Chapter 5. Reimbursement

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5.1 Physicians and Other Professional Providers

5.1.1 RBRVS Fee Schedule

Methodology

Highmark West Virginia currently uses a Resource Based Relative Value Scale (“RBRVS”) fee schedule to reimburse physicians and other professional providers. The schedule is generally based on the Centers for Medicare and Medicaid Services (“CMS”) fee schedule. RBRVS determines relative values for various procedures and services by computing the total work, practice expense and malpractice cost involved in performing each procedure or service. RBRVS establishes a consistent method of establishing the fee for each procedure code relative to other codes.

In establishing our RBRVS allowances, Highmark West Virginia generally uses the current year’s CMS Relative Value Units (“RVUs”), including the non-facility and facility practice expense RVUs (i.e. Site of Service). Effective July 1, 2009 the CMS WV Geographic practice cost indices (GPCI) is used to calculate the allowances for PPO, POS and Traditional business. For clinical laboratory services, we use the CMS RVUs or Ingenix, Inc. RVUs where CMS has not established an RVU. The WV GPCI will not be used to calculate allowances for clinical laboratory services. Effective, July 1, 2010, Highmark West Virginia will continue to use the 2009 CMS RVUs in the calculation of its fee schedules. If CMS does not have established RVUs, Highmark West Virginia may use 2008 INGENIX RVUs and the budget neutral factor to establish the allowance.

Highmark West Virginia currently establishes distinct market conversion factors for specific codes in the CPT and HCPCS codebooks. The conversion factors differ by product (i.e. Traditional, PPO and POS). The West Virginia Small Business Plan uses the West Virginia Public Employees Insurance Agency fee schedules. The FreedomBlue® Medicare Advantage products use the Medicare fee schedule and clinical laboratory fee schedule.

In addition to CPT codes, Highmark West Virginia reimburses a number of HCPCS codes under the RBRVS fee schedule. The listing found on Highmark West Virginia’s website, [www.highmarkbebswv.com](http://www.highmarkbebswv.com), on the Provider tab under “News & Bulletins” identifies: (1) those CPT codes that are paid under a conversion factor different from how the code is categorized in the CPT Codebook; and (2) those HCPCS codes paid under the RBRVS fee schedule. This listing may change each year as codes are updated.

To estimate the Highmark West Virginia reimbursement allowance for a particular service, see the example below:
2009 Non-Facility Pricing Amount =

\[
[(\text{Work RVU} \times \text{Work GPCI}) + (\text{Transitioned Non-Facility PE RVU} \times \text{PE GPCI}) + (\text{MP RVU} \times \text{MP GPCI})] \times \text{Conversion Factor (CF)}
\]

2009 Facility Pricing Amount =

\[
[(\text{Work RVU} \times \text{Work GPCI}) + (\text{Transitioned Facility PE RVU} \times \text{PE GPCI}) + (\text{MP RVU} \times \text{MP GPCI})] \times \text{Conversion Factor}
\]

Note: Laboratory service does not include WVGPCIs.

Actual reimbursement for a covered service will be calculated as the lesser of the reimbursement allowance or the provider’s charge, minus the member’s contribution (deductible, coinsurance, or copay). Multiple other factors such as, but not limited to, the member’s specific coverage, member eligibility, coordination of benefits, medical policy, multiple procedure reductions, consistency with billing guidelines and timeliness of claim filing may affect the amount of reimbursement ultimately paid.

The Highmark West Virginia RBRVS allowances are the same for all types of professional providers who furnish services reimbursed under the RBRVS fee schedule. In other words, we do not have different market conversion factors or RVUs for physician and non-physician providers.

Steel Schedule

Highmark West Virginia has established a distinct RBRVS fee schedule for certain steel company groups in the Upper Ohio Valley of West Virginia and Ohio. This schedule uses the CMS RVUs and WV GPCIs but has its own conversion factors. These “steel” conversion factors are the same regardless of the type of product (Traditional, PPO, POS) a steel group member may have. The “steel” schedule is applicable to professional providers located in a nine-county geographic area.

