

Private Fee-for-Service Reimbursement Grid



Service	Reimbursement Methodology
<i>Acute Care Hospital: Inpatient Services</i>	Reimbursements for these services are subject to the MS-DRG amount using the Medicare Prospective Payment System (PPS) methodology in all states except Maryland. The reimbursement is 94% of the approved charges for the state of Maryland. The MS-DRG payment is determined using the PPS Pricer Software published on the CMS website. Reimbursement for these services includes any appropriate capital Disproportionate Share Hospital (DSH) and capital Indirect Medical Education (IME) payments. Operating IME costs and Graduate Medical Education (GME) payments are fully carved out. Payments for nursing school, allied health education costs and capital exceptions are also carried out and paid through the fiscal intermediary. Organ acquisitions are reimbursed like Medicare, on a case-by-case basis. Bad debts are reimbursed on a case-by-case basis.
<i>Acute Care Hospital: Outpatient Services</i>	Reimbursements for these services are subject to the Outpatient Prospective Payment System (OPPS) under Ambulatory Payment Classifications (APC) methodology in all states except Maryland. The reimbursement is 94% of the approved charges for the state of Maryland. Services excluded from OPPS are reimbursed based on their respective fee schedule. These services are reimbursed subject to the outpatient PPS under APC methodology. Services excluded from OPPS are reimbursed based on their respective fee schedule.
<i>Acute Long Term Care: Inpatient Services</i>	Beginning in FY 2008, reimbursement is based on the Medicare Severity Diagnosis Related Group (MS-DRG) classification system for the LTCH PPS (MS-LTC-DRG). The high cost outlier fixed loss amount is at \$18,425.
<i>Acute Long Term Care: Outpatient Service</i>	These services are reimbursed subject to the outpatient PPS under APC methodology. Services excluded from OPPS are reimbursed based on their respective fee schedule.
<i>Ambulance: Independent and Provider-Based</i>	These services will be paid at 100% according to the ambulance fee schedule. Extra payments are made for ground transportation that exceeds 50 miles and for providers in certain rural areas. The ambulance company is paid costs if it is the only supplier within 35 miles of a Critical Access Hospital (CAH).
<i>Anesthesia: Physician Performed</i>	Reimbursement for this service is based on the Medicare anesthesia conversion factor (locality, multiplied by the sum of the uniform base units, plus the time units).
<i>Anesthesia: Physician Medical Direction of Two or More Nurse Anesthetists Concurrently</i>	The allowed amounts for these services are based on the Medicare anesthesia conversion factor (locality, multiplied by the sum of uniform base units, plus the time units, reduced by the application of the appropriate modifier).
<i>Ambulatory Surgery Center (ASC)</i>	Payments for services provided at Ambulatory Surgical Centers (ASC) are made based on the ASC fee schedule and adjusted by the appropriate wage index.
<i>Assistant at Surgery: Physicians</i>	This allowable charge for this service is 16% of the Medicare fee schedule amount for the global surgery.

