

## Actions

**Action:** Amend with New Rates / Add New Effective Date / Update Fee Sch

**Submission Type:** Hospital

## Facility and Contract Information

**Facility Name:** Manual Baytown Hospital1

**Profile Name:** UHC Non PPO

**Effective Date:** 1/1/25

**Payor Name:**

**Top Ten Payor:** false

**Rank:** N/A

#### **Who Will Load Profile: FinThrive**

#### **Who Will Promote Profile: FinThrive**

## **Who Will Reprice Profile: FinThrive**

**Pavor Type:** Commercial

• *ayr. type. commercial.*

# DRG Grouper

**Please specify which Grouper version your facility uses when submitting claims:**

**Does this Payer apply POA (Present-on-Admission) logic? N/A**

## Medicare and Managed Medicare Submissions

**Does Medicare Sequestration apply to this profile? No**

# Profile Notes

## **Profile Notes and Special Reprice Instructions:**

**Parent Case Description:**

**Non-Covered Charges Option: N/A**

## Payor Codes



**Utilized Product Match:** true

Contract Management  
Contract Action Request Form  
Case #06355250

**Uploaded My Products:** false

# UHC Non PPO Mini 2

## All Payer Appendix

**Facility Name(s): Internal Training**  
**Effective Date of this Appendix: 9/1/2025**

### APPLICABILITY

Unless another appendix to the Agreement applies specifically to a particular Benefit Plan as it covers a particular Customer, the provisions of this Appendix apply to Covered Services rendered to Customers covered by Benefit Plans sponsored, issued or administered by all Payers.

### SECTION 1 Definitions

Unless otherwise defined in this Section 1, capitalized terms used in this Appendix have the meanings assigned to them in the Agreement.

**Admission:** The admittance of a Customer to a licensed hospital bed, excluding Observation. Admission applies only to those services provided by order of a Physician.

**CMS:** Centers for Medicare and Medicaid Services.

**Covered Service:** A health care service or product for which a Customer is entitled to receive coverage from a Payer, pursuant to the terms of the Customer's Benefit Plan with that Payer.

**Customary Charge:** The fee for health care services charged by Facility that does not exceed the fee Facility would ordinarily charge another person regardless of whether the person is a Customer.

**Customer Expenses:** Copayments, deductibles, or coinsurance that are the financial responsibility of the Customer according to the Customer's Benefit Plan.

**Eligible Charges:** The Customary Charge for Covered Services, except for Covered Services listed under Sections 3.4 and/or 3.6 of this Appendix.

**Institutional Claim:** Any UB-04 or electronic version or successor form.

**MS-DRG or Medicare Severity Diagnosis-Related Groups:** A system of classification for inpatient hospital services based on the principal and secondary diagnoses (including the Present on Admission indicator), surgical procedures, sex, and discharge status. For purposes of determining

the contract rate under this Appendix, the MS-DRG at discharge, as that term is defined in the Final Rule, as published by CMS and most recently made effective under this Appendix, will be controlling. All changes in the definition of MS-DRGs specified in the Final Rule will be implemented under this Appendix on or before January 1, following publication in the Federal Register. Until changes in the definitions are implemented under this Appendix (as described in the previous sentence), the previous definitions will apply.

The Payment Method designated “MS-DRG” in this Appendix is applicable to Covered Services rendered to a Customer for an entire Admission. The contract rate is determined by applying the MS-DRG relative weight to the contracted base rate. Unless otherwise specified in this Appendix, payment under the MSDRG Payment Method, less any applicable Customer Expenses, is payment in full for all Covered Services rendered to the Customer including, but not limited to, Physician and other professional fees billed by Facility on an Institutional Claim, services rendered by non-Physician personnel (regardless of whether those personnel are employed by Facility and regardless of whether those services are characterized as professional services), “preadmission diagnostic and nondiagnostic services” (as defined by CMS) that occurs within three calendar days prior to Admission, nursing care, Observation, critical care, surgical services, diagnostic and therapeutic services (including, but not limited to, diagnostic imaging), ancillary services, durable medical equipment, supplies (including, but not limited to, anesthesia supplies), medications, and room and board.