5.1.2 Immunizations, Drugs, Injectables, Biologicals, Chemotherapy Agents

Allowances for these services are established as a percentage of Average Wholesale Price (“AWP”). Highmark West Virginia updates AWP monthly, based on changes in market prices.

For MDs and DOs, see Chapter 13 for more information regarding immunizations and vaccines.
5.1.3 Specialty Drugs

Taking steps to control the expensive cost of specialty drugs is one way that providers and Highmark West Virginia can work to make quality, affordable care available to members. In 2005, Highmark West Virginia initiated a cost containment program for specialty drugs consistent with our network provider agreements.

Preferred Purchasing Arrangement With Walgreens

Highmark West Virginia has contracted with Walgreens (formerly “Medmark”) to be the preferred provider of select specialty drugs for Highmark West Virginia members. Walgreens is a full service specialty pharmacy committed to supporting the needs of individuals affected by special conditions and therapies to include, but not limited to the following:

- Crohn’s Disease
- Endocrine Disorders
- Endometriosis
- Fertility
- Gaucher’s Disease
- Growth Hormone Deficiency
- Hemophilia
- Immune Disorders
- Macular Degeneration
- Movement Disorders
- Multiple Sclerosis
- Oncology
- Osteoarthritis
- Pulmonary Disorders
- Respiratory Syncytial Virus
- Rheumatoid Arthritis

Use of the specialty drug program is required for all Highmark West Virginia lines of business, including Traditional Indemnity, PPO and POS as well as BlueCard/ITS. It is not required for the Federal Employee Program. However, you may still elect to utilize it for these products for administrative convenience and cost savings for the member.

Under the program, a network provider must order designated specialty drugs through Walgreens for any prescription being delivered to the provider’s office or directly to the member. Walgreens will bill Highmark West Virginia directly for the drug. If a provider bills Highmark West Virginia, the claim will be denied and the member will be held harmless.

Purchase of certain specialty drugs through Walgreens is optional but not required. This option includes a number of oral oncology medications covered under our prescription drug benefit. Your use of Walgreens will help reduce costs for the member and group and provide the member access to additional clinical support.

A complete and current listing of the designated drugs covered by the program is published on the Highmark West Virginia website at [www.highmarkbcbswv.com](http://www.highmarkbcbswv.com) on the Provider tab under “Working with Highmark West Virginia.” You may also obtain the list by contacting your External Provider Relations Representative or the Office of Provider Relations at 1-800-798-7768.
How the Program Works

The following is an outline of how the program works and what services it offers:

- A Specialty Drug Authorization Form has been developed to streamline the process for ordering certain specialty drugs under the member’s medical benefit. A separate form has been developed for ordering oral oncology medications. These forms can be downloaded and printed from the Provider Forms section under the “Resource Center” on the Highmark West Virginia website, at [www.highmarkbcbswv.com](http://www.highmarkbcbswv.com).

- When completed in its entirety, the order form serves as both a legal prescription and a means to obtain preauthorization, if required. The preferred specialty drug program does not change Highmark West Virginia’s medical management policies concerning which drugs require preauthorization. For a complete list of drugs requiring preauthorization, please visit [www.highmarkbcbswv.com](http://www.highmarkbcbswv.com), click the Provider tab and select “Resource Center.”

- The provider completes the Specialty Drug Authorization Form and faxes it to Walgreens at 1-877-231-8302. A separate form should be used for each drug.

- Based on the prescription order, Walgreens provides the drug to the provider’s office or to the member. Walgreens offers express delivery and has registered nurses and clinical pharmacists available toll-free 24 hours a day, 7 days a week to answer providers’ and members’ questions. Walgreens can be reached at 1-888-347-3416.

- Walgreens will invoice Highmark West Virginia directly for the drug.

- The provider may bill Highmark West Virginia for any applicable office visit and drug administration services.

Highmark West Virginia continually reviews the specialty drug program and may include additional drugs on either a required or voluntary basis. Notice of any additions or changes will be furnished to providers through the Provider News or by special mailing.

