Sample Hospital
HOSPITAL REIMBURSEMENT ATTACHMENT
Effective 02/01/2023

Section 1
INPATIENT HOSPITAL SERVICES
COMMERCIAL RATES

HOSPITAL agrees to bill and accept as payment in full from **PAYER** the lesser of the rates as set out below or **HOSPITAL's** billed charges, less any applicable Copayments due from Members, for Covered Services provided to all Commercial Members.

Notwithstanding any other Diagnosis Related Group (DRG) payment rules that may exist or services identified in Table 1, the DRG Payment methodology used by **PAYER** is administered according to the following guidelines:

DRG Base Rate: The amount paid by **PAYER** for a DRG with a DRG Payment Weight of 1.0.

Rate
$ 14,630

DRG Payment Weight: The applicable prevailing DRG Payment Weights assigned to each DRG by CMS.

The DRG Payments are calculated as follows:

DRG Payment = DRG Base Rate x DRG Payment Weight

HOSPITAL agrees that payments made by **PAYER** according to the DRG Payment Methodology above are inclusive of all related supplies, materials, radiology, laboratory (technical and facility) therapies and drug and drug administration costs not otherwise specified for additional reimbursement in this Attachment. In calculating the length of stay, the date of admission shall be included, but the date of discharge shall not be included. All Total DRG Payments shall be based on the rate effective on the date of admission. The Total DRG Payment provides reimbursement for all **HOSPITAL** services for pre-admission, same day, and post-discharge testing rendered to a Member within seventy-two (72) hours of an inpatient admission or discharge.

Table 1

Service	Codes	Methodology	Rate
Normal Delivery Mother Only	DRG 768, 796, 797, 798, 805, 806, 807 Rev codes 101-219	2 Day Case Rate	$4,499
Cesarean Section Mother Only	DRG 783, 784, 785, 786, 787, 788 Rev codes 101-219	3 Day Case Rate	$6,526
Additional Maternity Days Mother Only	DRG 774, 775, 765, 766, 767, 768	Per Diem	$817
Level 1 Baby Nursery	Rev Codes: 170, 171, 179	Per Diem	$823
Level 2 (NICU)	Rev Code 172	Per Diem	$3,281
Level 3 (NICU)	Rev Code 173	Per Diem	$4,268
Level 4 (NICU)	Rev Code 174	Per Diem	$4,569
SNF Services	Rev Codes: 190, 191, 192, 193, 194, and	Per Diem	$1,729

	199		
Rehabilitation	Rev Codes 118, 128, 138, 148, 158	Per Diem	$2,201
Bariatric Surgery	DRG 619, 620, 621	Case Rate	$23,624

Implantable Devices – Carveout payment:
Implantable devices, Revenue codes 274, 275, 276 and 278, with EACH line ITEM, charges in excess of the threshold below will be reimbursed at 75% of charges. These will pay in addition to per diem and case rate but will be excluded from stoploss payment calculation. **PAYER** has right to audit invoices related to payments for implantable devices. **Hospital** will notify **PAYER** in advance should the System algorithm be modified in a manner that would increase the mark-up to **PAYER**.

Threshold
$3,975

Default Per Diem:
In the event CMS does not assign a weight to a particular DRG, CMS assigns a weight of zero to a particular DRG, or a case is not assigned to a DRG but is Medically Necessary, reimbursement shall be a per diem rate of

Rate
$4,689

Such cases shall be eligible for stoploss reimbursement.

Transfers:
In the event a Member is transferred from **Hospital** to another acute facility, **Hospital** reimbursement shall be calculated as follows, DRG Payment/ Arithmetic LOS x number of inpatient days at **Hospital**. In no event shall the transfer payment exceed the Total DRG Payment. **PAYER** will use the current arithmetic LOS as assigned by CMS which is publicly available through the CMS website.

Stoploss:
In the event **Hospital**'s total billed charges, minus charges for Implantable Devices, for a continuous inpatient admission exceeds the stoploss threshold below, contracted rate for the entire length of stay will be paid. In addition, **Hospital** will receive reimbursement of 49% of billed charges in excess of stoploss threshold. This Stoploss provision shall apply to all Inpatient claims, including claims that are reimbursed under Table 1 of this Attachment.

Threshold
$178,621

Example:
Total Charges (minus Implantable Devices Device Charges): $285,000.00
Contracted payment: $25,000
Stoploss Threshold: $222,792
Additional Stoploss Payment: (Total Charges) - (Stoploss Threshold) * 49%
Total Reimbursement: Contracted payment + Additional stoploss payment

Updates
The DRG groupers will be updated annually to reflect revisions and modifications to terminology and DRG codes made by CMS and the effective date of such updates shall be when CMS implements such revisions and modifications. Such updates shall be incorporated herein without notice to **Hospital** but will be supplied to **Hospital** upon written request.

