. Covered services not included in per visit rates reimbursed at 102% of the appropriate Medicare schedule.
Indian Health Service Facility (IHS)	Inpatient: Services are payable under the PPS using diagnosis related group methodology. Reimbursement will be at 102% of the DRG, including any application capital, disproportionate share hospital (DSH) and/or capital indirect medical expense (IME) payments. Operating IME costs and graduate medical education (GME) expenses are paid by CMS or the Fiscal Intermediary. Outpatient: 102% of Medicare APC (including Medicare coinsurance) or 102% of fee schedule if excluded from OPPS.
Laboratory	Paid at 102% Medicare laboratory Fee Schedule. Lab work performed at a Critical Access

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	Hospital will be paid per CAH methodology above.
Medicare Dependent or Sole Community Hospital	<p>Inpatient: 102% of the greater of PPS or the specific rate for a full year.</p> <p>Outpatient: 102% of Medicare APC (including Medicare coinsurance) or 102% of fee schedule if excluded from OPPTS.</p> <p>Sole Community Hospitals receive outpatient “hold harmless” (or TOPS) payment until 12/31/05</p> <p>Medicare Dependent Hospitals are paid PPS. In addition, if for any given full year the hospital specific rate (cost based target rate) is greater than PPS, the hospital is paid 50% of the difference.</p>
Non-Physician Health Care Professionals: <ul style="list-style-type: none"> • Clinical Nurse Specialist • Clinical Psychologist • Clinical Social Worker • Medical Nutrition Therapy • Nurse Practitioner • Physician Assistant • Physical Therapists • Occupational Therapist • Speech Therapist • Registered Dietician 	Paid at 102% of Medicare payment: <ul style="list-style-type: none"> • Clinical Nurse Specialist, 85% MFS • Clinical Psychologist, 100% MFS • Clinical Social Worker, 75% MFS • Medical Nutrition Therapy, 85% MFS • Nurse Practitioner, 85% MFS • Physician Assistant, 85% MFS • Physical Therapists 100% MFS • Occupational Therapist, 100% MFS • Speech Therapist, 100% MFS • Registered Dietician, 85% MFS
Physician Services <ul style="list-style-type: none"> • Anesthesia • Co-Surgeons • Team Surgery 	<ul style="list-style-type: none"> • Physician Services: 102% Medicare Fee Schedule. • Anesthesia: 102% of Medicare payment (Medicare anesthesia conversion factor by locality x sum of uniform base units + time units.) For Physician Medical Direction of 2 or more Nurse Anesthetists concurrently, 50% of the allowance for the service performed by the physician. • Co-Surgeons: 102% of 62.5% of global surgery rate set by Medicare Fee Schedule. • Team Surgery: By report.
Psychiatric Hospital	Paid at 102% of the Inpatient Psychiatric Facility PPS payment subject to the Transitional Tax Equity and Fiscal Responsibility act (TEFRA) blend.
	Outlier payments are effective after a loss of \$5,700 per stay.
Rehab Hospital	<p>Inpatient: 102% of Medicare PPS, using case-mix group (CMG) methodology for inpatient rehabilitation services.</p> <p>Outpatient: 102% of Medicare APC (including Medicare coinsurance) or 102% of fee schedule if excluded from OPPTS.</p>

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Religious Non-Medical Health Care Institution	Paid 102% of Medicare Payment Rate. Facility must submit documentation of Medicare rate with claim.
Rural Health Clinic (RHC): Independent and Provider Based	Paid at 102% of the lesser of the Medicare “all inclusive rate” or national per-visit limit. Providers will be reimbursed 80% of the allowed charge, plus 20% of the actual charge, minus the enrollee’s coinsurance. To expedite claims payment, the RHC should submit the cost report or interim rate letter prior to or with the claim.
Skilled Nursing Facility -(SNF) Swing Beds	Paid at 102% of Medicare's RUG rates, adjusted for each state's wage index. See Skilled Nursing Facility (SNF) reimbursement.
X-Rays	Paid at 102% Medicare Fee Schedule.

General Note:

Changes in the rate of reimbursement may occur without any direct advance notice to physicians, providers or suppliers. Changes will be based on changes to the CMS reimbursement methodology. MHP/MIC shall publish changes to the rate of reimbursement on its website (<http://www.Medica.com>) thirty (30) days in advance of the effective date of any change. MHP/MIC payment methodologies are reviewed by the CMS for accuracy.

You may also contact our Provider Service Center at 1-800-458-5512 if you have any questions regarding our reimbursement rates, or whether any changes are planned within the next thirty (30) days. Physicians and other health care professionals have the right to appeal under MHP/MIC. If a provider disagrees with our payment rate and has information that Original Medicare would pay more for a service, such documentation may be submitted for review and appropriate adjustment to payment. We reserve the right to retrospectively review claims for claims payment accuracy based on the information submitted.

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