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5.1.4 Anesthesia Services

**Reimbursement**

Reimbursement for anesthesia services is a base unit value and time unit calculation. Base units for anesthesia codes are derived from the American Society of Anesthesiology Guide. The base and time units are multiplied by the applicable Highmark West Virginia conversion factor to determine the maximum allowance.
Medical Policies

Highmark West Virginia Medical Policies referenced in this Section 5.1.4 may be accessed on its website, www.highmarkbcbswv.com. Click the Provider tab, then “Working with Highmark West Virginia.” Please note the different links for Highmark West Virginia Medical Policies, Medicare Advantage Medical Policies and Medicare Advantage Gap Fill Medical Policies.

Anesthesia Procedure Codes

When billing anesthesia services, please use the anesthesia procedure codes (00100-01999) and appropriate modifiers to report the administration of anesthesia.

If you report a “not otherwise specified” or “not otherwise classified” anesthesia service, include a complete description of the services performed. Highmark West Virginia cannot accept the terminology of an anesthesia procedure code as a description of the service or surgery performed. You must describe the actual service or surgery being performed, or advise of the related surgical code; otherwise, your claim may be rejected.

Here are some examples of how to report “not otherwise specified” or “not otherwise classified” anesthesia services:

Electronic billers: You must report narratives (complete description of the services performed) in the appropriate NOC narrative field of the electronic format you are utilizing.

Time Units

Anesthesia time begins when the anesthesiologist begins to prepare the patient for the induction of anesthesia in the operating room (or in an equivalent area) and ends when the anesthesiologist is no longer in personal attendance, that is, when the patient may be safely placed under postoperative supervision. (Note: this comes directly from the
anesthesia guidelines in the CPT manual). You must document this time in the anesthesia record.

Anesthesia services not requiring time reporting are reimbursed under the applicable RBRVS fee schedule.

**Report total anesthesia time as minutes, not start and stop time:** Highmark West Virginia will convert total minutes to time units. Highmark West Virginia determines the time units on the basis of one time unit for each 15 minute segment.

**Electronic billers:** Report minutes.

**Paper billers:** Report total anesthesia time as minutes in block 24G on the CMS-1500 claim form.

**Modifiers**

Please report the appropriate anesthesia modifier to denote whether the service was personally performed, medically directed or medically supervised:

- **AA:** Anesthesia services performed personally by anesthesiologist;
- **AD:** Medical supervision by a physician: more than four concurrent anesthesia procedures;
- **G8:** Monitored anesthesia care (MAC) for deep complex, complicated, or markedly invasive surgical procedures;
- **G9:** Monitored anesthesia care for patient who has a history of severe cardiopulmonary condition;
- **QK:** Medical direction of two, three or four concurrent anesthesia procedures involving qualified individuals;
- **QS:** Monitored anesthesia care service;
- **QX:** CRNA service; with medical direction by a physician;
- **QY:** Medical direction of one certified registered nurse anesthetist (CRNA) by an anesthesiologist;
- **QZ:** CRNA service without medical direction by a physician.

**Qualifying Circumstances**

+99100 – Anesthesia for patient of extreme age, younger than 1 year and older than 70.
+99116 – Anesthesia complicated by utilization of total body hypothermia.
+99135 – Anesthesia complicated by utilization of controlled hypotension.
+99140 – Anesthesia complicated by emergency conditions (specify).

Qualifying circumstances CPT codes 99100-99140 represent the provision of anesthesia services under particularly difficult circumstances that necessitate the skills of a
physician beyond those usually required. These procedures would not be reported alone, but would be reported as additional procedure codes to qualify an anesthesia procedure or service.

You must report the appropriate qualifying circumstances code in addition to the anesthesia CPT code on the same claim. **Do not report units. (This applies to both paper and electronically billed claims.)** You must also report the applicable anesthesia modifier with the qualifying circumstance code.

