

2009 WellCare PFFS Proxy Reimbursement Grid*

TYPE OF SERVICE	PAYMENT METHODOLOGY
Acute Care Hospital— Inpatient Outliers	Outlier payment is 80% for cases that exceed the outlier threshold of \$22,650 (in 2008) plus the diagnosis-related group (DRG) payment—which includes capital indirect medical education (IME) and disproportionate share hospital (DSH).
Acute Care Hospital— Inpatient Services	Prospective payment system (PPS) reimbursement diagnosis-related groups (DRG). For discharge dates on or after Oct. 1, 2007, the MS-DRG classifications are used. Includes capital, disproportionate share hospital (DSH), capital indirect medical education (IME), and special payment adjustments to Medicare Dependent Hospitals (MDH) and Sole Community Hospitals (SCH) when applicable. Operating IME costs are not paid by Medicare Advantage Plans for Medicare Advantage beneficiaries. Pass-through payments for capital IME, certified registered nurse anesthetists (CRNA) and costs associated with nursing and allied health education programs if applicable. Add-on payments for approved new services/technologies and blood-clotting factor. Organ acquisitions reimbursed on a cost basis at an approved transplant facility.
Acute Care Hospital— Outpatient Outliers	Calculated at the line-item level. If the estimated cost for each individual outpatient prospective payment system (OPPS) service exceeds 1.75 times the payment amount, and the cost exceeds the payment amount plus a \$1,575 fixed-dollar threshold, the hospital will receive 50% of the difference between 1.75 times the payment amount and the estimated cost.
Acute Care Hospital— Outpatient Services	Outpatient prospective payment system (OPPS) ambulatory payment classification (APC). Add-on payments for Transitions Outpatient Payments (TOPS), if applicable. Effective Jan. 1, 2006, sole community hospitals (SCH) in rural areas receive an additional 7.1% payment adjustment. Services excluded from OPPS reimbursed their respective fee schedule. In accordance with MMA 2003, clinical diagnostic laboratory tests covered at 100% reasonable cost in certain rural hospitals with fewer than 50 beds, for cost-reporting periods beginning on or after July 1, 2004, but before June 30, 2008.
Acute Care Hospital— Transfer to Post Acute	Expanded Transfer Definition: A qualified discharge from one of 273 diagnosis-related groups (DRG) to a post-acute care provider will be treated as a transfer case and reimbursed the per diem methodology stated above, with the following exception: 25 DRGs are paid under a methodology where 50% of the DRG plus the per diem is paid on the first day of the stay. For each subsequent day, 50% of the per diem is paid up to the full DRG amount.
Acute Care Hospital— Transfers Between	Transferring hospitals are reimbursed a per diem rate. The per diem rate is the full diagnosis-related group (DRG) amount divided by the geometric mean length of stay for the DRG. Twice the per diem is paid on the first day and the per diem for every following day up to the transfer or the full DRG amount. Transfer cases classified into DRG 789 or DRG 927-929 or 933-935 are paid at the full DRG instead of the per diem methodology.
Acute Long Term Care— Inpatient	Long Term Care Hospitals (LTCH) prospective payment system (PPS) diagnosis-related groups (DRG) effective for cost-reporting periods beginning on or after Oct. 1, 2002. For dates of discharge Oct. 1, 2007, and after, the MS-LTC-DRG classifications are used. Payment subject to a five-year blend in 20% increments unless LTCH elects to be paid based on 100% federal PPS rate. Short-stay and high-cost outliers apply.
Ambulance	Reimbursed at 100% of the Medicare Ambulance Fee Schedule for transportation and mileage only. All other services billed by the ambulance provider are considered incidental to the transport and mileage and will be bundled into the payment applied for mileage and transportation.
Ambulatory Surgery Center	Ambulatory surgical centers (ASC) are reimbursed based on rates established for the groups of ASC procedures. The base rates are adjusted to reflect the wage index value applicable to the area in which the ASC is located.
Anesthesia—Physician Medical Direction of Two or More Nurse Anesthetists Concurrently	According to Medicare's methodology: Medicare anesthesia conversion factor by locality x sum of uniform base units + time units 50% of the allowance for the service performed by the physician. Please note: Our payment system rounds down to the nearest unit for tenths less than 5 and rounds up to the nearest unit for tenths greater than or equal to 5.
Anesthesia—Physician Performed	According to Medicare's methodology: Medicare anesthesia conversion factor by locality x sum of uniform base units + time units. Please note: Our payment system rounds down to the nearest unit for tenths less than 5 and rounds up to the nearest unit for tenths greater than or equal to 5.
