Reimbursement methodology

Humana's Medicare Advantage (MA) Non-network Private Fee-for-Service (PFFS)

Humana Gold Choice® (Individual Plan)

Humana®

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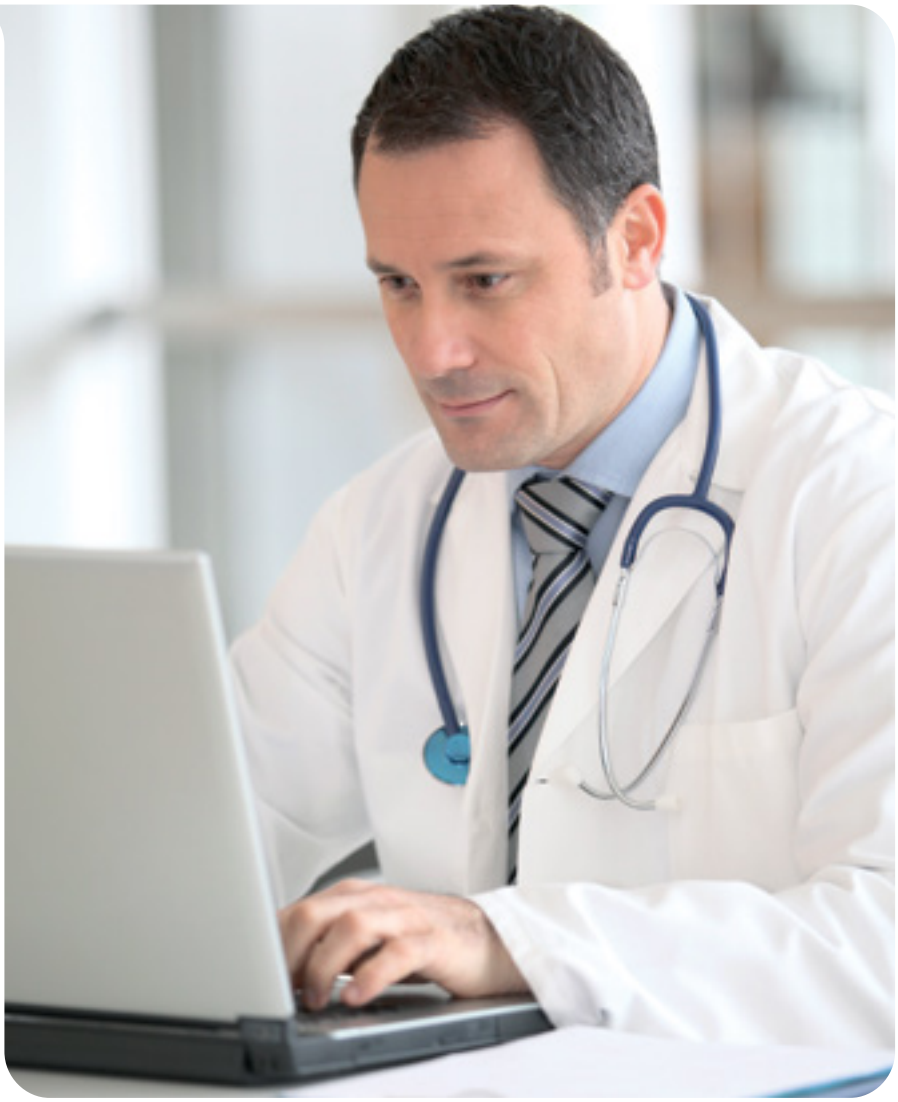
2017 reimbursement methodology

Humana's reimbursement methodology for Medicare Advantage non-network PFFS is established in accordance with prevailing federal rules and policies.

Under current Centers for Medicare & Medicaid Services (CMS) policy, Humana's MA non-network PFFS reimbursement rates listed herein apply.



Humana's MA non-network PFFS: Reimbursement methodology

The following grid pages detail Humana's MA non-network PFFS reimbursement methods for specific types of claims. Any questions related to claim reimbursement methodology should be directed to customer care at **1-800-457-4708**.