**Exception:** You can report physical status modifier with the applicable anesthesia CPT code. (00100-01999):

<table>
<thead>
<tr>
<th>Physical Status Modifier</th>
<th>Description</th>
<th>Modifying Units</th>
</tr>
</thead>
<tbody>
<tr>
<td>P1</td>
<td>A normal healthy patient (Physical status 1)</td>
<td>0</td>
</tr>
<tr>
<td>P2</td>
<td>A patient with mild systemic disease (Physical status 2)</td>
<td>0</td>
</tr>
<tr>
<td>P3</td>
<td>A patient with severe systemic disease (Physical status 3)</td>
<td>1</td>
</tr>
<tr>
<td>P4</td>
<td>A patient with severe systemic disease that is a constant threat to life (Physical status 4)</td>
<td>2</td>
</tr>
<tr>
<td>P5</td>
<td>A moribund patient who is not expected to survive without the operation (Physical status 5)</td>
<td>3</td>
</tr>
<tr>
<td>P6</td>
<td>A declared brain-dead patient whose organs are being removed for donor purposes (Physical status 6)</td>
<td>0</td>
</tr>
</tbody>
</table>

The modifying units listed above are subject to change according to the Relative Value Guide established by the American Society of Anesthesiologists (ASA) and approval of Highmark West Virginia.

**Anesthesia Related to Obstetrical Care**

This may include any of the following procedures:
- 01960: anesthesia for vaginal delivery only
- 01961: anesthesia for cesarean delivery only
- 01962: anesthesia for urgent hysterectomy following delivery
- 01967: neuraxial labor analgesia/anesthesia for planned vaginal delivery (this includes any repeat subarachnoid needle placement and drug injection and/or any necessary replacement of an epidural catheter during labor)
• +01968: anesthesia for cesarean delivery following neuraxial labor analgesia/anesthesia
• +01969: anesthesia for cesarean hysterectomy following neuraxial labor analgesia/anesthesia

01968 and 01969 are add-on codes and they cannot be billed as a primary procedure. Code 01967 should be reported for epidural anesthesia care provided either: (1) during labor only; or (2) during labor and vaginal delivery. Total time reported should reflect actual time in personal attendance with the patient. Payment for code 01967 will be based on the appropriate number of base units (BU) and total time units (TU) in attendance with the patient, either during labor only or during labor with vaginal delivery.

When procedure code 01967 is reported in conjunction with either 01968 or 01969, the base units and time units for each code should be reimbursed. Time units reported should reflect actual time in personal attendance. **Payment for continuous epidurals will be reimbursed up to a maximum of 15 time units for 01967, 01960, 01961 and for the combined time billed with 01967 and 01968. (A maximum of eight time units will apply to the West Virginia Small Business Plan.)**

Refer to Medical Policy A-5.

**Medical Direction of an Employed CRNA**

Services performed by an employed CRNA require medical direction or personal supervision by the physician. The physician must be immediately available within the operating suite or within the immediate vicinity to assume primary care of the patient if needed.

When reporting medical direction of a CRNA employee, submit one claim with two separate lines for the anesthesiologist and CRNA services. Use the appropriate modifiers that identify the anesthesiologist and CRNA, as well as physical status or qualifying circumstances, if applicable.

Payment for the anesthesiologist who employs the CRNA will be 60% of the allowed amount and payment for the CRNA will be 40%. (Exception: Medicare Advantage products will be reimbursed at a 50/50 split.) Payment is calculated with the conversion factor multiplied by the total number of allowed units. **Do not include the CRNA’s name or provider number on the claim.**

Here is an example of correct reporting on a paper claim:
Medical Direction of a Non-Employed CRNA

When reporting medical direction of a non-employed CRNA, submit one line item and use the appropriate modifiers, as well as physical status, if applicable.

Services will be reimbursed at 100% of the allowed amount when personally performed by the physician or CRNA without medical direction by an anesthesiologist.

Anesthesia Administered by the Operating Surgeon

Modifier 47 is appropriate to use when general or regional anesthesia has been administered by the operating surgeon. When anesthesia is reported by the operating surgeon, assistant surgeon, or attending professional provider, it is not covered. Anesthesia administered for covered services is eligible for reimbursement when ordered by the attending professional provider other than the operating surgeon, assistant surgeon, or attending professional provider.

Moderate Sedation

When moderate sedation has been administered by the physician, codes 99143-99150, as appropriate, should be reported.

Report the AA modifier and the actual number of minutes when billing moderate sedation codes 99143, 99144, 99148, and 99149. Report AA modifier and actual number of minutes when billing 99145 and 99150 until December 31, 2008.