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<i>Assistant at Surgery: Physician Assistant</i>	This allowable charge for this service is determined as 85% times 16% of the Medicare fee schedule amount for the global surgery.
<i>Blood</i>	Reimbursement for blood is according to the OPSS for hospital outpatient services.
<i>Braces</i>	Braces are covered when furnished incident to physicians' services or on a physician's order. Reimbursement is based on the Medicare Durable Medical Equipment Prosthetic, Orthotic and Supplies (DMEPOS) fee schedules.
<i>Cancer Hospitals: Inpatient Services</i>	These services are exempt from the inpatient PPS. Cost-based reimbursement is paid on a per-day basis for routine and ancillary services and based on most recent cost-report data. Payment is applicable to Medicare approved services only.
<i>Cancer Hospitals: Outpatient Services</i>	Reimbursements for these services are subject to the OPSS under APC methodology. Services excluded from the OPSS are reimbursed based on their respective fee schedule.
<i>Certified Registered Nurse Anesthetist (CRNA)</i>	Reimbursement for this service is based on the Medicare anesthesia dollar conversion factor (locality, multiplied by the sum of uniform base units, plus the time units, reduced by the application of the appropriate modifier).
<i>Chemical Dependency: Inpatient</i>	Reimbursement for these services is subject to the Inpatient Prospective Payment Systems (IPPS) and is calculated based on DRGs.
<i>Children's Hospitals: Inpatient Services</i>	These services are exempt from the inpatient PPS, and reimbursement is cost-based. Routine services and ancillary services are reimbursed as a per diem. Ancillary services' reimbursement is based on the recent cost-report data.
<i>Children's Hospitals: Outpatient Services</i>	Reimbursements for these services are subject to the OPSS under APC methodology. Services excluded from OPSS are reimbursed based on their respective fee schedules.
<i>Clinical Nurse Specialist</i>	Reimbursement is based on 85% of the Medicare physician fee schedule for comparable services.
<i>Clinical Psychologist</i>	Reimbursement is based on the Medicare physician fee schedule for comparable services.
<i>Clinical Social Workers</i>	Reimbursement is based on 75% of the Medicare physician fee schedule for comparable services.
<i>Clinical Trial Services</i>	Medicare directly reimburses all approved clinical trial services provided to a Medicare Advantage plan enrollee according to the appropriate fee-for-service methodology.
<i>Community Mental Health Centers</i>	Reimbursement for these services is under the OPSS and paid on a per-unit (or per diem) basis.
<i>Comprehensive Outpatient Rehabilitation Facility (CORF)</i>	Reimbursement is based on the Medicare physician fee schedule. Vaccines are reimbursed under the OPSS.

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<i>Co-Surgeons</i>	The Medicare Fee Schedule is increased by 25% and then each co-surgeon is reimbursed at 62.5% of the global surgery under the Medicare physician fee schedule.
<i>Co-Surgeons Team Surgery: Critical Access Hospital (CAH)</i>	Team surgery is reimbursed “by report.” Reimbursement is on a reasonable cost basis. The Lesser of Costs or Charges (LCC) rule does not apply. Outpatient professional services are paid based on the fee schedules. CAHs are exempt from OPSS and the lab fee schedule.
<i>Critical Access Hospital (CAH)</i>	Inpatient and Outpatient services as well as swing beds are paid on a reasonable cost basis. CAHs are generally paid 101% of costs. If a physician elects to reassign their claims to the CAH (election of method II), the CAH is paid 115% of the physician fee schedule.
<i>Diabetic Shoes</i>	Reimbursement is based on the CMS Carrier Therapeutic Shoe Payment Limits. These payment limits are calculated as outlined in the Medicare Carriers Manual (MCM), section 2134. These shoes are reimbursed outside of the Medicare DMEPOS fee schedule.
<i>Drugs: Part B</i>	Reimbursement is based on current Medicare payment methodology. Payment is based on 106% of the “average sales price” (ASP) for most drugs. Exceptions include blood, drugs delivered through DME, influenza, pneumococcal and hepatitis B vaccines, and certain new drugs which are all still paid based on 95% Average Wholesale Price (AWP).
<i>Durable Medical Equipment</i>	These services are reimbursed based on the Medicare DMEPOS fee schedule.
<i>Epoetin (EPO)</i>	Effective January 1, 2005, Epoetin Alfa (EPO) will be paid based on the Average Sales Price (ASP) Pricing File.
<i>ESRD Facility</i>	Payment for ESRD services from independent and hospital-based ESRD facilities will be based upon the composite rate, with additional payments made to those facilities that have received an approved exception from their Fiscal Intermediary. In general, the composite rate is payment for the complete dialysis treatment, except for physicians’ professional services, separately billable laboratory services, and separately billable drugs.
<i>Federal Qualified Health Center (FQHC): Independent and Provider-Based</i>	<p>Federally Qualified Health Center (FQHC) reimbursement is 80% of the lesser of the all-inclusive rate or the upper limit plus 20% of the FQHCs actual charge.</p> <p>The FQHC upper payment limit per visit for urban FQHCs effective January 1, 2010, through December 31, 2010, is \$125.72 and the 2009 Rural FQHC upper payment limit is \$108.81. The facility can proactively send a copy of its most recent interim rate letter from the Medicare FI by sending via fax to the corresponding Provider Service facsimile in your area:</p> <p>Delaware, Maryland & Washington, DC: 1-800-447-0465</p> <p>Texas: San Antonio 210-340-9074 El Paso 915-577-4196 Houston 713-643-5981 Dallas 469-362-6628</p>

