

**MEDICARE ADVANTAGE PRIVATE FEE-FOR-SERVICE PLAN
MODEL TERMS AND CONDITIONS OF PAYMENT**

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1. Introduction

Select Advantage is a Medicare Advantage private fee-for-service PFFS plan offered by QCC Insurance Company. Select Advantage allows members to use any provider, such as a physician, health professional, hospital, or other Medicare provider in the United States that agrees to treat the member after having the opportunity to review these terms and conditions of payment, as long as the provider is eligible to provide health care services under Medicare Part A and Part B also known as 'Original Medicare' eligible to be paid by Select Advantage for benefits that are not covered under Original Medicare.

The law provides that if you have an opportunity to review these terms and conditions of payment and you treat a Select Advantage member, you will be “deemed” to have a contract with us. Section 2 explains how the deeming process works. The rest of this document contains the contract that the law allows us to deem to hold between you, the provider, and Select Advantage. Any provider in the United States that meets the deeming criteria in Section 2 becomes deemed to have a contract with Select Advantage for the services furnished to the member when the deeming conditions are met. **No prior authorization, prior notification, or referral is required as a condition of coverage when medically necessary, plan-covered services are furnished to a member.** However, a member or provider may request an advance coverage determination before a service is provided in order to confirm that the service is medically necessary and will be covered by the plan. Note that the terms prior authorization, prior notification, and advance coverage determination have different meanings. Prior authorization and prior notification rules are described in Section 4, and advance coverage determination is described in Section 7.

2. When a provider is deemed to accept Select Advantage’s terms and conditions of payment

A provider is considered by law to be *deemed* to have a contract with Select Advantage when all of the following three criteria are met:

- 1) The provider is aware, in advance of furnishing health care services, that the patient is a member of Select Advantage. All of our members receive a member ID card that includes the Select Advantage logo that clearly identifies them as PFFS members. The provider may further validate eligibility by calling our Customer Service Department at 1-800-ASK-BLUE, prompt 2 for Provider Services.
- 2) The provider either has a copy of, or has reasonable access to, our terms and conditions of payment this document. The terms and conditions are available at www.site65.com. The terms and conditions may also be obtained by calling our Customer Service Department at 1-800-ASK-BLUE, prompt 2 for Provider Services.
- 3) The provider furnishes covered services to a Select Advantage member.

If all of these conditions are met, the provider is deemed to have agreed to Select Advantage's terms and conditions of payment for that member specific to that visit. **Note:** You, the provider, can decide whether or not to accept Select Advantage's term and conditions of payment each time you see a Select Advantage member. A decision to treat one plan member does not obligate you to treat other Select Advantage members, nor does it obligate you to accept the same member for treatment at a subsequent visit.

For example: If a Select Advantage member shows you an enrollment card identifying him/her as a member of Select Advantage and you provide services to that member, you will be considered a deemed provider. Therefore, it is your responsibility to obtain and review the terms and conditions of payment prior to providing services, except in the case of emergency services (see below).

If you DO NOT wish to accept Select Advantage's terms and conditions of payment, then you should not furnish services to a Select Advantage member, except for emergency services. If you nonetheless do furnish non-emergency services, you will be subject to these terms and conditions whether you wish to agree to them or not. Providers furnishing emergency services will be treated as non-contract providers and paid at the payment amounts they would have received under Original Medicare.

3. Provider qualifications and requirements

In order to be paid by Select Advantage for services provided to one of our members, you must:

- Have a National Provider Identifier in order to submit electronic transactions to Select Advantage, in accordance with HIPAA requirements.
- Submit paper claims to QCC Insurance Company at the following address:

Select Advantage Claims
P.O. Box 69350
Harrisburg, PA 17110

Claims for Routine Eye Exams and Eyewear 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 the following address:

Davis Vision
Vision Care Processing Unit
P.O. Box 1525
Latham, NY 12110

- Furnish services to a Select Advantage member within the scope of your licensure or certification.