Effective January 1, 2009, when billing the add-on moderate sedation codes, report the actual units on the claim. One unit equals each additional 15 minutes. Report in Box 24G on the CMS 1500. This applies to the following codes:

+99145 Moderate sedation services (other than those described by codes 00100-01999) provided by the same physician performing the diagnostic or therapeutic service that the
sedation supports, requiring the presence of an independent trained observer to assist in the monitoring of the patient’s level of consciousness and physiological status; each additional 15 minutes intra-service time (List separately in addition to code for primary service)

+99150 Moderate sedation services (other than those described by codes 00100-01999), provided by a physician other than the health care professional performing the diagnostic or therapeutic service that the sedation supports; each additional 15 minutes intra-service time (List separately in addition to code for primary procedure).

Effective April 17, 2010, when using procedure codes 99143-99145 or 99148-99150, providers must report units, not minutes, for these codes. Please reference the “News & Bulletins” section found on the Provider tab on the Highmark West Virginia website (www.highmarkbcbswv.com). Refer to Medical Policies A-2 and A-17.

Anesthesia Administered For A Noncovered Surgical Procedure

When a claim is received for anesthesia services which are provided in conjunction with a noncovered surgical procedure (i.e. cosmetic, not medically necessary), the physician’s charge for the anesthesia service is not covered. Anesthesia services are reimbursable only if performed in conjunction with a covered surgical procedure.

Refer to Medical Policy A-1.

The Medical Policies referenced in this Section 5.1.4 are Highmark West Virginia policy numbers. When treating Medicare Advantage members, please refer to the Medicare Advantage or Medicare Advantage Gap Fill policies. It is important to submit your claims as outlined in this section to avoid unnecessary rejection or delay of processing.

If you have questions, please contact the Office of Provider Relations at 1-800-798-7768 or your External Provider Relations Representative.

5.1.5 Availability of Fees

Network professional providers may request Highmark West Virginia’s maximum allowable fees for up to 100 codes two times per year. Please contact your External Provider Relations Representative or call the Office of Provider Relations at 1-800-798-7768.

Network providers can access all of Highmark West Virginia’s fees for different products, via NaviNet®. This information is available by: (1) individual procedure code; and (2) most frequently billed codes by specialty.
For more information, please see the section on NaviNetSM in Chapter 1 of this Provider Manual or contact the Office of Provider Relations at the number listed above. For MDs and DOs, see Chapter 13 of this Provider Manual for more information.

5.1.6 Reviews and Updates

Generally, codes and RVUs are updated bi-annually in January and July, and allowances are reviewed annually. Updates may be delayed if CMS delays publication of final RVUs or makes further changes after publication. The RVRBS fee schedule conversion factor table and recent updates in the Provider News reflect the most current reimbursement updates. Highmark West Virginia’s RVRBS fee schedule conversions are available on the website at www.highmarkbcbswv.com.

5.2 Facilities and Organizational Providers

5.2.1 Summary of Reimbursement Methodologies

The reimbursement methodologies for the various facility and organizational providers with which Highmark West Virginia contracts are summarized below. Payment methods for Medicare Advantage are listed separately from other commercial products (e.g. indemnity, PPO, POS, WVSBP).