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Health Professional Shortage Area (HPSA)	Reimbursement is at the Medicare physician fee schedule plus a 10% bonus for health professional in a designated PSA area based on the physician's ZIP code. Bonus will be paid on a quarterly settlement basis.
Hemophilia Clotting Factors Billed by Provider (e.g., Hospital, Skilled Nursing Facility, Home Health Agency)	Reimbursement for inpatient care is an add-on payment to the PPS. In an outpatient setting, reimbursement is on a cost basis. All other settings, including a Skilled Nursing Facility (SNF) and Home Health Agency (HHA), are paid 95% of Drug Topics Red Book average wholesale price.
Hemophilia Clotting Factors Billed by Supplier (eg. DME, supplier, independent pharmacy, Red Cross)	These services are reimbursed at 95% of the average wholesale price in the Drug Topics Red Book.
Home Dialysis Supplies and Equipment	Reimbursement is based on appropriate Medicare fee schedules.
Home Health Agencies: Independent and Provider-Based	Reimbursements for these services are subject to the PPS under the Home Health Resource Groups (HHRG) methodology. 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 Payment Adjustment (LUPA), Significant Change In Condition (SCIC), Partial Episode Payment (PEP), therapies and outliers. Limited services are reimbursed under OPPS. DME is reimbursed based on the Medicare DMEPOS fee schedule.
Home Infusion	Reimbursement is based on Medicare DMEPOS fee schedule for applicable services. Pumps are covered only when used for administration of specific drugs for specific diagnoses.
Hospital Outliers: Inpatient Services, Long Term Care Hospitals	Payment is 80% of the excess of the cost of an admission over the sum of the DRG payment (including IME and DSH) and a threshold amount. The cost of an admission is determined by multiplying the hospital's cost to charge ratio by its charge.
Hospital Outliers: Inpatient Services	Payment is 80% of the excess of the cost of an admission over the sum of the DRG payment (including IME and DSH) and a threshold amount. The threshold amount changes each year. The cost of an admission is determined by multiplying the hospital's cost to charge ratio by its charge.
Hospital Outliers: Outpatient Services	If the estimated costs for a bill exceeds 1.75 times the OPPS payments (including Pass-through), or the sum of the OPPS rate plus the \$2,175.00 fixed dollar threshold, the hospital will receive 50% of the difference.
Hospital Transfer: Acute to Acute	The full DRG amount is paid to the final charging hospital, and each transferring hospital is paid a per diem rate. The per diem rate is the full DRG amount that would have been paid in a non-transfer situation, divided by the geometric mean length of stay for the DRG. Reimbursement is calculated as either twice the per diem for the first day, plus the per diem for each following day, up to the transfer or the full DRG amount.