Assistant Surgeon (Physician)	16% of the amount applicable for global surgery under the Medicare fee schedule.

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Assistant Surgeon (Physician Assistant)	85% of Assistant Surgeon (Physician) payment, which is 16% of the amount applicable for global surgery under the Medicare fee schedule.
Bad Debt	Plan will only pay for allowable bad debt on coinsurance for which a beneficiary is directly responsible to pay. Also, allowable bad debts only occur after a facility has repeatedly failed to collect. Hospitals receive 70% of allowable bad debt; other facilities receive 100% of allowable bad debt. Includes: skilled nursing facilities (SNF), Rural Health Clinics, Federally Qualified Health Centers (FQHC) and Community Mental Health Clinics. End stage renal disease (ESRD) facilities: bad debts are capped so that their reimbursement does not exceed their costs.
Blood	Reimbursed under outpatient prospective payment system (OPPS) for hospital outpatient services.
Braces	100% of the Medicare Durable Medical Equipment Prosthetic, Orthotic and Supplies Fee Schedule (DMEPOS). Covered when furnished incident to a physician's services or on a physician's order.
Cancer Hospitals— Inpatient	Inpatient prospective payment system (IPPS) exempt. Cost-based reimbursement. Routine services reimbursed a per diem. Ancillary services reimbursed cost to charge ratio. Data extracted from 2005–2008 HCRIS Data Set. Applicable to Medicare-approved services only.
Cancer Hospitals— Outpatient	Outpatient prospective payment system (OPPS) ambulatory payment classification (APC). Services excluded from OPPS reimbursed their respective fee schedule. Cancer hospitals permanently held harmless from OPPS. In accordance with MMA 2003, clinical diagnostic laboratory tests covered at 100% reasonable cost in certain rural hospitals with fewer than 50 beds, for cost-reporting periods beginning on or after July 1, 2004, but before June 30, 2008.
Certified Registered Nurse Anesthetist (CRNA)	According to Medicare's methodology: Medicare anesthesia conversion factor by locality x sum of uniform base units + time units. Payment is made on an assignment basis only. The above allowance is divided equally between the anesthesiologist and the anesthetist (50% each). Please note: Our payment system rounds down to the nearest unit for tenths less than 5 and rounds up to the nearest unit for tenths greater than or equal to 5.
Children's Hospitals— Inpatient	Inpatient Prospective Payment System (IPPS) exempt. Cost-based reimbursement. Routine services reimbursed a per diem. Ancillary services reimbursed cost to charge ratio. Data extracted from 2005 to 2008 HCRIS Data Set. Applicable to Medicare-approved services only.
Children's Hospitals— Outpatient	Outpatient prospective payment system (OPPS) ambulatory payment classification (APC). Services excluded from OPPS reimbursed their respective fee schedule. Children's hospitals permanently held harmless from OPPS. In accordance with MMA 2003, clinical diagnostic laboratory tests covered at 100% reasonable cost in certain rural hospitals with fewer than 50 beds, for cost-reporting periods beginning on or after July 1, 2004, but before June 30, 2008.
Clinical Nurse Specialist	85% of the Medicare Physician Fee Schedule (MPFS).
Clinical Psychologist	100% Medicare Physician Fee Schedule (MPFS). Psychologists will receive payment for administering diagnostic psychological tests and supervising the administration of these tests.
Clinical Social Worker	75% of the amount paid to a clinical psychologist for comparable services.
Clinical Trial Services	Medicare directly reimburses all approved clinical trial services provided to a Medicare Advantage (MA) enrollee according to the appropriate fee-for-service methodology.
Community Mental Health Centers	Outpatient prospective payment system (OPPS) per diem ambulatory payment classification (APC) Grouper/Pricer software. It contains an Outpatient National Medicare Provider Rate File (ONMPRF), which provides Plan with the capability to Group/Price APC claims for ANY Medicare-approved provider.
Comprehensive Outpatient Rehabilitation Facility (CORF) and Outpatient Rehabilitation Facility (ORF)	Reimbursement based on the Medicare Physician Fee Schedule (MPFS). Vaccines reimbursed 95% average wholesale price (AWP).
Co-surgeons	The fee schedule amount applicable to the payment for each co-surgeon is 62.5% of the global surgery under the Medicare Physician Fee Schedule (MPFS).

