

**QCC Insurance Company**  
**PFFS**  
**Private Fee-for-Service Plan Payment Rates**

Payment for services covered under QCC Insurance Company’s Private Fee-for-Service (PFFS) is based on Medicare Fee-for-Service payment rates. Member copayments and/or coinsurance will be deducted from a physician or provider’s payment. It is each physician or provider’s responsibility to collect any applicable member copayment or coinsurance amount. Physicians and other health care providers who agree to our plan’s Terms and Conditions may not balance-bill enrollees above any applicable copayments and/or coinsurance. The Select Advantage PFFS payment amount, plus the member copayment or coinsurance, is payment in full.

- Claims should be submitted to QCC Insurance Company in the same billing format (CMS-1500 or UB-04) used for an Original Medicare claim of the same type. Please follow all Medicare requirements regarding use of codes and modifiers.
- Claims for Routine Eye Exams for Davis Vision providers should be submitted using the standard Davis Vision process. Claims for non Davis Vision providers should be submitted on a CMS-approved Claim Form and CMS-approved CPT and HCPCS codes to Davis Vision for reimbursement.
- The member also has an eyewear benefit. Members can access Davis Vision providers who have agreed to accept the plans terms and conditions and payment will be made directly to the provider through the normal Davis Vision process. Members can also access eyewear benefits through any other non Davis Vision provider. The non Davis Vision provider or member may complete the reimbursement form and submit to Davis Vision for reimbursement. The member is responsible for any amounts in excess of the eyewear benefit.
- Use the provider/facility IDs issued by us, if applicable, instead of Medicare-issued provider/facility IDs. Providers without IDs issued by Independence Blue Cross, QCC Insurance Company’s PFFS’ parent company should submit claims using their Medicare-issued ID number.

<i>Type of Service</i>	<i>PFFS Payment</i>
<b>Acute-Care Hospital (including Medicare Dependent Hospitals, Sole Community Hospitals and Indian Health Service Facilities)</b>	<b><u>Inpatient Services</u></b> Acute-care hospitals are paid a diagnosis-related group (DRG) amount using the Medicare prospective payment system (PPS). Payment will include capital, disproportionate share (DSH), capital indirect medical education (IME), and special payment adjustments to Medicare-Dependent Hospitals (MDH) and Sole Community Hospitals (SCH) when applicable. If applicable, payment will also include pass-through payments for capital, certified registered nurse anesthetists (CRNA), and costs associated with nursing and allied health education programs, and/or add-on payments for approved new services/technologies and blood clotting factor.

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Organ acquisitions at a Medicare approved transplant facility will be reimbursed on a cost basis at an approved transplant facility.

Payment will not include operating IME or direct graduate medical education (DGME). Those payments will continue to be made by the fiscal intermediaries (FI) to eligible facilities.

**Inpatient Outliers**

Paid per Medicare guidelines. Payment is 80% of the excess of the cost of an admission over the sum of the DRG payment (including IME and DSH) and the threshold amount established by the Centers for Medicare & Medicaid Services (CMS).

**Inpatient Transfers (Acute to Acute, Acute to Post-Acute)**

Transferring hospitals will be reimbursed a prorated amount per Medicare guidelines.

**Outpatient Services**

Paid per Medicare guidelines. Services subject to outpatient prospective payment system (OPPS) are paid by the ambulatory payment classification (APC) methodology (full APC amount including fee-for-service (FFS) coinsurance, less any applicable cost-sharing under Select Advantage PFFS). Services excluded from OPPS are reimbursed at their respective fee schedule.

**Outpatient Outliers**

Calculated at the line item level. If the estimated cost for an individual OPPS service (line-item level) exceeds 1.75 times the APC payment amount, and the cost exceeds the payment amount plus a fixed dollar threshold, the outlier payment will be 50% of the difference between 1.75 times the payment amount and the estimated cost.

**Maryland Hospitals**

Health Services Cost Review Commission (HSCRC) mandated rate thresholds. Reimbursed 94% of approved charges for inpatient (IP) and outpatient (OP) services.