- Provide only services that are covered by our plan and that are medically necessary by Medicare definitions.
- Meet applicable Medicare certification requirements (e.g., if you are an institutional provider such as a hospital or skilled nursing facility).
- Not have opted out of participation in the Medicare program under §1802(b) of the Social Security Act, unless providing emergency or urgently needed services.
- Not be on the HHS Office of Inspectors General excluded and sanctioned provider lists.
- Not be a Federal health care provider, such as a Veterans' Administration provider, except when providing emergency care.
- Comply with all applicable Medicare and other applicable Federal health care program laws, regulations, and program instructions, including laws protecting patient privacy rights and HIPAA that apply to covered services furnished to members.
- Agree to cooperate with Select Advantage to resolve any member grievance involving the provider within the time frame required under Federal law.
- For providers who are hospitals, home health agencies, skilled nursing facilities, or comprehensive outpatient rehabilitation facilities, provide applicable beneficiary appeals notices (See Section 10 for specific requirements)
- Not charge the member in excess of the cost sharing allowed under these Terms and Conditions under any condition, including in the event of plan bankruptcy.

4. Payment to providers

Plan payment

Select Advantage reimburses deemed providers the amount they would have received under Original Medicare for Medicare covered services, minus any amounts paid directly by Original Medicare such as for direct graduate medical education and minus any member required cost sharing, for all medically necessary services covered by Medicare. We will process and pay clean claims within 30 days of receipt. If a clean claim is not paid within the 30-day time frame, then we will pay interest on the claim according to Medicare guidelines. Section 5 has more information on prompt payment rules. Payment to providers for which Medicare does not have a publicly published rate will be based on the estimated Medicare amount. For more detailed information about our payment methodology for all provider types, go to http://www.site65.com/plan_finder/select_advantage/for_providers.html.

Deemed providers furnishing such services must accept the fee schedule amount, minus applicable member cost sharing, as payment in full.

Member benefits and cost sharing

Payment of cost sharing amounts is the responsibility of the member. Providers should collect the applicable cost sharing from the member at the time of the service when possible. **You can only collect from the member the appropriate Select Advantage co-payments or coinsurance amounts described in these terms and conditions.** After collecting cost sharing from the member, the provider should bill Select Advantage for covered services. Section 5 provides instructions on how to submit claims to us. If a member is a dual-eligible Medicare beneficiary (that is, the member is enrolled in our PFFS plan and a state Medicaid program) that the state holds harmless for Medicare cost sharing, then the provider cannot collect any cost sharing from the member at the time of service. Instead, the provider may only look to the State Medicaid agency to collect the Medicaid allowable cost sharing amounts.

To view a complete list of covered services and member cost sharing amounts under Select Advantage, go to http://www.site65.com/plan_finder/benefits_summary.html. You may call us at 1-800-ASK-BLUE to obtain more information about covered benefits, plan payment rates, and member cost sharing amounts under Select Advantage. Be sure to have the member's ID number, including the 3 character alpha prefix (on the ID card) when you call.

Select Advantage follows Medicare coverage decisions for Medicare-covered services. Services not covered by Medicare are not covered by Select Advantage, unless specified by the plan. Information on obtaining an advance coverage determination can be found in Section 7. Select Advantage does not require members or providers to obtain prior authorization, prior notification, or referrals from the plan as a condition of coverage. Under prior authorization, a plan requires beneficiaries or providers to seek authorization from the plan prior to obtaining services. There is no such requirement for Select Advantage members.

Note: Medicare supplemental policies, commonly referred to as Medigap plans, cannot cover cost sharing amounts for Medicare Advantage plans, including PFFS plans. All cost sharing is the member's responsibility.

Balance billing of members

A provider may collect only applicable plan cost sharing amounts from Select Advantage members and may not otherwise charge or bill members. Balance billing is prohibited by providers who furnish plan-covered services to Select Advantage members.

Hold harmless requirements

In no event, including, but not limited to, nonpayment by Select Advantage, insolvency of Select Advantage, and/or breach of these terms and conditions, shall a deemed provider bill, charge,

collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against a member or persons acting on their behalf for plan-covered services provided under these terms and conditions. This provision shall not prohibit the collection of any applicable coinsurance, co-payments, or deductibles billed in accordance with the terms of the member's benefit plan.

If any payment amount is mistakenly or erroneously collected from a member, you must make a refund of that amount to the member.