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<i>Hospital Transfer: Acute to Post-Acute</i>	A qualified discharge from a list of DRGs published by CMS to a post-acute care provider will be treated as a transfer case. The transferring hospital is paid a per diem rate. The per diem rate is the full DRG amount that would have been paid in a non-transfer situation, divided by the geometric mean length of stay for the DRG. Total reimbursement is calculated as either twice the per diem for the first day and the per diem for each following day up to the transfer, or the full DRG amount. DRGs 209, 210, and 211 are paid under a methodology where 50% of the DRG, plus the per diem, is paid on the first day of the stay. For each subsequent day, 50% of the per diem is paid up to the full DRG amount.
<i>Immunosuppressive Drugs, Transplant</i>	Reimbursement is based on the fee schedule obtained from the state carrier. Reimbursement is subject to the OPSS if the beneficiary is in the outpatient department of a Medicare participating hospital. In all other settings, subject to limits, the payment is 95% of the median average wholesale price.
<i>Indian Health Service Facility (IHS): Inpatient Services</i>	These services are subject to the PPS under DRG methodology. Reimbursement for these services includes any appropriate capital DSH and capital IME payments. Operating IME costs and GME payments are fully carved out.
<i>Indian Health Service Facility (IHS): Outpatient Services</i>	Reimbursement is excluded from the OPSS and is at an all-inclusive rate. Outpatient professional services are reimbursed based on their respective fee schedules.
<i>Injections</i>	Specific injection services are reimbursed separately if the physician does not render other services at the time of the injection. Chemotherapy injections are paid in addition to the office visit for the same date of service. Reimbursement is based on the applicable fee schedule.
<i>Laboratory</i>	The reimbursement rate is 100% of the Medicare laboratory fee schedule.
<i>Mammography Screening</i>	The reimbursement rate is 100% of the Medicare physician fee schedule.
<i>Medical Nutrition Therapy</i>	The reimbursement rate is 100% of the Medicare physician fee schedule.
<i>Medicare Dependent Hospital: Inpatient Services</i>	These services are reimbursed subject to the PPS under DRG methodology. The PPS rate equals the greater of the federal rate or the applicable hospital specific rate (based on cost-report data). Reimbursement includes capital IME and DSH payments where appropriate.
<i>Medicare Dependent Hospital: Outpatient Services</i>	These services are reimbursed subject to the OPSS under APC methodology. Services excluded from OPSS are reimbursed based on their respective fee schedules.
<i>Nurse Practitioner</i>	The reimbursement rate is 85% of the Medicare physician fee schedule.
<i>Oral Anti-Cancer Drugs</i>	These services are reimbursed using the appropriate national fee schedule.
<i>Oral Anti-Nausea Drugs</i>	These services are reimbursed using the appropriate national fee schedule.
<i>Parenteral and Enteral Nutrition (PEN)</i>	Reimbursement is based on the Parenteral and Enteral Nutrition (PEN) fee schedule.
<i>Physical Therapy / Occupational Therapy / Speech Therapy</i>	The reimbursement rate is 100% of the Medicare physician fee schedule, up to the Medicare annual limit.

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<i>Physician Scarcity Area (PSA)</i>	100% of Medicare Fee Schedule (MFS) + 5% bonus.
<i>Audiologist</i>	The reimbursement rate is 100% of the Medicare physician fee schedule. In a Health Professional Shortage Area (HPSA), a 10% additional reimbursement will be paid. In a Physician Scarcity Area (PSA), an additional 5% reimbursement will be paid.
<i>Physician (MD)</i>	The reimbursement rate is 100% of the Medicare physician fee schedule. In an HPSA, a 10% additional reimbursement will be paid. In a physician scarcity area (PSA), an additional 5% reimbursement will be paid.
<i>Physician (DO)</i>	The reimbursement rate is 100% of the Medicare physician fee schedule. In an HPSA, a 10% additional reimbursement will be paid. In a PSA, an additional 5% reimbursement will be paid.
<i>Physician (Podiatrist)</i>	The reimbursement rate is 100% of the Medicare physician fee schedule. In an HPSA, a 10% additional reimbursement will be paid. In a PSA, an additional 5% reimbursement will be paid.
<i>Physician (Chiropractor)</i>	The reimbursement rate is 100% of the Medicare physician fee schedule. In an HPSA, a 10% additional reimbursement will be paid. In a PSA, an additional 5% reimbursement will be paid.
<i>Physician (Optometrist)</i>	The reimbursement rate is 100% of the Medicare physician fee schedule. In an HPSA, a 10% additional reimbursement will be paid. In a PSA, an additional 5% reimbursement will be paid.
<i>Physician (Dentist)</i>	For services covered under the Medicare Physician Fee Schedule, reimbursement is at the Medicare Allowable Amount on the Medicare physician fee schedule. In an HPSA, a 10% additional reimbursement will be paid. In a PS, an additional 5% reimbursement will be paid. Other dental services not covered under the Medicare Physician Fee Schedule are reimbursed based on the Bravo's Dental Fee Schedule .
<i>Physician (Oral and Maxillofacial Surgeon)</i>	The reimbursement rate is 100 percent of the Medicare physician fee schedule. In an HPSA, a 10% additional reimbursement will be paid. In a PSA, an additional 5% reimbursement will be paid.
<i>Physician Assistant</i>	Reimbursement is at 85% of the Medicare Allowable Charge on the Medicare physician fee schedule.
<i>Prosthetic Devices</i>	The reimbursement rate is based on the Medicare DMEPOS fee schedule.
<i>Psychiatric Hospital: Inpatient Services</i>	The new PPS system uses a federal per diem base amount of \$651.76 in 2010 which is then adjusted for one of 17 MS-DRGs, co-morbidities, age, rural add-on, teaching add-on, outlier reimbursement, wage index, the presence of an emergency department, and ECT treatment. There is also an extra payment which tapers down during the first 21 days of an admission. Reimbursement is applicable only to Medicare-approved services.
<i>Psychiatric Hospital: Inpatient Services; Outlier Payments</i>	Outlier payments are effective after a loss of \$6,565 (adjusted for wage index, rural, teaching etc.) per stay. The loss-sharing ratio is 80% for the first 9 days, and 60% thereafter.
<i>Registered Dietitian</i>	The reimbursement rate is based on 85% of the Medicare physician fee schedule for comparable services.