FACILITY OR SERVICE	HUMANA'S REIMBURSEMENT METHODOLOGY
Acute Care Hospital: Inpatient Services	Humana reimburses for these services using the prospective payment system (PPS), under Medicare Severity Diagnosis Related Group (MS-DRG) methodology. Reimbursement for these services includes appropriate capital and operating disproportionate share hospital (DSH), which includes both the traditional formula payment and separate uncompensated care payment, and capital indirect medical education (IME) payments. Operating IME costs, graduate medical education (GME) payments, nursing school, allied health education costs and capital exceptions are all carved out and paid through the Medicare Administrative Contractor for Parts A and B (MAC). Organ acquisitions are reimbursed, as in Medicare, on a case-by-case basis. In the event CMS adjusts reimbursement on any components within the inpatient prospective payment system (IPPS), Humana's reimbursement will be adjusted accordingly.
Acute Care Hospital: Outpatient Services	Reimbursement for these services is subject to the Medicare outpatient prospective payment system (OPPS).
Acute Long-term Care: Inpatient Services	Reimbursement for these services is subject to the Medicare long-term care hospital prospective payment system (LTCH PPS).
Acute Long-term Care: Outpatient Services	These services are reimbursed subject to the outpatient PPS under ambulatory payment classification (APC) methodology. Services excluded from OPPS are reimbursed based on their respective fee schedules.
Ambulance: Independent and Provider-based	These services are reimbursed subject to Medicare's ambulance fee schedule.
Anesthesia: Physician Performed	Reimbursement for these services is based on the Medicare anesthesia dollar conversion factor by locality, multiplied by the sum of the uniform base units, plus the time units.

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Anesthesia: Physician Medical Direction of Two or More Nurse Anesthetists Concurrently	Allowed amounts for these services are based on the Medicare anesthesia conversion factor by locality, multiplied by the sum of uniform base units, plus the time units, reduced by the application of the appropriate modifier.
Ambulatory Surgical Center (ASC)	Reimbursement for ASC services is subject to the Medicare ASC payment methodology, adjusted by the appropriate wage index.
Assistant at Surgery: Physician	The allowable charge for these services is 16 percent of the 85 percent of the Medicare fee schedule amount for the global surgery, not to exceed 13.6 percent of the global amount.
Assistant at Surgery: Physician Assistant	The allowable charge for these services is determined as 16 percent of 65 percent of the Medicare fee schedule amount for the global surgery, not to exceed 10.4 percent of the global amount.
Blood	Reimbursement for blood is according to the Outpatient Prospective Payment System (OPPS) for hospital outpatient services.
Braces	Reimbursement is based on the Medicare durable medical equipment, prosthetic, orthotic and supplies (DMEPOS) fee schedules.
Cancer Hospital: Inpatient Services	These services are exempt from the Intpatient Prospective Payment System (IPPS). 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.
Cancer Hospital: Outpatient Services	Reimbursements for these services are subject to the OPPS, under APC methodology. Services excluded from the OPPS are reimbursed based on those services' respective fee schedules.
Certified Registered Nurse Anesthetist (CRNA)	Reimbursement for these services is based on the Medicare anesthesia dollar conversion factor by locality, multiplied by the sum of uniform base units, plus the time units, reduced by the application of the appropriate modifier. CRNAs should forward a copy of their license and CRNA certificate with their initial claim if billing independently for services.
Chemical Dependency: Inpatient	Reimbursement for these services is subject to the IPPS and is calculated based on MS-DRGs.

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Children's Hospital: Inpatient Services	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.
Children's Hospital: Outpatient Services	Reimbursements for these services are subject to the OPPS, under APC methodology. Services excluded from OPPS are reimbursed based on those services' respective fee schedules.
Clinical Nurse Specialist	Reimbursement is based on 85 percent of the Medicare physician fee schedule for comparable services.
Clinical Psychologist	Reimbursement is based on 100 percent of the Medicare physician fee schedule for comparable services.
Clinical Social Worker	Reimbursement is based on 75 percent of the Medicare physician fee schedule for comparable services.
Community Mental Health Center	Reimbursement for these services is under the OPPS and paid on a per-unit (or per diem) basis.
Comprehensive Outpatient Rehabilitation Facility (CORF)	Reimbursement is based on the Medicare physician fee schedule.
Co-surgeons	Each co-surgeon is reimbursed at 62.5 percent of the global surgery under the Medicare physician fee schedule.
Co-surgeons Team Surgery	Team surgery is reimbursed "by report."
Critical Access Hospital (CAH)	CAHs will be paid at 101 percent of costs. Outpatient professional services are paid based on the Medicare physician fee schedules. If CAHs bill for physician fee-schedule services, then they are paid at 115 percent of that fee schedule. CAHs are exempt from OPPS and the lab fee schedule. **Upon receipt, CAHs should submit a copy of their Medicare Administrative Contractor for Parts A and B (MAC) interim rate letter to their Humana provider relations contact.**
Diabetic Shoes	Reimbursement is based on the Medicare DMEPOS fee schedule.