5. Filing a claim for payment

- We request that you submit claims as soon as possible after a service is provided. You must submit a claim for an Original Medicare covered service within the same time frame you would have to submit under Original Medicare, which is within 15-27 months from the date of service. Failure to be timely with claim submissions may result in non-payment. The criteria for Original Medicare submission of claims can be found in section 70 of Chapter 1 of the Medicare Claims Processing Manual located at <http://www.cms.hhs.gov/manuals/downloads/clm104c01.pdf>.
- **Prompt Payment** – Select Advantage will process and pay clean claims within 30 days of receipt. If a clean claim is not paid within the 30-day time frame, Select Advantage will pay interest on the claim according to Medicare guidelines. A clean claim includes the minimum information necessary to adjudicate a claim, not to exceed the information required by Original Medicare. Select Advantage will process all non-clean claims and notify providers of the determination within 60 days of receiving such claims.
- Submit claims using the standard CMS-1500, CMS-1450 (UB-04), or the appropriate electronic filing format.
- Use the same coding rules and billing guidelines as Original Medicare, including Medicare CPT Codes, HCPCS codes and defined modifiers. Bill diagnosis codes to the highest level of specificity.
- Include the following on your claims:
 - National Provider Identifier;
 - The member's ID number, including the three character alpha prefix (on member ID) card;
 - Date(s) of service;
 - Federal tax ID number;
 - Laboratories must include their CLIA number.
- For providers that are paid based upon interim rates, include with your claim a copy of your current interim rate letter if the interim rate has changed since your previous claim submission.

- Coordination of Benefits: All Medicare secondary payer rules apply. These rules can be found in the Medicare Secondary Payer Manual located at <http://www.cms.hhs.gov/Manuals/IOM/list.asp>. Providers should identify primary coverage and provide information to Select Advantage at the time of billing.
- Where to submit a claim:
 - Hospice and clinical trial providers should continue to file claims using their current process.
 - All other claims electronic or paper should be submitted to your local Blue Plan. To obtain the claims filing address, go to http://www.ibx.com/providers/pffs/plan_finder.html.
- If you have problems submitting claims to us or have any billing questions, contact our technical billing resource at 1-800-ASK-BLUE, prompt 2 for Provider Services.

6. Maintaining medical records and allowing audits

Deemed providers shall maintain timely and accurate medical, financial and administrative records related to services they render to Select Advantage members. Unless a longer time period is required by applicable statutes or regulations, the provider shall maintain such records for at least 10 years from the date of service. Deemed providers must provide Select Advantage, the Department of Health and Human Services, the Comptroller General, or their designees access to any books, contracts, medical records, patient care documentation, and other records maintained by the provider pertaining to services rendered to Medicare beneficiaries enrolled in a Medicare Advantage plan, consistent with Federal and state privacy laws. Such records may be used for activities in the following situations: Centers for Medicare & Medicaid Services and Select Advantage audits of risk adjustment data; Select Advantage determinations of whether services are covered under the plan, are reasonable and medically necessary, and whether the plan was billed correctly for the service; and in order to make advance coverage determinations. Select Advantage will not use medical record reviews to create artificial barriers that would delay payments to providers. Both voluntary and mandatory provision of medical records must be consistent with HIPAA privacy law requirements.

7. Getting an advance coverage determination

Providers may choose to obtain a written advance coverage determination (also known as an organization determination) from us before furnishing a service in order to confirm whether the service is medically necessary and will be covered by Select Advantage. To obtain an advance coverage determination, call us at 1-800-227-3119 (be sure to have the member's ID number including the 3 character alpha prefix when you call). Select Advantage will make a decision and notify you within 14 days of receiving the request, with a possible 14-day extension either due to the member's request or Select Advantage justification that the delay is in the member's best interest. In cases where you believe that waiting for a decision under this time frame could place the member's life, health, or ability to regain maximum function in serious jeopardy, you can request an expedited determination. To obtain an expedited determination, call us at 1-800-227-

3119 (be sure to have the member's ID number including the 3 character alpha prefix when you call). We will notify you of our decision within 72 hours.

In the absence of an advance coverage determination, Select Advantage can retroactively deny payment for a service furnished to a member if we determine that the service was not covered by our plan or was not medically necessary. However, providers have the right to dispute our decision by exercising member appeals rights.