**Observation:** Services furnished by Facility on the Facility’s premises, regardless of the length of stay, including use of a bed and periodic monitoring by Facility’s nursing or other staff, which are reasonable and necessary to evaluate an outpatient condition or determine the need for a possible Admission to Facility as an inpatient. Observation applies only to those services provided by order of a Physician.

**Outpatient Encounter:** Covered Services rendered to a Customer by Facility on an outpatient basis from the time of registration for outpatient services until discharge.

**Payment Method:** A methodology for determining contract rates under this Appendix.

**Per Case:** The Payment Method designated “Per Case” in this Appendix and applicable to Covered Services rendered to a Customer during an entire Admission or one Outpatient Encounter. Unless otherwise specified in this Appendix, payment under the Per Case Payment Method, less any applicable Customer Expenses, is payment in full for all Covered Services rendered to the Customer including, but not limited to, Physician and other professional fees billed by Facility on an Institutional Claim, services rendered by non-Physician personnel (regardless of whether those personnel are employed by Facility and regardless of whether those services are characterized as professional services), “preadmission diagnostic and nondiagnostic services” (as defined by CMS) that occur within three calendar days prior to Admission, nursing care, Observation, critical care, surgical services, diagnostic and therapeutic services (including, but not limited to, diagnostic imaging), ancillary services, durable medical equipment, supplies (including, but not limited to, anesthesia supplies), medications, and room and board.

**Per Diem:** The Payment Method designated “Per Diem” in this Appendix and applicable to Covered Services rendered to a Customer for each day of an Admission of a Customer. Unless otherwise specified in this Appendix, payment under the Per Diem Payment Method, less any applicable

Customer Expenses, is payment in full for all Covered Services rendered to the Customer during each day of the Admission including, but not limited to, Physician and other professional fees billed by Facility on an Institutional Claim, services rendered by non-Physician personnel (regardless of whether those personnel are employed by Facility and regardless of whether those services are characterized as professional services), "preadmission diagnostic and nondiagnostic services" (as defined by CMS) that occur within three calendar days prior to Admission, nursing care, Observation, critical care, surgical services, diagnostic and therapeutic services (including, but not limited to, diagnostic imaging), ancillary services, durable medical equipment, supplies (including, but not limited to, anesthesia supplies), medications, and room and board.

**Per Unit:** The flat rate Payment Method designated "Per Unit" in this Appendix and applicable to Covered Services rendered to a Customer for each unit of service for which a Per Unit Payment Method is indicated in this Appendix. Facility is required to identify procedures by revenue code and CPT/HCPCS code to receive payment. The number of units for each procedure or service rendered will be billed in accordance with the guidelines in the latest edition of the Current Procedural Terminology (CPT) manual as published by the American Medical Association or the latest edition of the HCPCS code set as published by CMS. Unless otherwise specified in this Appendix, payment under the Per Unit Payment Method, less any applicable Customer Expenses, is payment in full for all Covered Services rendered to the Customer including, but not limited to, Physician and other professional fees billed by Facility on an Institutional Claim, services rendered by non-Physician personnel (regardless of whether those personnel are employed by Facility and regardless of whether those services are characterized as professional services), nursing care, diagnostic and therapeutic services, durable medical equipment, supplies (including, but not limited to, anesthesia supplies), medications, and Facility and ancillary services. The units reported for Covered Services for which the contract rate is a Per Unit must always equal the number of times a procedure or service is performed.

**Per Unit via Facility Fee Schedule:** The Payment Method designated "Per Unit via Facility Fee Schedule" in this Appendix, based on the CPT/HCPCS specific fee listed in the applicable fee schedule for each unit of service and applicable to Covered Services rendered to a Customer for which a Per Unit via Facility Fee Schedule Payment Method is indicated in this Appendix. Facility is required to identify procedures by revenue code and CPT/HCPCS code to receive payment. The number of units for each procedure or service rendered will be billed in accordance with the guidelines in the latest edition of the Current Procedural Terminology (CPT) manual as published by the American Medical Association or the latest edition of the HCPCS manual as published by CMS. Unless otherwise specified in this Appendix, payment under the Per Unit via Facility Fee Schedule Payment Method, less any applicable Customer Expenses, is payment in full for all Covered Services rendered to the Customer including, but not limited to, Physician and other professional fees billed by Facility on an Institutional Claim, services rendered by non-Physician personnel (regardless of whether those personnel are employed by Facility and regardless of whether those services are characterized as professional services), nursing care, diagnostic and therapeutic services, durable medical equipment, supplies (including, but not limited to, anesthesia supplies), medications, and Facility and ancillary services. The units reported for Covered Services for which the contract rate is a Per Unit via Facility Fee Schedule must always equal the number of times a procedure or service is performed.