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Critical Access Hospital (CAH) Outpatient	Prospective payment system (PPS) exempt. Paid 101% of reasonable costs for services furnished during cost-report periods on and after January 1, 2004. Critical access hospitals (CAH) must provide the plan with a copy of their most recent interim rate letter from their fiscal intermediary (FI) and the plan will pay the interim cost-to-change ration (CCR). The plan requests an update of the cost report data/FI interim rate letter annually. CAH's electing the Optional Method of outpatient reimbursement receive 115% of what Medicare would pay under the Medicare Fee Schedule (MFS) for professional services, the equivalent of 112% full MFS. Physicians rendering services in a CAH that has elected the Optional Method and is located in a health professional shortage area (HPSA) and/or physician scarcity area (PSA) are entitled to the 10% HPSA bonus payment and/or 5% PSA bonus payment. (PSA bonus effective until June 30, 2008.)
Critical Access Hospitals (CAH) Inpatient	Prospective payment system (PPS) exempt. Paid 101% of reasonable costs for services furnished during cost report periods on or after January 1, 2004. Reimbursed based on a per diem rate provided by the critical access hospital's (CAH) fiscal intermediary (FI). CAHs must provide the plan with a copy of their most recent interim rate letter from their FI and the plan will pay the interim inpatient per diem. The plan requests an update of the cost report data/FI interim rate letter annually.
Diabetic Shoes	100% of the Medicare Durable Medical Equipment Prosthetic, Orthotic, and Supplies Fee Schedule (DMEPOS).
Drugs	Reimbursed average sales price (ASP) plus 6%. Exceptions: Pneumococcal and influenza vaccines, drugs infused through DME (reported with KD modifier) and new drugs are reimbursed 95% average wholesale price (AWP).
Durable Medical Equipment	100% of the Medicare Durable Medical Equipment Prosthetic, Orthotic, and Supplies Fee Schedule (DMEPOS).
Epoetin (EPO)	Epoetin (EPO) paid average sale price (ASP) plus 6%, adjusted in accordance with Transmittals 751 and 1403. Current rate for EPO is \$9.58 per 1,000 units.
ESRD Facility	Paid case mix adjusted composite rate based on geographic location and whether facility is hospital-based or independent. Pediatric facilities may apply for a composite rate exception if they do not already have one. Providers with an approved exception have the option of continuing to be paid at their exception rate or at their basic case-mix adjusted composite rate. Provider must notify the plan if they have an exception rate. Starting January 1, 2006, there is a four-year transition period from MSA/Non-MSA designation to CBSA/Non-CBSA designation. Therefore, for 2007, 25% of the wage-adjusted composite rate will reflect the MSA/Non-MSA adjustments and 75% of the CBSA/Non-CBSA adjustments. Effective January 1, 2008, there is a 15.5% drug add-on adjustment. Epoetin (EPO) paid ASP plus 6%, adjusted in accordance with Transmittals 751 and 1403. Current rate for EPO is \$9.58 per 1,000 units. Non-routine services, payable outside of the composite rate, are reimbursed based on a fee schedule.
Federally Qualified Health Centers (FQHC)	Paid 80% of the lower of the all-inclusive rate or the upper limit, plus 20% of the FQHC's actual charge. 2007 Urban FQHC limit: \$115.33...2007 Rural FQHC limit: \$99.17...2008 Urban FQHC limit: \$117.41...Rural FQHC limit: \$100.96.
Health Professional Shortage Area (HPSA)	100% of the Medicare Fee Schedule (MFS) + 10% bonus.
Hemophilia clotting factors billed by provider (e.g. Hosp, SNF, HHA)	Add on payment for beneficiaries in an inpatient setting. Outpatient setting paid on a cost basis.
Hemophilia clotting factors billed by supplier (e.g. DME, supplier, independent pharmacy, Red Cross)	Drugs not paid on a cost or prospective payment basis will be paid under the new average sales price (ASP) drug payment system.
Home Dialysis Supplies & Equipment	Method I or II per Medicare

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Home Health	Prospective payment system (PPS) Home Health Resource Group (HHRGs) Providers reimbursed per 60-day episode via request for anticipated payment (RAP) and claim submission. Includes adjustments for low-utilization payment adjustment (LUPA), significant change in condition (SCIC), partial episode payment (PEP), therapies and outliers. Limited services reimbursed under OPPS. DME reimbursed at 100% Durable Medical Equipment, Prosthetic, Orthotic, Supplies (DMEPOS) fee schedule. Note: Effective April 1, 2004, rural agencies are paid a 5% add-on payment.