8. Provider payment dispute resolution process

If you believe that the payment amount you received for a service is less than the amount indicated in our terms and conditions of payment, you have the right to dispute the payment amount by following our dispute resolution process.

To file a payment dispute with Select Advantage, send a written dispute to your local Blue Plan. The appropriate address can be obtained at http://www.site65.com/pdfs/plan_finder/pffs/appeals_form.pdf.

Additionally, please provide appropriate documentation to support your payment dispute. A remittance advice from a Medicare carrier would be considered such documentation. Claims must be disputed within 120 days from the date payment is initially received by the provider.

We will review your dispute and respond to you within thirty days. We will inform you in writing if your payment dispute is denied.

After completing Select Advantage's dispute resolution process, if you believe that we have reached an incorrect decision regarding your payment dispute, you may file a request for review of this determination with an independent entity contracted by CMS. To file a request for review of a payment dispute with the independent entity, you may contact the entity directly at:

Phone 904-791-6430

Fax 904-361-0551

Write First Coast Service Options, Inc.
PFFS Payment Disputes
P.O. Box 44017
Jacksonville, Florida 32231-4017

9. Member and provider appeals and grievances

Select Advantage members have the right to file appeals and grievances when they have concerns or problems related to coverage or care. Members may appeal a decision made by Select Advantage to deny coverage or payment for a service or benefit that they believe should be covered or paid for. Members should file a grievance for all other types of complaints.

A provider may appeal decisions on behalf of a member as an appointed representative, or appeal on his or her own right using the member's appeal process by signing a waiver of liability promising to hold the member harmless regardless of the outcome. There must be existing potential member liability (e.g., a claim, as opposed to an advance coverage determination, is denied as not a medically necessary or a covered service) in order for a provider to appeal utilizing the member's appeal process. If you appeal on your own right, you agree to abide by the statutes, regulations, standards, and guidelines applicable to the Medicare PFFS Member appeals and grievance process.

The Select Advantage Member Evidence of Coverage (EOC) provides more detailed information about the member appeal and grievance process. You can call our Customer Service Department at 1-800-331-0017 (be sure to have the member's ID number including the 3 character alpha prefix when you call) for more information on our member appeals and grievance policies and procedures.

Waiver of liability statements and appeals should be sent to Select Advantage at

Medicare Member Appeals Unit
PO Box 13652
Philadelphia, PA 19101-3652.

Or fax us at 1-888-289-3008.

10. Providing members with notice of their appeals rights – Requirements for Hospitals, SNFs, CORFs, and HHAs

Hospitals must notify Medicare beneficiaries who are hospital inpatients about their discharge appeal rights by complying with the requirements for providing the Important Message from Medicare (IM), including the time frames for delivery. For copies of the notice and additional information regarding this requirement, go to:
http://www.cms.hhs.gov/BNI/12_HospitalDischargeAppealNotices.asp

Skilled nursing facilities, home health agencies, and comprehensive outpatient rehabilitation facilities must notify Medicare beneficiaries about their right to appeal a termination of services decision by complying with the requirements for providing Notice of Medicare Non-Coverage NOMNC, including the time frames for delivery. For copies of the notice and the notice instructions, go to: <http://www.cms.hhs.gov/MMCAG/Downloads/NOMNCFORM.pdf> and <http://www.cms.hhs.gov/MMCAG/Downloads/NOMNCInstructions.pdf>

In addition, the provider should send a copy of any NOMNC issued to http://www.site65.com/plan_finder/select_advantage/for_providers.html.

Hospitals, home health agencies, comprehensive outpatient rehabilitation facilities or skilled nursing facilities, must provide members with a detailed explanation on behalf of the plan if a member notifies the Quality Improvement Organization (QIO) that the member wishes to appeal a decision regarding a hospital discharge or termination of home health agency, comprehensive outpatient rehabilitation facility or skilled nursing facility services within the timeframes specified by law.

For home health agencies, comprehensive outpatient rehabilitation facilities or skilled nursing facilities, to obtain the Detailed Explanation of Non-Coverage go to:
<http://www.cms.hhs.gov/MMCAG/Downloads/DENC.pdf>

For hospitals, to obtain the Detailed Notice of Discharge go to:
http://www.cms.hhs.gov/BNI/12_HospitalDischargeAppealNotices.asp#TopOfPage

Hospitals, home health agencies, comprehensive outpatient rehabilitation facilities or skilled nursing facilities should also send these detailed notices to Select Advantage at the following address:

Medicare Member Appeals Unit
PO Box 13652
Philadelphia, PA 19101-3652.