**Per Visit:** The flat rate Payment Method designated "Per Visit" in this Appendix and applicable to Covered Services rendered to a Customer on one-calendar day period, for each Service Category

within Section 2 for which a Per Visit Payment Method is indicated in this Appendix. Unless otherwise specified in this Appendix, payment under the Per Visit Payment Method, less any applicable Customer Expenses, is payment in full for all Covered Services rendered to the Customer including, but not limited to, Physician and other professional fees billed by Facility on an Institutional Claim, services rendered by non-Physician personnel (regardless of whether those personnel are employed by Facility and regardless of whether those services are characterized as professional services), nursing care, diagnostic and therapeutic services, durable medical equipment, supplies (including, but not limited to anesthesia supplies), medications, and Facility and ancillary services. Facility is required to identify each date of service when submitting claims spanning multiple dates of service.

**PPR (Percentage Payment Rate):** The percentage applied to Facility's detail line item Eligible Charge to determine the contract rate for those Covered Services for which the contract rate is calculated as a percentage of Eligible Charges.

**Physician:** A Doctor of Medicine ("M.D.") or a Doctor of Osteopathy ("D.O.") or another health care professional as authorized under state law and Facility bylaws to admit or refer patients for Covered Services.

## SECTION 2 Contract Rate for Covered Services

- 2.1 **Contract Rate.** For Covered Services rendered by Facility to a Customer, the contract rate will be the lesser of (1) Facility's aggregate Eligible Charges, or (2) the aggregate applicable contract rate determined in accordance with Sections 2.2, 2.3, 3 and/or 4 of this Appendix. Payment by Payer of the contract rate under this Appendix will be less any applicable Customer Expenses, and is subject to the requirements set forth in the Agreement.
- 2.2 **Inpatient Covered Services.** For the provision of Covered Services to a Customer during an Admission, the contract rate is determined as described in this Section 2.2. Unless otherwise specified in this Appendix, the contract rate for an Admission is the contract rate in effect on the date the Admission begins.

**Table 1: Inpatient Service Category Table**

<b>Hospice</b> ~ (see note ~ below) Revenue Codes 0115, 0125, 0135, 0145, 0155, 0655-0656 However, this service category does not apply where one of these revenue codes is billed in connection with any service category defined by Bill Types on this Inpatient Service Category Table.	<b>Per Diem</b>	<b>\$800.00</b>
<b>Inpatient Skilled Nursing Services</b> ~ (see note ~ below) Bill Types 211-219	<b>Per Diem</b>	<b>\$806.00</b>

United will group each claim to an MS-DRG based on the applicable and correct coding information provided on the claim, subject to the review of the medical records by United in accordance with the Agreement. The contract rate is determined by (i) applying the Base Rate in effect on the date of Admission, (ii) identifying the final MS-DRG (as determined by United from the coding information) to determine the applicable relative weight, and (iii) multiplying the Base Rate by the relative weight for the MS-DRG in effect under this Appendix as of the date of discharge (except for the time period between CMS' update and the United update, where the final MS-DRG and the relative weight will be based on the relative weight loaded in the United claims platform on the date the claim is processed).

\*Covered Services rendered to a mother and her newborn child will be paid as separate Admissions.

~ If Facility has a separate Inpatient Skilled Nursing unit, Hospice unit, or Rehabilitation unit, the charges for the Inpatient Skilled Nursing, Hospice, or Rehabilitation stay are to be submitted separately from the acute hospital stay.

@ The contract rate for a new, replacement, or modified MS-DRG code(s) will be at the existing contract rate for the appropriate MS-DRG(s) it replaced or modified.