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Reimbursement Methods for Indemnity, PPO, POS, WVSBP</th>
<th>Reimbursement Methods for Medicare Advantage</th>
<th>Commercial Billing Form</th>
<th>Medicare Advantage Billing Form</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospitals</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Acute</td>
<td>Inpatient: DRG, Per Diem, Percent of Charge</td>
<td>DRG, Percent of Charge</td>
<td>UB</td>
<td>UB</td>
</tr>
<tr>
<td></td>
<td>Outpatient: Percent of Charge, OPPS</td>
<td>Percent of Charge, OPPS</td>
<td>UB</td>
<td>UB</td>
</tr>
<tr>
<td>Critical Access</td>
<td>Inpatient: DRG, Per Diem, Percent of Charge</td>
<td>Per Diem</td>
<td>UB</td>
<td>UB</td>
</tr>
<tr>
<td></td>
<td>Outpatient: Percent of Charge</td>
<td>Percent of Charge</td>
<td>UB</td>
<td>UB</td>
</tr>
<tr>
<td>Swing Bed</td>
<td></td>
<td>Per Diem</td>
<td>UB</td>
<td>UB</td>
</tr>
<tr>
<td>Skilled Nursing</td>
<td></td>
<td>UB</td>
<td>UB</td>
<td>UB</td>
</tr>
<tr>
<td>Rural Health Clinic</td>
<td>Fee Schedule</td>
<td>Cost to Charge Ratio</td>
<td>CMS 1500</td>
<td>UB</td>
</tr>
<tr>
<td>Long Term Care</td>
<td></td>
<td>Per Diem</td>
<td>UB</td>
<td>UB</td>
</tr>
<tr>
<td>Rehab-Physical</td>
<td>Inpatient: Per Diem, Percent of Charge</td>
<td>Per Diem</td>
<td>UB</td>
<td>UB</td>
</tr>
<tr>
<td></td>
<td>Outpatient: Percent of Charge</td>
<td>Percent of Charge</td>
<td>UB</td>
<td>UB</td>
</tr>
<tr>
<td>Behavioral Health</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Provider Type</td>
<td>Reimbursement Methods for Indemnity, PPO, POS, WVSBP</td>
<td>Reimbursement Methods for Medicare Advantage</td>
<td>Commercial Billing Form</td>
<td>Medicare Advantage Billing Form</td>
</tr>
<tr>
<td>-----------------------</td>
<td>-----------------------------------------------------</td>
<td>---------------------------------------------</td>
<td>-------------------------</td>
<td>--------------------------------</td>
</tr>
<tr>
<td>Inpatient</td>
<td>Per Diem, Percent of Charge</td>
<td>Per Diem</td>
<td>UB</td>
<td>UB</td>
</tr>
<tr>
<td>Outpatient</td>
<td>Per Diem, Percent of Charge</td>
<td>Percent of Charge</td>
<td>UB</td>
<td>UB</td>
</tr>
</tbody>
</table>

**Ancillary Providers**

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Reimbursement Methods for Medicare Advantage</th>
<th>Commercial Billing Form</th>
<th>Medicare Advantage Billing Form</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ambulance – Ground</td>
<td>Based on Medicare Fee Schedule</td>
<td>UB</td>
<td>UB</td>
</tr>
<tr>
<td>Ambulatory Surgery Center</td>
<td>Percent of Medicare Fee Schedule</td>
<td>CMS 1500</td>
<td>CMS 1500</td>
</tr>
<tr>
<td>Durable Medical Equipment (A, E, K, L, Q Codes)</td>
<td>Percent of WV DMERC/POS Fee Schedule</td>
<td>CMS 1500</td>
<td>CMS 1500</td>
</tr>
<tr>
<td>Federally Qualified Health Centers</td>
<td>Fee schedule</td>
<td>Cost to Charge Ratio</td>
<td>CMS 1500</td>
</tr>
<tr>
<td>Hearing Aid Facility</td>
<td>Percent of Charges up to a Maximum Member Benefit</td>
<td>CMS 1500</td>
<td>UB</td>
</tr>
<tr>
<td>Home Health Agency</td>
<td>Per Visit, Percent of Charge</td>
<td>UB</td>
<td>CMS 1500</td>
</tr>
<tr>
<td>Home Infusion Therapy</td>
<td>Fee Schedule for Per Diem Services, Percent of WVP for drugs</td>
<td>CMS 1500</td>
<td>CMS 1500</td>
</tr>
<tr>
<td>Hospice</td>
<td>Per Diem, Percent of Charge</td>
<td>Not covered</td>
<td>UB</td>
</tr>
<tr>
<td>Renal Dialysis</td>
<td>Percent of Charge, Per Treatment</td>
<td>Per Treatment</td>
<td>UB</td>
</tr>
<tr>
<td>Rural Health Clinic</td>
<td>Fee schedule</td>
<td>Cost to Charge Ratio</td>
<td>CMS 1500</td>
</tr>
<tr>
<td>Skilled Nursing Facility</td>
<td>Inpatient Per Diem, Percent of Charge</td>
<td>UB</td>
<td>UB</td>
</tr>
<tr>
<td></td>
<td>Outpatient Per Diem, Percent of Charge</td>
<td>UB</td>
<td>UB</td>
</tr>
</tbody>
</table>

In some cases, the provider agreement itself includes the detailed components of the pricing methodology as well as the actual payment rates. If you have any questions about the reimbursement method or amount for a particular Highmark West Virginia product, please contact your External Provider Relations Representative.