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<b>Acute LTC</b>	<p>Inpatient services paid per long-term-care hospital (LTCH) PPS (DRGs.) Short stay and high cost outliers apply.</p> <p>Outpatient services paid per the Medicare physician fee schedule (MPFS).</p>
<b>Ambulance Independent and Provider Based</b>	<p>Paid per Medicare ambulance fee schedule. Extra payments are made for long-distance trips and for providers in certain rural areas per Medicare guidelines.</p>
<b>Ambulatory Surgical Center (ASC)</b>	<p>ASC fee schedule, wage adjusted when appropriate.</p>
<b>Anesthesia</b>	<p>Anesthesia reimbursed per Medicare payment methodology.</p> <p>Physician performed: Medicare anesthesia conversion factor by locality x sum of uniform base units + time units.</p> <p>Physician Medical Direction of 2 or more nurse anesthetists concurrently: 50% of the allowance for the service performed by the physician.</p> <p>CRNA Medicare conversion factor by locality x sum of uniform base units + time units. Some rural hospitals may elect cost reimbursement for CRNA services.</p>

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<b>Assistant at Surgery</b>  <b>Co-Surgeons</b>	Physician is assistant: payment is 16% Medicare Fee Schedule (MFS). Physician assistant is assistant: payment is 85% times 16% MFS. Co-Surgeons: for each co-surgeon, 62.5% of the global surgery under the Medicare physician fee schedule. Team Surgery by report.
<b>Blood (Outpatient)</b>	100% of Medicare APC.
<b>Cancer Hospitals</b>  <b>Children's Hospitals</b>	Inpatient services reimbursed at the Medicare payment rate for Medicare approved facilities: Billed charges based on a calculated cost-to-charge ratio (CCR). 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 its FI. Outpatient services are paid per Medicare OPPS. Services excluded from OPPS are reimbursed at the respective fee schedule.
<b>Clinical Trial Services</b>	Clinical trials are not payable by QCC Insurance Company. FIs will reimburse qualifying clinical trial claims on behalf of Select Advantage PFFS members. Providers need to submit the bills to the carriers and intermediaries using the appropriate modifiers and ICD-9 codes.
<b>Community Mental Health Centers</b>	Paid per outpatient PPS (APC). Outliers reimbursed when appropriate.
<b>Critical Access Hospital (CAH)</b>	Inpatient and outpatient services reimbursed at 101% of the rate payable under Medicare (101% of billed charges based on a calculated cost-to-charge ratio). CCRs are calculated from the most recently filed cost report data provided by the facility. An annual request will be made for updated cost report data/FI interim rate letter. CAHs may provide a copy of their most recent interim rate letter from their FI and be paid the interim inpatient per diem or CCR.
<b>Drugs</b>	Reimbursed at the Medicare rate of Average Sales Price (ASP) plus 6%. Exceptions will also be paid per Medicare methodology: Pneumococcal and influenza vaccines, drugs

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	infused through DME (reported with KD modifier) and new drugs are reimbursed 95% AWP.
<b>Durable Medical Equipment, Prosthetics, Orthotics, and Supplies</b>	Payment is the amount determined by the Medicare Durable Medical Equipment Prosthetic, Orthotic, and Supplies Fee Schedule.  Payment for equipment rental follows Medicare guidelines.
<b>ESRD Facility Independent and Provider Based</b>	Paid Medicare composite rate. Exception payments made when appropriate. Services not included in the composite rate are paid according to the appropriate Medicare fee schedule.
<b>FQHC Independent and Provider Based</b>	Paid at the Medicare assigned upper national payment limit per visit.
<b>Home Health Agencies Independent and Provider Based</b>	Home Health services will be paid at 100% of Medicare PPS using home health resource group (HHRG) methodology. Providers reimbursed per 60-day episode via request for anticipated payment (RAP) and claim submission. Includes adjustments for low utilization payment adjustment (LUPA), significant change in condition (SCIC), partial episode payment (PEP) therapies, and outliers. Covered services not included in per visit rates reimbursed at the appropriate Medicare Fee Schedule.  HHAs are permitted to bill nursing services and allowable DME/medical supplies on the same UB claims rather than perform split billing.
<b>Laboratory</b>	Payment based on Medicare laboratory fee schedule.
<b>Parenteral and Enteral Nutrition</b>	Paid per the PEN fee schedule.
<b>Physician Services</b>	<b>Physicians</b> paid according to the Medicare physician fee schedule.