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Drugs (Part B)	Reimbursement only applies to Medicare-approved services. The allowed amount is the lesser of the billed charges or 106 percent of the average sales price (ASP) calculated from data submitted to CMS from drug companies. Exceptions include blood, drugs delivered through durable medical equipment (DME), influenza, pneumococcal and hepatitis B vaccines and certain new drugs, which are still paid based on 95 percent average wholesale price.
Durable Medical Equipment	These services are reimbursed based on the Medicare DMEPOS fee schedule.
End-stage Renal Disease (ESRD) Facility	ESRD facilities will be paid 100 percent of the new bundled ESRD Prospective Payment System (ESRD PPS). The bundled payment includes all renal dialysis services furnished for outpatient maintenance dialysis, including ESRD-related drugs and biological and other ESRD-related items and services that formerly were separately payable under the previous payment methodologies. The bundled payment rate is adjusted for a number of factors relating to patient characteristics, such as complicating conditions that affect the cost of treatment. There are additional adjustments for ESRD facilities related to other factors.
Federally Qualified Health Center (FQHC): Independent and Provider-based	Reimbursement for these services is subject to Medicare's FQHC Prospective Payment System. The FQHC PPS payment rate is based on the national average cost per encounter for all FQHCs and is adjusted annually by the Medicare Economic Index (MEI). This rate may vary per FQHC based on the FQHC Geographic Adjustment Factor (FQHC GAF) and per the type of service provided.
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 home health resource groups (HHRGs) methodology. Providers are reimbursed per 60-day episode of care via submission of a request for anticipated payment (RAP) and the subsequent 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 DMEPOS fee schedule.

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Home Infusion	Reimbursement is based on the DMEPOS fee schedule for applicable services. Pumps are covered only when used for administration of specific drugs for specific diagnoses.
Hospital Outlier: Inpatient Services (Acute Care)	Humana's non-network PFFS plans pay outliers for inpatient services, based on Medicare reimbursement methodology for outlier calculations.
Hospital Outlier: Outpatient Services (Acute Care)	Humana's non-network PFFS plans pay outliers for outpatient services, based on Medicare reimbursement methodology for outlier calculations.
Hospital Transfer: Acute to Acute	The full MS-DRG amount is paid to the final discharging hospital, and each transferring hospital is paid a per diem rate. The per diem rate is the full MS-DRG amount that would have been paid in a nontransfer situation, divided by the geometric mean length of stay for the MS-DRG. Reimbursement is calculated as twice the per diem for the first day, plus the per diem for each following day, up to the transfer or the full MS-DRG amount.
Hospital Transfer: Acute to Post-acute	A qualified discharge from a CMS-specified MS-DRG 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 MS-DRG amount that would have been paid in a nontransfer situation, divided by the geometric mean length of stay for the MS-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 MS-DRG amount. Some CMS specified transfer MS-DRGs are paid under a methodology where 50 percent of the MS-DRG, plus the per diem, is paid on the first day of the stay. For each subsequent day, 50 percent of the per diem is paid up to the full MS-DRG amount.
Immunosuppressive Drugs, Transplant	Reimbursement is based on the fee schedule obtained from the state carrier. Reimbursement is subject to the OPPS if the beneficiary is in the outpatient department of a Medicare participating hospital. In all other settings, subject to limits, the payment is 106 percent of the average sales price.
Indian Health Service (IHS) Facility: Inpatient Services	These services are subject to the PPS, under MS-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.
Indian Health Service (IHS) Facility: Outpatient Services	Reimbursement is excluded from the OPPS and is at an all-inclusive rate. Outpatient professional services are reimbursed based on those services' respective fee schedules.