Home Infusion	Reimbursement per Medicare Durable Medical Equipment Prosthetic, Orthotic, and Supplies (DMEPOS) fee schedule for applicable services. Hospice All Hospice-related services shall be billed to CMS Medicare directly.
Immunosuppressive Drugs	Paid under outpatient prospective payment system (OPPS) if beneficiary is in the outpatient department of a Medicare participating hospital. In all other settings paid Average Sales Price (ASP) plus 6%.
Indian Health Service Facility (HIS)—Inpatient Services	Prospective payment system (PPS) reimbursement diagnosis-related groups (DRG) Grouper/ Pricer software. It contains a National Medicare Provider Rate File (NMPRF), which provides Plan with the capability to Group/Price DRG claims for ANY Medicare approved provider. See Acute Care Hospital.
Indian Health Service Facility (HIS)—Outpatient Services	All-inclusive rate. Excluded from outpatient prospective payment system (OPPS). Fee schedule for outpatient professional services. Effective January 1, 2005, all other part B services reimbursed according to appropriate methodology. Effective January 1, 2006, therapy reimbursed according to the Medicare Physician Fee Schedule (MPFS).
Injections	Physicians can also be paid for injections and vaccinations even when performed on the same day as other Medicare-covered services. Priced per ASP drug file for 2008.
Laboratory	100% of Medicare laboratory fee schedule.
Long Term Care Hospitals	Long Term Care Hospitals (LTCH) prospective payment system (PPS) diagnosis-related groups (DRG) effective for cost-reporting periods beginning on or after Oct. 1, 2002. For dates of discharge Oct. 1, 2007, and after the MS-LTC-DRG classifications are used. Payment subject to a five-year blend in 20% increments unless LTCH elects to be paid based on 100% federal PPS rate. Short-stay and high-cost outliers apply.
Low-Volume Hospitals	Per CMS guidelines, hospitals more than 25 miles from the closest acute care hospital and with less than 800 discharges per year may qualify for an additional payment not to exceed 25%.
Mammography Screening	100% Medicare Fee Schedule (MFS).
Maryland Hospitals	HSCRC mandated rate thresholds. Reimbursed 94% of approved charges for IP and OP services.
Medical Nutrition Therapy	85% of Medicare Physician Fee Schedule (MPFS).
Nurse Practitioner	85% of Medicare Physician Fee Schedule (MPFS).
Oral Anti-Cancer Drugs	Drugs not paid on a cost- or prospective-payment basis will be paid under the new ASP drug payment system.
Oral Anti-Nausea Drugs	Drugs not paid on a cost- or prospective-payment basis will be paid under the new ASP drug payment system.
Oxygen and Oxygen Equipment	100% of the Medicare Durable Medical Equipment Prosthetic, Orthotic, and Supplies (DMEPOS) fee schedule.
Parenteral and Enteral Nutrition	100% of the parenteral and enteral nutrition (PEN) fee schedule.
Physical, Occupational or Speech Therapist	100% of the Medicare Physician Fee Schedule (MPFS). Physical therapist (PT) and speech therapist (w) therapy cap for 2008 \$1,810 and a separate cap of \$1,810 for occupational therapist (OT). Therapy cap limit for 2009 is \$1,840 for PT and ST and an additional \$1,840 cap for OT.
Physician Assistant	85% of Medicare Physician Fee Schedule (MPFS).

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Physician Scarcity Area (PSA)	100% of Medicare Fee Schedule (MFS) + 5% bonus.
Physician Services (Audiologist)	100% of the Medicare Physician Fee Schedule (MPFS). 10% health professional shortage area (HPSA) payment where appropriate and 5% physician scarcity area (PSA) payment where appropriate (effective through June 30, 2008, for PSA).
Physician Services (Chiropractor, Dentist, Optometrist, Podiatrist)	100% of the Medicare Physician Fee Schedule (MPFS). 10% health professional shortage area (HPSA) payment where appropriate and 5% physician scarcity area (PSA) payment where appropriate (effective through June 30, 2008, for PSA).
Physician Services (MD, DO, Oral, and Maxillofacial Surgeon)	100% of the Medicare Physician Fee Schedule (MPFS). 10% health professional shortage area (HPSA) payment where appropriate and 5% physician scarcity area (PSA) payment where appropriate (effective through June 30, 2008, for PSA).
Prosthetic Devices	100% of the Medicare Durable Medical Equipment Prosthetic, Orthotic and Supplies Fee Schedule.