Section 2
OUTPATIENT HOSPITAL SERVICES

COMMERCIAL RATES

Hospital agrees to accept as payment in full for covered services, the lesser of the rates listed for **PAYER**'s ASC Grouper Rates as set out below or **Hospital's** billed charges for covered Ambulatory Surgical Services provided to Members, less any applicable Member Copayments.

PAYER's ASC Groupers are based on the 2007 CMS Ambulatory Surgery Grouper listing but are supplemented to include additional codes that are not grouped by CMS. **PAYER** assigns a grouper for these additional services by placing them in groupers with similar valued relative value units (RVUs)

A complete list of **PAYER**'s ASC Groupers has been supplied to **Hospital** prior to the effective date of this Agreement, the receipt of which is hereby acknowledged by the provider. This list will be updated to reflect revisions and modifications to terminology and CPT codes. Such updates shall be incorporated herein without notice to **Hospital** but will be supplied to **Hospital** upon written request.

Hospital agrees that ambulatory surgical payment rates are all inclusive, including but not limited to the services of nurses, technicians, and other staff involved in patient care; the members use of the facility including but not limited to its operating room, recovery room, waiting room, surgical supplies, imaging, diagnostic testing, medical equipment, drugs, biologicals and pharmaceuticals; materials for anesthesia including the anesthesia; and any other miscellaneous supplies.

Additionally, the rates listed include pre-surgical testing when provided by **Hospital** within 72 hours prior to the surgical procedure.

Any code not identified by an ASC Grouper will be paid at the rate for Grouper 4 unless specified otherwise.

PAYER's ASC Groupers above are paid per procedure. If 2 surgeries are billed that fall into the same grouper, both will be paid. Multiple procedure logic will be applied.

Payment for all surgical procedures (per grouper or per procedure) will be calculated at 100% for the primary procedure, 50% for the second procedure and 25% for each additional procedure.

Grouper:	Methodology:	Rate
ASC 1	Per Procedure	$1,482
ASC 2	Per Procedure	$1,981
ASC 3	Per Procedure	$2,268
ASC 4	Per Procedure	$2,801
ASC 5	Per Procedure	$3,188
ASC 6	Per Procedure	$3,006
ASC 7	Per Procedure	$4,422
ASC 8	Per Procedure	$3,658
ASC 9	Per Procedure	$5,694
ASC 10	Per Procedure	$168
ASC 11	Per Procedure	$211
ASC 12	Per Procedure	$299
ASC 13	Per Procedure	$299
ASC 14	Per Procedure	$321
ASC 15	Per Procedure	$385
ASC 16	Per Procedure	$394
ASC 17	Per Procedure	$405
ASC 18	Per Procedure	$445
ASC 19	Per Procedure	$461
ASC 20	Per Procedure	$474

ASC 21	Per Procedure	$568
ASC 22	Per Procedure	$568
ASC 23	Per Procedure	$585
ASC 24	Per Procedure	$585
ASC 25	Per Procedure	$616
ASC 26	Per Procedure	$643
ASC 27	Per Procedure	$670
ASC 28	Per Procedure	$731
ASC 29	Per Procedure	$791
ASC 30	Per Procedure	$818
ASC 31	Per Procedure	$930
ASC 32	Per Procedure	$990
ASC 33	Per Procedure	$1,052
ASC 34	Per Procedure	$1,066
ASC 35	Per Procedure	$1,075
ASC 36	Per Procedure	$1,095
ASC 37	Per Procedure	$1,117
ASC 38	Per Procedure	$1,330
ASC 39	Per Procedure	$1,342
ASC 40	Per Procedure	$1,387
ASC 41	Per Procedure	$1,388
ASC 42	Per Procedure	$1,436
ASC 43	Per Procedure	$1,492
ASC 44	Per Procedure	$1,538
ASC 45	Per Procedure	$1,565
ASC 46	Per Procedure	$1,659
ASC 47	Per Procedure	$1,738
ASC 48	Per Procedure	$1,761
ASC 49	Per Procedure	$1,775
ASC 50	Per Procedure	$1,819
ASC 51	Per Procedure	$1,860
ASC 52	Per Procedure	$1,879
ASC 53	Per Procedure	$2,052
ASC 54	Per Procedure	$4,412
ASC 55	Per Procedure	$5,584
ASC 56	Per Procedure	$5,537

ASC Grouper Carve Outs

Separate from the above, the following procedures shall be reimbursed at the rates set forth below. All ASC grouper carve outs are paid on a per grouper methodology. If 2 surgeries are billed that fall into the same grouper carve out, 1 case rate will be allowed. For example, If 2 laparoscopic procedures listed below are billed, only 1 will be allowed. If 1 laparoscopic procedure and 1 Arthroscopic procedure listed below are billed, both will be allowed. If ASC grouper carve outs are billed with procedures that fall into **PAYER**'s ASC Groupers, both will be allowed. Multiple surgery logic will be applied in all cases.