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Injections	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 any office visit that occurs on that date of service. Reimbursement is based on the applicable fee schedule.
Laboratory	The reimbursement rate is 100 percent of the Medicare laboratory fee schedule.
Mammography Screening	The reimbursement rate is 100 percent of the Medicare physician fee schedule.
Maryland Hospitals	The reimbursement is 94 percent of the approved charges for inpatient and outpatient services.
Medical Nutrition Therapy	The reimbursement rate is 85 percent of the Medicare physician fee schedule.
Medicare Dependent Hospital: Inpatient Services	These services are reimbursed subject to the PPS, under MS-DRG methodology. In the event CMS adjusts reimbursement on any components within the IPPS, Humana's reimbursement will be adjusted accordingly. 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, when appropriate. 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 will be paid a percentage of the difference.
Medicare Dependent Hospital: Outpatient Services	These services are reimbursed subject to the OPPS, under APC methodology. Services excluded from OPPS are reimbursed based on those services' respective fee schedules.
Nurse Practitioner	The reimbursement rate is 85 percent of the Medicare physician fee schedule.
Oral Anti-cancer Drugs	These services are reimbursed using the appropriate national fee schedule.
Oral Anti-nausea Drugs	These services are reimbursed using the appropriate national fee schedule.
Parenteral and Enteral Nutrition (PEN)	Reimbursement is based on the PEN fee schedule.
Physical Therapy/Occupational Therapy/Speech Therapy	The reimbursement rate is 100 percent of the Medicare physician fee schedule.

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Physician (Doctor of Medicine)	The reimbursement rate is 100 percent of the Medicare physician fee schedule.
Physician (Doctor of Osteopathy)	The reimbursement rate is 100 percent of the Medicare physician fee schedule.
Physician (Podiatrist)	The reimbursement rate is 100 percent of the Medicare physician fee schedule.
Physician (Chiropractor)	The reimbursement rate is 100 percent of the Medicare physician fee schedule for covered services.
Physician (Optometrist)	The reimbursement rate is 100 percent of the Medicare physician fee schedule.
Physician (Dentist)	The reimbursement rate is 100 percent of the Medicare physician fee schedule for covered services.
Physician (Oral and Maxillofacial Surgeon)	The reimbursement rate is 100 percent of the Medicare physician fee schedule.
Physician Assistant	The reimbursement rate is 85 percent of the Medicare physician fee schedule.
Prosthetic Devices	The reimbursement rate is based on the Medicare DMEPOS fee schedule.
Psychiatric Hospital: Inpatient Services	Reimbursements for these services are subject to the inpatient psychiatric facility prospective payment system (IPF PPS).
Psychiatric Hospital: Outpatient Services	These services are subject to the OPPS, under APC methodology. Services excluded from the OPPS are reimbursed based on those services' respective fee schedules.
Registered Dietitian	The reimbursement rate is based on 85 percent of the Medicare physician fee schedule for comparable services.
Rehabilitation Hospital: Inpatient Services	Reimbursement is 100 percent of the inpatient rehabilitation facility (IRF) PPS, based on case mix group (CMG) methodology. Payment is based on discharge rates, incorporating facility-level and case-level adjustments.

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Rehab Hospital: Outpatient Services	These services are subject to the OPPS, under APC methodology. Services excluded from the OPPS are reimbursed based on those services' fee schedules.
Religious Nonmedical Health Care Institutions	Reimbursement is on a reasonable cost basis.
Rural Health Clinic (RHC): Independent and Provider-based	These centers are reimbursed based upon 80 percent of the lesser of their all-inclusive rate or the national per-visit limit, plus 20 percent of the total charges for covered services, minus the plan's copay. RHCs owned by rural hospitals with fewer than 50 beds are not subject to the national per-visit limit. **Upon receipt, RHCs should forward a copy of their Medicare Administrative Contractor for Parts A and B (MAC) interim rate letter to their Humana provider relations representative.**
Skilled Nursing Facility: Independent and Provider-based	Reimbursement is subject to the PPS, under resource utilization groups (RUG) methodology.
Sole Community Hospital: Inpatient Services	These services are reimbursed subject to the PPS, under the MS-DRG methodology. The PPS rate equals the greater of the federal rate or the applicable hospital-specific rate (based upon cost report data).
Sole Community Hospital: Outpatient Services	These services are subject to the OPPS, under APC methodology.
Surgical Dressings	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 a home health agency (HHA) and those applied while a patient is being treated in an outpatient hospital department or as an acute-care inpatient. Reimbursement for HHAs is bundled into the PPS, under the home health resource group (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 therefore, are not separately reimbursable.

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Swing Bed	Swing bed reimbursement is based on the skilled nursing facility (SNF) PPS. CAH swing beds are exempt from skilled nursing facility PPS and are paid at 101 percent of reasonable costs.
X-ray	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 services' respective fee schedule.