Service	Reimbursement Methodology
<i>Rehab Hospital: Inpatient Services</i>	Reimbursement is subject to the PPS based on Case-Mix Group (CMG) methodology. Payment is based on discharge rates, incorporating facility-level and case-level adjustments.
<i>Rehab Hospital: Outpatient Services</i>	These services are subject to the OPSS under APC methodology. Services excluded from the OPSS are reimbursed based on their respective fee schedules.
<i>Religious Non-Medical Health Care Institutions</i>	Reimbursement is on a reasonable-cost basis.
<i>Rural Health Clinic (RHC): Independent and Provider-Based</i>	<p>These facilities are reimbursed based on 80% of the per visit payment limit plus 20% of the total charges of covered services. Effective January 1, 2010, through December 31, 2010, the Rural Health Clinics (RHC) upper payment limit per visit is \$77.76. RHCs owned by rural hospitals with less than 50 beds are paid on a cost basis, as per-visit limits do not apply. The all-inclusive method applies only to RHC services, not to other services performed at an RHC. Bravo Health requires an interim rate letter on file date span services were rendered to an PFFS enrollee. Please send via fax to the corresponding Provider Service facsimile in your area:</p> <p>Delaware, Maryland & Washington, DC: 1-800-447-0465</p> <p>Texas: San Antonio 210-340-9074 El Paso 915-577-4196 Houston 713-643-5981 Dallas 469-362-6628</p>
<i>Skilled Nursing Facilities (SNF): Independent and Provider-Based</i>	Reimbursement is according to the PPS under Related Utilization Groups (RUG) methodology. There is a 28% add-on payment for AIDS patients.
<i>Sole Community Hospital: Inpatient Services</i>	These services are subject to the PPS under DRG methodology. The PPS rate equals the greater of the federal rate or the applicable hospital-specific rate (based on cost-report data).
<i>Sole Community Hospital: Outpatient Services</i>	These services are subject to the OPSS under APC methodology. Services excluded from the OPSS are reimbursed based on their respective fee schedules.
<i>Surgical Dressings</i>	<p>Reimbursement for surgical dressings is limited to primary and secondary dressings required for the treatment of a wound caused by, or treated by, a surgical procedure. Surgical dressings required after debridement of a wound are also covered. The Medicare DMEPOS fee schedule applies to all surgical dressings, except those applied “incident to” a physician’s professional services, those furnished by an HHA, and those applied while a patient is being treated in an outpatient hospital department or in an acute care inpatient facility. Reimbursement for HHAs is bundled into the PPS under HHRG methodology. 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, and are, therefore, not separately reimbursable.</p>

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<i>Swing Beds</i>	Reimbursement is according to the Skilled Nursing Facility PPS methodology. Critical Access Hospital swing beds are exempt from SNF PPS and are paid 101% of reasonable costs.
<i>VA Hospitals</i>	VA facilities are not Medicare certified, and, therefore, are not reimbursable.
<i>X-ray</i>	Reimbursement under Part B is based on the Medicare physician fee schedule. Part A outpatient reimbursement is calculated under the OPPS. Services excluded from the OPPS are reimbursed based on the respective fee schedule.

Claims Submission

Member Services:

1-800-291-0396

Electronic Claims:

Submit via Emdeon (formerly WebMD)

Bravo Health Carrier Code: 52192

Paper Claims:

CMS-1500 or UB-04
(CMS Approved claim forms)

Mail to: Bravo Health
P.O. Box 981706
El Paso, TX 79998-1706

NOTE: Bravo Health uses Medicare processing rules.

For claims issues, please contact Member Services at **1-800-291-0396**.