ASC Grouper CarveOuts	Codes	Rate
Lithotripsy	CPT Codes 43265, 50590, and 52353 Rev 360-361,369,490,499,750, 790	$10,634
Cardiac Catheterization / Pacemaker or Defibrillator Placement	CPT Codes 93451-93464, 93503-93505, 93530-93533, 93561-93572, 33206-33208, 33210-33214, 33216-33217, 33224-33225, 33240, 33249 Rev 360-361,369,480,481,490,499,750	$11,529
PTCA	CPT codes 92920, 92921, 92924, 92925, 92928, 92929, 92933, 92934, 92937, 92938, 92941, 92943, 92944, 92973-92975, 92977-92979, 92986, 92987, 92990, 92992, 92993, 92997, 92998, C9600-C9607, C9608 Rev 360-361,369,480,481,490,499,750	$11,529
Arthroscopic Procedures	CPT codes 29800-29847, 29850-29892, 29894-29898, 29899, 29900-29999 Rev 360-361,369,490,499,750	$7,094
Bariatric Procedures	CPT codes 43770-43774, 43659 Rev 360-361,369,490,499,750	$15,075
Laparoscopic Procedures	CPT codes 38120-38129, 38570-38589, 43279, 43280-43289, 43644-43645, 43647, 43648, 43651-43659, 44180, 44186-44188, 44202, 44203-44205, 44206-44238, 44970-44979, 45395, 45397, 45400, 45402, 45499, 47370-47371, 47379, 47560-47579, 49320-49329, 49650-49659, 50541-50549, 50945, 50947-50949, 51990-51992, 51999,54690-54699, 55550-55559, 55866, 57425, 58541-58554, 58570-58573,58578, 58660-58679, 59150-59151, 60650-60659, 63001-63066; HCPC codes: G0342, S2079 Rev 360-361,369,490,499,750	$9,334
Endoscopy/GI Procedures	CPT codes 43200-43205, 43212, 43215-43217, 43220, 43226, 43227, 43229, 43231, 43232, 43235-43251, 43255, 43257, , 43259-43264, 43266, 43270, , 43273, 43274, 43275, 43276, 43277, 43641, 43760, 43761, 43830-43832, 44360, 44361, 44363-44366, 44369, 44370, 44372, 44373, 44376-44380, 44382, 44384, 44385, 44386, 44388-44392, 44394, 44401, 44402, 45100, 45160, 45300, 45303, 45305, 45307-45309, 45315, 45317, 45320, 45321, 45327, 45330-45335, 45337, 45338, 45340, 45341, 45342, 45346, 45347, 45378, 45379, 45380, 45381, 45382, 45384, 45385, 45386, 45388, 45389, 45391, 45392 Rev 360-361, 369, 490, 499, 750, 759	$3,548

Implantable Devices – Carveout payment:
Implantable devices, Revenue codes 274, 275, 276 and 278, with EACH line ITEM, charges in excess of threshold below will be reimbursed at 75% of charges. These will pay in addition to outpatient rates but will be excluded from stoploss payment calculation. **PAYER** has right to audit invoices related to payments for implantable devices. **Hospital** will notify **PAYER** in advance should the System algorithm be modified in a manner that would increase the mark-up to **PAYER**.

Threshold
$3,975

Other Outpatient Services

Services	Codes Required	Methodology	Rate
Observation	Revenue Code 762	Flat Fee	$1,482
Treatment Room	Revenue Codes 760, 761, 769	Per Date of Service	$1,373
Trauma Team Activation *State Designated Facilities Only	Revenue Codes – 681-689	Flat Fee	$2,663
Emergency Room	Revenue Codes - 450, 451, 452, 459 Level I – CPT code 99281 Level II – CPT code 99282 Level III – CPT code 99283	Flat Fee	$1,508
Emergency Room	Revenue Codes - 450, 451, 452, 459 Level IV – CPT code 99284 Level V – CPT code 99285 Critical Care - CPT Code 99291 Critical Care - CPT Code 99292	Flat Fee	$1,508
Urgent Care	Revenue Code 456	Flat Fee	$214
MRI	Revenue Codes - 610, 611, 612, 614-616, 618, 619	Flat Fee Per Scan	$1,330
CT Scan	Revenue Codes - 350, 351, 352, 359	Flat Fee Per Scan	$1,152
PET Scan	Revenue Code 404	Flat Fee Per Scan	$3,548
Clinic Charges	Revenue Codes 510, 512, 515, 520, 521	Not payable as facility service. Service should be billed by physician on a CMS 1500 Form.	$0
Sleep Studies	CPT codes 95805 – 95811 Revenue codes 740, 920, 929	Flat fee	$1,597
Laboratory	Revenue Codes 300 – 319 or CPT Codes 80047-89398 CPT 36415	% of fee schedule technical component $0.00	230%