11. If you need additional information or have questions

If you have general questions about Select Advantage's terms and conditions of payment, contact us at our Customer Service Department, at 1-800-ASK-BLUE, prompt 2 for Provider Services TTY: 1-800-227-3119, Monday through Friday, from 8 a.m. to 5 p.m.

- If you have questions about submitting claims, call us at 1-800-ASK-BLUE.
- If you have questions about plan payments, call us at 1-800-ASK-BLUE.

Payment Methodology Grid

Select Advantage generally reimburses deemed providers the amount they would have received under Original Medicare for Medicare covered services, minus any amounts paid directly by Original Medicare (such as for direct graduate medical education) and minus any member required cost sharing, for all medically necessary services covered by Medicare. Payment for certain providers will be based on the estimated Medicare amount and calculated using a proxy method developed by CMS. Select Advantage does not do cost settlements. For providers paid on a cost basis, Select Advantage makes payment based on the interim rate letter from the fiscal intermediary or Medicare contractor. Select Advantage does not pay for hospice services or clinical trials. Hospice and clinical trial providers should continue to file claims with Original Medicare using their current process.

Provider	Payment Methodology
Acute Care Hospital - Inpatient Services	<p>Payment for covered inpatient services are based upon the inpatient Prospective Payment System (IPPS). Acute care hospitals are paid a DRG amount using the Medicare prospective payment system (PPS) in all states except Maryland. The DRG payments include amounts for capital indirect medical education (IME) and capital disproportionate share hospital (DSH). Organ acquisitions for members are reimbursed on a cost basis at an approved transplant facility. The following items are excluded from our payment, but are paid directly to the hospital by original Medicare:</p> <ul style="list-style-type: none"> 1) DGME 2) Operating IME <p>Acute care hospitals should submit a “no pay” bill to their Medicare contractor for stays by Medicare Advantage members.</p>
Acute Care Hospital - Inpatient Services Outliers	<p>Payment is 80% of the excess of the cost of an admission over the sum of the DRG payment (including capital IME and DSH) and a threshold amount determined by CMS. The cost of an admission is determined by multiplying the hospital’s cost to charge ratio by its charge.</p>
Acute Care Hospital – Outpatient Services.	<p>Services subject to the Outpatient Prospective Payment System (OPPS) are paid using the Ambulatory Payment Classification (APC) methodology. When processing an APC claim, components that comprise the total reimbursement amount (e.g., accounting for outlier, drugs and devices paid as pass through) will be included. Services excluded from OPPS are reimbursed based on their respective fee schedule. Hospitals exempt from OPPS include those in Maryland, Indian Health Service, and Critical Access Hospitals.</p>
Ambulance	<p>Total reimbursement will equal 100% of the ambulance fee schedule with extra payments made for ground transportation exceeding 50 miles, and for providers</p>

Provider	Payment Methodology
	in certain rural areas, as provided under Original Medicare payment methodology.
Ambulatory Surgical Centers	ASCs are paid based on the CMS fee schedule. Payments are area wage adjusted.
Anesthesiologists – Personally Performed	Payment will be calculated using the Medicare methodology: the sum of uniform base units and time units multiplied by the anesthesia conversion factor specific to the locality.
Anesthesiologists – Direction of two or more nurse anesthetists concurrently	Payment will be on the basis of 50 percent of the allowance for the service performed by the physician alone.
Assistant at Surgery - Physician	For assistant at surgery services performed by physicians, the fee schedule amount equals 16 percent of the amount otherwise applicable for the global surgery.
Assistant at Surgery – Physician Assistant	For assistant at surgery services performed by physician assistants, the fee schedule amount equals 85 percent x 16 percent of the amount otherwise applicable for the global surgery.
Audiologists	Audiologists are paid the lesser of the actual charge for services or 100% of the Medicare physician fee schedule.
Cancer Hospitals – Inpatient Services	The Medicare IPPS methodology will be used as described for Acute Care Hospital Inpatient Services for Cancer Hospitals that are subject to IPPS. For PPS-exempt hospitals, reimbursement is based on the lesser of their actual costs or their TEFRA limited costs. Payment adjustments are then made depending on the difference between these two costs. Facilities are required to supply a copy of their most recent annual FI rate letter to show the interim per diems for inpatient services.
Cancer Hospitals – Outpatient Services	The Medicare OPSS methodology will be used to group/price APC claims for any Medicare approved provider subject to OPSS. For PPS-exempt hospitals, costs are reimbursed using a payment to charge ratio. Facilities are required to supply a copy of their annual FI rate letter to show the cost-to-charge ratios for outpatient services.
Certified Registered Nurse Anesthetists	CRNAs are paid the Medicare anesthesia conversion factor by locality x the sum of uniform base units + time units. Payment is made on an assignment basis only. The above allowance is divided between the anesthesiologist and the anesthetist for directed services.