**2.2.1 Transfer of Customer.** This Section applies only when a MS-DRG or MS-DRG plus Per Diem after Threshold Payment Method applies to all or some of the Covered Services rendered by Facility, with regard to an Admission in which Facility makes a transfer of the Customer. A transfer (as defined by CMS) is when a Customer is admitted to Facility and is subsequently transferred for additional treatment. If the length of stay of the Admission in Facility is less than the National Geometric Mean Length of Stay (GMLOS) (as published by CMS) less one, the contracted rate will be determined according to this Section 2.2.1, rather than the contract rate that would otherwise apply under this Appendix.

If Facility receives a transferred Customer, the contract rate is determined under this Appendix without regard to this Section 2.2.1.

**2.2.1.1** Transfer from Facility to a short term acute care facility or to post acute care (for those MS-DRGs designated as qualified discharges by CMS except for MS-DRGs designated by CMS as "special pay" MS-DRGs). The contract rate under this Section 2.2.1.1 is determined based on an imputed per diem rate (the "Imputed Per Diem Rate") as described in the next sentence. The Imputed Per Diem Rate is determined by dividing i) the applicable contract rate that would otherwise apply under this Appendix by ii) the GMLOS. The contract rate for the first day of the Admission is two times the Imputed Per Diem Rate and the contract rate for each subsequent day of the Admission is the Imputed Per Diem Rate; however, the contract rate under this Section 2.2.1.1 will not exceed the contract rate that would otherwise have applied under this Appendix.

**2.2.1.2** Transfer from Facility to post acute care for MS-DRGs designated by CMS as "special pay" MS-DRGs. The contract rate under this Section 2.2.1.2 is determined based on an imputed per diem rate as described above in Section 2.2.1.1. The contract rate for the first day of the

Admission is 50% of the contract rate that would otherwise have applied under this Appendix plus the Imputed Per Diem Rate. The contract rate for all subsequent days of the Admission is 50% of the Imputed Per Diem Rate; however, the contract rate under this Section 2.2.1.2 will not exceed the contract rate that would otherwise have applied under this Appendix.

**2.2.1.3 CMS Modifications.** In the event that CMS modifies its approach to reimbursing for transfers in the Medicare Inpatient Prospective Payment System (IPPS), United will use reasonable commercial efforts to implement changes under this Section 2.2.1.3 as of the effective date of the changes in the Medicare IPPS.

**2.2.2 Readmission within 30 Days.** If a Customer is admitted to Facility or another hospital within the same system as Facility within 30 days of discharge, the applicable contract rate will be determined according to this Section 2.2.2. Readmission review applies:

- (a) Based on CMS readmission guidelines; and
- (b) To readmissions with a related diagnosis (as determined by United); and
- (c) To the determination of the contract rate for the subsequent Admission.

Upon request from United, Facility agrees to forward all medical records and supporting documentation of the first and subsequent Admissions to United. If United determines that either the initial discharge or subsequent Admission(s) were clinically inappropriate, Facility will be financially responsible for all or a portion of Covered Services provided to Customer as part of the readmission. United may combine the initial discharge and subsequent related Admission(s) where the initial discharge and subsequent related Admission(s) were clinically appropriate (for example, scheduled readmissions or leaves of absence), to determine the correct contract rate according to this Appendix. Upon request from Facility, United and Facility agree to review, in good faith, the clinical appropriateness of the initial discharge and subsequent Admission(s).

**2.2.3 Inpatient Outlier.** When the length of stay exceeds thirty (30) days during a single Admission ("Inpatient Outlier Threshold"), the contract rate will be a Per Diem of \$3,716.00 for each day in excess of the Inpatient Outlier Threshold in addition to the applicable contract rate set forth in section 2.2. This section 2.2.3 applies to all inpatient service categories except any service for which the contract rate is zero, Rehabilitation, Hospice, Inpatient Skilled Nursing Services, Nursery and Obstetrics.

**2.3 Outpatient Covered Services.** For Outpatient Covered Services, appropriate CPT/HCPCS codes, as described by the National Uniform Billing Committee and CPT/HCPCS code guidelines, must be submitted on the Institutional Claim in order to be eligible for reimbursement.