Other Radiology Services Not Listed Above	Revenue Codes 320, 321, 322, 323, 324, 329 or CPT Codes 70010-79999	% of fee schedule technical component	230%
Occupational Therapy	Revenue Codes 430, 431, 432, 433, 434, 439	Per Date of Service	$179
Speech Therapy	Revenue Codes 440, 441, 442, 443, 444, 449	Per Date of Service	$179
Physical Therapy	Revenue Codes 420-424, 429	Per Date of Service	$179
Respiratory Therapy	Revenue Codes 410 - 419	Per Date of Service	$179
HBO	Revenue Code 413	Per Date of Service	$4,022
Dialysis	Revenue Codes 820-825, 829-835, 839-845, 849-855, 859	Per Date of Service	$711
All other outpatient services not specified previously		% of fee schedule global component	230%
Services not listed above and not listed in XXX-XXX Fee Schedule			60% of Billed Charges

Flat Fees are inclusive of all services performed within the stated category definition per claim. Payment for Flat fees is made in addition to other Flat Fees. However when undefined service categories, categories based upon a percentage of charge, and/or categories based upon a fee schedule are billed in conjunction with flat fee services, only the flat fees will be paid with no additional payment for the other services. Per Unit Fees are considered to be Flat Fees and all of the above is applicable.

Per date of service are inclusive of all services performed within the stated category definition per calendar day. Payment for per date of service are only allowed in addition to percent of fee schedule, percent of charge or other per date of service categories and are not paid in addition to flat fees.

Fee Schedule Description

PAYER's fee schedule is based on a fixed 2017 Medicare Resource Based Relative Value Scale (RBRVS) fee schedule and payment systems, including the site-of-service payment differential. **PAYER** may have modified schedule to include codes and/or fees for services which are not covered by RBRVS (hereinafter "**Gap Codes**"). In most cases, the Gap Codes are adjusted by **PAYER** using the relative value unit ("**RVU**") multiplied by Medicare's conversion factor and geographic factor to assign the fee. A copy of the fee schedule will be made available to **Hospital**, upon request**.** This fee schedule as provided to **Hospital** shall remain fixed through the term of this Agreement and will not be updated to include new codes/services not currently listed in fee schedule unless modified through Amendment signed by both parties.

Section 3
Not Applicable

Section 4
Rate Changes

4.1 Hospital agrees to participate in **PAYER's** Hospital Incentive Program as described in the **HOSPITAL INCENTIVE PROGRAM ATTACHMENT.** Additionally, **Hospital** and **PAYER** agree to the following annual rate increase guidelines outlined in section 4.2 and 4.3.

4.2 Percent of charge reimbursement rates:

4.2 Percent of charge rates:

In the event the **Hospital** establishes a global increase in its billed charges for services that are reimbursed at a percentage of billed charges in 2019 and 2020, **Hospital** agrees that if the rate increase results in an global increase in **Hospital's** ChargeMaster in excess of five percent (5%), **Hospital** and **PAYER** shall adjust these percent of charge rates to **PAYER** so that no higher than a five percent (5%) increase shall be paid by **PAYER** in accordance with the reimbursement rates set out in this attachment. In addition, **Hospital** agrees that the then current threshold amount for stoploss and implantable devices shall be adjusted upward by the amount of the actual percentage increase.

4.3 Fixed rates:

Effective February 1, 2021 **Hospital** and **PAYER** agree the reimbursement amount for all services reimbursed on a fixed rate methodology, with the exception of those services reimbursed on a fee schedule, shall have a minimum inflator of five percent (5%), with a maximum inflator of six percent (6%), applied as set forth below. **Hospital** will participate in **PAYER's** Hospital Incentive Program, for which **Hospital** will have the potential to earn an additional one percent (1%) over the minimum five percent (5%) increase, for a payment increase up to a maximum of six percent (6%) by meeting the performance standards as outlined in the Hospital Incentive Program. If none of the Hospital Incentive Program performance standards are met, only the minimum inflator will apply.