Provider	Payment Methodology
Chiropractors	Chiropractors are paid the lesser of the actual charge for services or 100% of the Medicare physician fee schedule for Medicare covered services.
Children's Hospitals	The Medicare IPPS methodology will be used as described for Acute Care Hospital Inpatient Services for Children's Hospitals that are subject to IPPS. For PPS-exempt hospitals, reimbursement is based on the lesser of their actual costs or their TEFRA limited costs. Payment adjustments are then made depending on the difference between these two costs. Facilities are required to supply a copy of their annual FI rate letter to show the interim per diems for inpatient services.
Children's Hospitals – Outpatient Services	The Medicare OPPS methodology will be used to group/price APC claims for any Medicare approved provider subject to OPPS. For PPS-exempt hospitals, costs are reimbursed using a payment to charge ratio. Facilities are required to supply a copy of their annual FI rate letter to show the cost-to-charge ratios for outpatient services.
Clinical Nurse Specialist	Clinical Nurse Specialists are paid the lesser of the actual charge for services or 85% of the Medicare physician fee schedule.
Clinical Psychologist	Clinical Psychologists are paid the lesser of the actual charge for services or 100% of the Medicare physician fee schedule.
Clinical Social Worker	Clinical Social Workers are paid the lesser of the actual charge for services or 75% of the Medicare physician fee schedule.
Comprehensive Outpatient Rehabilitation Facility (CORF)	Reimbursement is based on the Medicare physician fee schedule.
Co-Surgeons	For each co-surgeon, the allowed amount is 62.5% of the global surgery allowed amount under the Medicare fee schedule.
Critical Access Hospitals	Reimbursement for inpatient and outpatient services will be based on the critical access hospital's most recent interim rate letter from their Medicare fiscal intermediary or contractor. In order to ensure appropriate reimbursement we request that you provide that letter to us.
Durable Medical Equipment (DME)	Reimbursement is calculated using DMEPOS Fee Schedules.
ESRD Facility	Payment is based on the CMS Composite Rate methodology, this includes geographic and patient case-mix adjustments.
Federally Qualified Health Centers	Facilities are required to supply a copy of their most recent annual FI rate letter to show the interim per diems for inpatient services and a valid Medicare billing