### 5.2.2 Reviews and Updates

Facilities and Organizational Provider allowances are updated in accordance with provider specific agreements.

### 5.3 Outpatient Prospective Payment System

Highmark West Virginia uses an Outpatient Prospective Payment System ("OPPS") methodology to reimburse hospital outpatient services modeled after the system used by traditional Medicare for three products. These products are: (1) the FreedomBlue® Medicare Advantage PPO, reimbursement at traditional Medicare rates; (2) the West Virginia Small Business Plan (for West Virginia providers only), reimbursement at the West Virginia Public Employees Insurance Agency’s rates, as authorized by the statute.
governing the WVSBP and (3) Highmark West Virginia Commercial products, reimbursement methodology is based on the current Medicare Hospital Outpatient Prospective Payment System (OPPS) Payment Methodology (“Medicare Methodology”); and all applicable Medicare guidelines and policies, inclusive of any current updates implemented by CMS to be applied once reviewed by Highmark West Virginia. Payment rates will be in accordance with the Hospital Agreement and applicable Medicare-based OPPS Pricer as published quarterly by the Centers for Medicare and Medicaid Services (“CMS”) and such updates as applicable by Highmark West Virginia. All updates are implemented prospectively and retroactive adjustments are not applied. For more information regarding the Highmark West Virginia Methodology, please see the Hospital OPPS Guides which provide more detailed information. These Guides are available on the Highmark West Virginia website at www.highmarkbcbswv.com under the Provider tab under “News & Bulletins.”

Outpatient claims should be submitted on a UB form following traditional Medicare guidelines for billing.

To facilitate prompt payment, Highmark West Virginia has eliminated some traditional Medicare Outpatient Code Editor (OCE) edits to benefit the provider. For example, the Highmark West Virginia claims system will reject individual line items that hit edits requiring additional information, where traditional Medicare would reject the entire claim and return it to the provider for recoding and resubmission. In addition, Highmark West Virginia has turned off OCE edit 18, the “inpatient procedure only” edit. If the procedure is a covered benefit for the member as an outpatient service, then Highmark West Virginia will reimburse using the pricing formula outlined in the Guides applicable to the product.

For additional information about the OPPS payment methodology, please contact your External Provider Relations Representative.

5.4 Present on Admission

Present on Admission Submission for All Inpatient Acute-Care Hospitals, including Critical Access Hospitals Effective January 1, 2010

Effective January 1, 2010 MSBCBS will require the submission of Present on Admission (POA) information on inpatient claims for all hospital providers. In the summer 2008 Provider News, MSBCBS informed acute-care hospitals that POA was a requirement on claims submitted for inpatient services. This requirement will now be expanded to all inpatient acute-care hospitals, including critical access hospitals for all claims. Claims with inpatient discharges on or after January 1, 2010 that do not contain a POA indicator for each diagnosis code submitted will be returned to the hospital. Provider can reference...
Highmark West Virginia website at www.highmarkbcbswv.com under the Provider tab and select “News & Bulletins” to locate bulletin MS-HOSP-2009-002.

5.5 Potential Reduction in Payment for Hospital Acquired Conditions (HAC)

Medicare Grouper Version 27, to be effective January 1, 2010 for all DRG-reimbursed inpatient acute-care hospitals, including critical access hospitals for Commercial business, features logic that prevents the assignment of a higher MS-DRG to a claim reporting certain conditions not present on admission (when no other condition on the claim would otherwise trigger a higher MS-DRG).