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<p><b>Non-Physician Health Care Professionals</b></p>	<p>10% health professional shortage area (HPSA) payment where appropriate.</p> <p>Balance-billing is NOT ALLOWED for Select Advantage PFFS members.</p> <p><b>Non-Physician Health Care Professionals</b> paid per Medicare:</p> <ul style="list-style-type: none"> <li>• Physician assistants: 85% MFS</li> <li>• Nurse practitioner: 85% MFS</li> <li>• Clinical nurse specialist: 85% MFS</li> <li>• Registered dietitian: 85% MFS</li> <li>• Clinical psychologist: 100% MFS</li> <li>• Clinical social worker: 75% MFS</li> <li>• Audiologist, chiropractor, podiatrist, optometrist, and dentist: 100% MFS</li> <li>• Medical nutrition therapy: 85% MFS</li> <li>• Physical therapist: 100% MFS</li> <li>• Occupational therapist: 100% MFS</li> <li>• Speech therapist: 100% MFS</li> </ul>
<p><b>Psych Hospital</b></p>	<p>Inpatient services paid per Inpatient Psychiatric Facility PPS Payment subject to Transitional Tax Equity and Fiscal Responsibility act (TEFRA) blend.</p> <p>Outpatient services paid under Outpatient PPS (APCs). Services excluded from OPSS reimbursed under the appropriate Medicare fee schedule.</p>

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<b>Rehab Hospital</b>	<p>Inpatient services reimbursed paid under Medicare PPS, using case-mix group (CMG) methodology for inpatient rehabilitation services (IRF PPS). Case-level adjustments include transfers, short-stay cases, cases in which the patient expires, and outliers.</p> <p>Outpatient services reimbursed at the MPFS.</p>
<b>Religious Non-Medical Health Care Institutions</b>	<p>Paid at the Medicare payment rate. Facility must provide documentation of Medicare rate with claim in order for payment to be calculated.</p>
<b>Rural Health Clinic Independent and Provider Based</b>	<p>Paid at the Medicare assigned national payment limit per visit.</p>
<b>Skilled Nursing Facilities (SNFs) Independent and Provider Based</b>	<p>PPS Reimbursement Resource Utilization groups (RUGS), adjusted for each state's wage index.</p> <p>Part B services reimbursed at the MPFS.</p>
<b>Swing Beds</b>	<p>SNF PPS reimbursement RUG rates. CAH swing beds are exempt from SNF PPS and paid 101% of reasonable costs for services furnished during cost report periods on and after January 1, 2004.</p>
<b>VA Hospitals</b>	<p>VA hospitals will be reimbursed only for emergency or urgently needed services rendered to non-veterans.</p>
<b>Routine Eye Exam</b>	<p>Providers offering routine eye exams must accept Davis Vision's allowable reimbursement amounts whether they are non participating or participating providers in the Davis Vision plan. Members are responsible for any applicable copayments.</p>
<b>Eyewear</b>	<p>The member has an eyewear benefit. Members can go to Davis Vision providers who have agreed to accept the plans terms and conditions and payment will be made directly to the provider through the normal Davis Vision process. Members can also access eyewear benefits through any other non Davis Vision provider. The non Davis Vision provider or member may complete the reimbursement form and submit to Davis Vision for reimbursement. The member is responsible for any</p>

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	amounts above and beyond the plan allowance for the eyewear benefit.
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**General Notes**

QCC Insurance Company's PFFS payment methodologies are reviewed by the CMS for accuracy. Payment methodologies will be updated within 90 days of CMS publication of a change in payment methodology or rate.

Physicians and/or other health care professionals have the right to appeal payments made under QCC Insurance Company's *PFFS* by submitting documentation on Original Medicare's payment rate for a service. QCC Insurance Company will review the information and make appropriate payment adjustments.

*Independence Blue Cross PFFS* reserves the right to retroactively review claims for claims payment accuracy based on the information submitted.