Provider	Payment Methodology
	number. For FQHC services, reimbursement is at 80% of the lesser of the all-inclusive rate or the national limit, plus 20% of the actual charge. Medicare services not covered under the FQHC “all-inclusive rate” are paid at the same rate that the FQHC would receive under original Medicare.
Home Health Agencies	Payments are made on a PPS basis, using CMS home health resource groups. Providers are reimbursed per 60-day episode of care via submission of a request for accelerated payment (RAP) and the claim. Reimbursement includes adjustments for low utilization (LUPA), significant change in condition (SCIC), partial episode payment (PEP), therapies and outliers. DME is reimbursed based on the DME POS fee schedule.
Laboratories	Payments are based on the CMS lab fee schedule.
Long term care hospitals	Payments are made on an inpatient PPS basis using Medicare Severity LTC–DRGs. Rates are adjusted for short stay outliers and high cost outliers.
Maryland Hospitals	Maryland hospitals are paid at rates set by the Health Services Cost Review Commission (HSCRV) in accordance with the Medicare waiver.
Nurse Practitioners	Nurse Practitioners are paid the lesser of the actual charge for services or at 85% of the Medicare physician fee schedule if a physician, facility, or other provider of services does not charge for the same service.
Optometrists	Optometrists are paid the lesser of the actual charge for services or 100% of the Medicare physician fee schedule for Medicare covered services.
Physical, Occupational or Speech Therapists	Physical, Occupational and Speech Therapists are paid the lesser of the actual charge for services or 100% of the Medicare physician fee schedule.
Physicians (MDs and DOs)	MDs and DOs are paid the lesser of the actual charge for the services or 100% of the Medicare physician fee schedule. A 10% bonus is paid if the services are furnished in a health professional shortage area. A 5% bonus is paid if they are furnished in a physician scarcity area (PSA).
Physicians (Podiatrists)	Podiatrists are paid the lesser of the actual charge for the services or 100% of the Medicare physician fee schedule. A 10% bonus is paid if the services are furnished in a health professional shortage area. A 5% bonus is paid if they are furnished in a physician scarcity area (PSA).
Physicians (Oral and Maxillofacial Surgeons)	Oral and Maxillofacial Surgeons are paid the lesser of the actual charge for services or 100% of the Medicare physician fee schedule. A 10% bonus is paid if these services are furnished in a health professional shortage area. A 5% bonus is paid if they are furnished in a physician scarcity area (PSA).

Provider	Payment Methodology
Physicians (Dentists)	Dentists are paid the lesser of the actual charge for the services or 100% of the Medicare physician fee schedule. A 10% bonus is paid if these services are furnished in a health professional shortage area. A 5% bonus is paid if they are furnished in a physician scarcity area (PSA).
Physician Assistants	Physician Assistants are paid at the lesser of the actual charge for services or 85% of the Medicare physician fee schedule if a physician, facility, or other provider of services does not charge for the same service.
Psychiatric Hospitals – Inpatient	Payment is made based on the prospective payment system for inpatient psychiatric facility care (IPFPPS). An outlier payment is made when a psychiatric hospital’s estimated total costs for a case exceed a threshold established by CMS plus the total payment amount for the case.
Psychiatric Hospitals – Outpatient	Payment is made based on the outpatient prospective payment system (OPPS).
Registered Dieticians	Registered Dieticians are paid the lesser of the actual charge for services or 85% of the Medicare physician fee schedule.
Rehab hospitals - Inpatient	Rehab hospitals are paid using the Inpatient Rehabilitation Facility Prospective Payment System (IRF PPS). A case-mix adjusted payment is made using case mix groups (CMGs) for varying numbers of days of IRF care.
Rehab hospitals - Outpatient	Payment is made based on the outpatient prospective payment system (OPPS).
Rural Health Clinics	Rural Health Clinics are reimbursed based on 80% of the per-visit payment limit plus 20% of the actual charges of covered services. The all-inclusive methodology applies only to RHC services, not to other services performed at an RHC such as lab, the technical components of diagnostic tests, etc. RHCs owned by rural hospitals (Critical Access Hospitals) with less than 50 beds are paid on a cost basis and are PPS exempt and paid on a reasonable cost basis. These RHCs are reimbursed based on a per diem rate for inpatient services and on a cost-to-charge ratio basis for outpatient services. To ensure appropriate payment, RHC’s must provide a copy of their most recent interim letter from their Fiscal Intermediary or Medicare Contractor. Medicare services not covered under the RHC “all-inclusive rate” are paid at the same rate that the FQHC would receive under original Medicare.
Skilled Nursing Facilities	Payment is made based on the prospective payment system (PPS) for SNFs. A case-mix adjusted payment for varying numbers of days of SNF care is made using one of the Resource Utilization Groups (RUGs). The RUG is identified in

Provider	Payment Methodology
	the first 3 positions of the HIPPS code. There may be an add-on payment for AIDS patients.
Swing Beds	Covered swing bed facility services will be reimbursed based upon the Skilled Nursing Facility Prospective Payment System. Swing beds in a CAH facility are paid at a per diem based on the rate letter from the FI.
Routine Eye Exam	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.
Eyewear	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 amounts above and beyond the plan allowance for the eyewear benefit.