**2.3.1** Observation, Outpatient Therapeutic, Diagnostic, Emergency, Urgent Care Covered Services. For the provision of Observation, therapeutic, diagnostic, Emergency, and Urgent Care Covered Services rendered by Facility to a Customer on an outpatient basis (except for Outpatient Procedures addressed in Section 2.3.2 of this Appendix), the contract rate will be determined according to this Section 2.3.

If more than one type of Covered Service for which a Per Visit, Per Unit via Facility Fee Schedule, or Per Unit, Payment Method applies are provided to a Customer during one calendar day, each of the applicable Payment Methods will be considered in calculating the aggregate contract rate for those Covered Services; provided, however, if the Customer receives any Covered Service for which a Per Case Payment Method applies, all Covered Services which would otherwise be paid pursuant to a Per Visit, Per Unit via Facility Fee Schedule, or Per Unit, Payment Method, will instead be included in the Per Case contract rate and will not be separately reimbursed.

The contract rate for outpatient Covered Services rendered by Facility to a Customer, as detailed on Table 2 below, will be determined according to the Payment Method listed in the table.

**Table 2: Outpatient Diagnostic and Therapeutic Service Category Table**

SERVICE CATEGORY	PAYMENT METHOD	CONTRACT RATE
<b>Observation</b> (Revenue Code: 0762)	Per Case	\$2,442.00
<b>IV Therapy</b> (Revenue Codes 0261, 0269)	Per Visit	\$109.00
<b>Radiation Therapy</b> (Revenue Codes 0330, 0333, 0339 without CPT Codes 61796-61800, 63620-63621, 77371, 77372, 77373)	Per Case	\$758.00
<b>Chemotherapy Administration</b> (Revenue Codes: 0331-0332, 0335)	Per Visit	\$423.00
<b>Physical Therapy</b> (Revenue Codes: 0420-0424, 0429)	Per Visit	\$251.00

<b>Hemodialysis</b> (Revenue Codes 0820-0825, 0829)	Per Visit	\$496.00
<b>Peritoneal Dialysis, CAPD and CCPD</b> (Continuous Ambulatory Peritoneal Dialysis and Continuous Cycling Peritoneal Dialysis) (Revenue Codes 0830-0835, 0839-0845, 0849-0855, 0859)	Per Visit	\$418.00
<b>MEG</b> (Revenue Codes 0860-0861)	Per Visit	\$161.00
<b>Neuropsychological Testing and Biofeedback for NONPSYCHIATRIC disorders only</b> (Revenue Codes 0900, 0917-0918)	Per Visit	\$470.00
<b>Other Diagnostic Services</b> (Revenue Codes 0920, 0929 without CPT Codes 95782-95783, 95800-95801, 95805-95811, G0398-G0400)	Per Visit	\$286.00
<b>Sleep Studies - Unattended</b> (Revenue Codes 0740, 0920, 0929 with CPT Codes 95800-95801, 95806, G0398-G0400)	Per Visit	\$2,526.00
<b>Sleep Studies - Attended</b> (Revenue Codes 0740, 0920, 0929 with CPT Codes 95782-95783, 95805, 95807-95811)	Per Visit	\$5,050.00
<b>Peripheral Vascular Lab</b> (Revenue Code: 0921)	Per Visit	\$603.00
<b>EMG</b> (Revenue Code: 0922)	Per Visit	\$679.00
<b>Allergy Testing</b> (Revenue Code: 0924)	Per Visit	\$157.00

## UHC Facility Lab Fee Schedule Exhibit

Facility acknowledges receipt of an electronic version of the UHC Facility Lab Fee Schedule Exhibit. Attached is the "Facility Fee Schedule Specifications" and "Representative Facility Fee Schedule Sample".

## **UHC OPG (Outpatient Procedure Grouper) Exhibit**

Facility acknowledges receipt of an electronic version of the UHC OPG (Outpatient Procedure Grouper)  
Exhibit.

**REVENUE CODE:**

0360, 0361, 0369  
0481  
0490, 0499  
0750  
0790

**WITH CPT / HCPCS CODES THAT ARE CONSIDERED “OPG ELIGIBLE” AS NOTED WITH A “Y” IN  
THE MOST CURRENT UHC OPG (OUTPATIENT PROCEDURE GROUNDER) EXHIBIT**