Beginning with discharges on and after January 1, 2010, MSBCBS will also apply a separate methodology and process to potentially reduce payment to non-DRG reimbursed hospitals for claims reporting any of the following conditions if not identified as present on admission (in the absence of other complications or major complications on the claim):

- Pressure ulcer, Stages III and IV
- Falls and trauma
- Surgical site infection after bariatric surgery for obesity, certain orthopedic procedures and bypass surgery (mediastinitis)
- Vascular-catheter associated infection
- Catheter-associated urinary tract infections
- Administration of incompatible blood
- Air embolism
- Foreign object unintentionally retained after surgery
- Deep vein thromboses and pulmonary emboli associated with knee and hip replacements
- Certain manifestations of poor glycemic control

Provider can reference Highmark West Virginia website at www.highmarkbcbswv.com under the Provider tab and select “News & Bulletins” to locate bulletin MS-HOSP-2009-003.

5.6 Non-Payment for Three “Wrong” Surgical Events for all Hospital Providers

Consistent with CMS Policy, MSBCBS will also not make payment for the following three “Wrong” surgical events:
The **wrong surgical procedure** was performed
- Surgery was performed on the **wrong body part**
- Surgery was performed on the **wrong patient**

Provider can reference Highmark West Virginia website at [www.highmarkbcbswv.com](http://www.highmarkbcbswv.com) under the Provider tab and select “News & Bulletins” to locate bulletin MS-HOSP-2009-003.

## 5.7 Proprietary Nature of Fees and Methodologies

Highmark West Virginia considers its fee schedules, reimbursement rates and reimbursement methodologies to be proprietary in nature. Provider agrees to keep such information confidential and not to disclose it to third parties without the prior written consent of Highmark West Virginia. This section does not apply to rates contained in hospital discount contracts filed with and made publicly available by the West Virginia Health Care Authority.

## 5.8 Collection of Member Liability

Highmark West Virginia permits health care providers of all types -- facility, professional and ancillary -- to collect deductible, copayment and estimated coinsurance amounts at the time of service, so long as all of the following criteria are met:

- The provider's standard operating policy or procedure is to collect from patients the amount due at the time of service, and patients are given advance written notification of this policy. The provider does not apply this operational policy in a fashion that discriminates against Highmark West Virginia members.
- The provider makes reasonable attempts to estimate the member's liability for the service and does not collect any amount above the estimated member’s liability, or contractual allowance for any service, whichever is less.
- The provider submits all claims for Highmark West Virginia members to Highmark West Virginia for adjudication. When the remittance advice is received, the provider (or its system) compares the amounts identified as member liability on the remittance with the amount paid by the member. If the amount paid by the member exceeds the amount identified as member liability on the remittance advice, the provider refunds the difference to the member within 30 days of receipt of the remittance.

Please see Chapter 6, Section 2.12 for other instances when a provider may directly bill the member.
Estimating Member Liability

While copayment amounts are easily calculated, deductible and coinsurance amounts may pose additional challenges to provider accounting.

For non-BlueCard® members, providers can use the Benefit Accumulator feature of NaviNet™ to see a snapshot of deductible amounts the member has already satisfied in this benefit year. However, providers are reminded that this "snapshot" is necessarily based on paid claims and cannot account for amounts from any claims incurred but not yet billed or finalized in Highmark West Virginia's system. The potential exists for member overpayments (and the corresponding need for refund) if additional claims were in process for this member at the time of this particular service.

Benefit Accumulator information is not available at this time for BlueCard® business. To learn more about amounts which have been accumulated toward the deductible for a BlueCard® member, the provider should utilize the BlueCard® Eligibility line at (800) 810-BLUE. Such calls are directed to the member's home plan, based on the alpha prefix on the ID card; the home plan will then provide the accumulation data if it is available.

As providers should be aware, member coinsurance liability is calculated based on Highmark West Virginia's allowances, not on charges. Facilities need to make this calculation carefully, taking into account all the known circumstances of the claim which will be submitted for the service. Again, the potential exists for member overpayments (or underpayments) when this calculation is performed before the service is actually rendered.

In view of these challenges, providers may wish to work with their members at or before the time of service to identify and formalize appropriate payment arrangements.