Psychiatric Hospitals—Inpatient	For hospital fiscal years beginning after Oct. 1, 2005, the payments will be a blend of 75% of the old TEFRA payment and 25% of the new prospective payment system (PPS) payment. The first PPS payment period for all hospitals will extend to June 30, 2006, after which all PPS updates will be for the 12-month periods beginning July 1, 2006. The second payment period uses a blend of 50% of TEFRA/50% PPS and the third and last transition year uses 25% to no less than 70% of the TEFRA amount for this 3-year transition period. The new PPS system uses a federal per diem base amount of \$575.95, which is then adjusted for one of the 15 DRG, co-morbidities, age, rural add-on, teaching add-on, outlier payments, wage index, the presence of an emergency department and ECT treatment. There is also an extra payment, which tapers down during the first 21 days of an admission.
Psychiatric Hospitals—Outpatient	Outpatient prospective payment system (OPPS) ambulatory payment classification (APC) Grouper/Pricer software. It contains an Outpatient National Medicare Provider Rate File (ONMPPRF), which provides Plan with the capability to Group/Price APC claims for ANY Medicare-approved provider.
Registered Dietitian	85% of Medicare Physician Fee Schedule (MPFS).
Rehab Hospital—Inpatient Services	Prospective payment system (PPS) case mix groups (CMGs). Providers reimbursed per discharge rates adjusted for facility-level and case-level characteristics. Facility-level adjustments include area wage adjustments, an adjustment for facilities located in rural areas, teaching facilities and an adjustment for treating low income patients (LIP). Case-level adjustments include transfers, short-stay cases, cases in which the patient expires and outliers. PPS phase-in complete. CMGs reimbursed 100% federal rate.
Rehab Hospital—Outpatient Services	Outpatient prospective payment system (OPPS) ambulatory payment classification (APC). Add-on payments for transitions outpatient payments (TOP), if applicable. Effective Jan. 1, 2006, sole community hospitals (SCH) in rural areas receive an additional 7.1% payment adjustment. Services excluded from OPPS reimbursed at their respective fee schedule. In accordance with MMA 2003, clinical diagnostic laboratory tests covered at 100% reasonable cost in certain rural hospitals with fewer than 50 beds, for cost-reporting periods beginning on or after July 1, 2004, but before June 30, 2008.
Religious Non-Medical Health Care Institutions	Facility must provide its pricing information. If unable to obtain, claim paid at 50% of billed charges. If payment is incorrect, facility can submit a copy of Medicare RA showing correct pricing. We will adjust claim to reflect correct pricing.
Rural Health Clinics (RHC)	Paid 80% of the lower of the provider specific rate or the per visit payment limit, plus 20% of the RHC's actual charges. 2007 per visit limit: \$74.29/2008 per visit limit: \$75.63. Note: Per-visit limits do not apply to RHCs owned by rural hospitals with less than 50 beds and are paid on a cost basis.
Skilled Nursing Facilities Independent or Provider—Based	Prospective payment system (PPS) reimbursement Resource Utilization Groups (RUGS) 100% Federal Rate.

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Sole Community Hospital	Paid the greater of prospective payment system (PPS) or the hospital-specific rate for a full year. Pricer calculates the greater of the two.
Surgical Dressings	The Medicare Durable Medical Equipment Prosthetic, Orthotic and Supplies (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. Hospital outpatient reimbursed under Prospective Payment System (PPS) Ambulatory Payment Classification (APC). HHA's payment is bundled into PPS Home Health Resource Group (HHRGs). 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.
Swing Beds	Skilled nursing facilities (SNF) prospective payment system (PPS) Resource Utilization Groups (RUGs) 100% federal rate. Critical Access Hospitals (CAH) swing beds are exempt from SNF PPS and paid 101% of reasonable costs for services furnished during cost-report periods on and after January 1, 2004.
Team Surgery	Reimbursement determined on a case-by-case basis.
Transitional Outpatient Payments System (TOPS)	TOPS payments are made to hospitals paid less under PPS than under the old cost system. Rural hospitals with 100 beds or less and sole community hospitals will receive payments until Dec. 31, 2005. Sole community hospitals with cost-reporting periods of other than a calendar year will receive payments for less than the additional two years.
VA Hospitals	Federal providers are excluded from participation in the Medicare program. However, federal hospitals, like other nonparticipating hospitals, may be paid for emergency inpatient and emergency outpatient hospital services. Hospital-filed claims — Inpatient: Lower of actual charges or rates published for Federal Hospitals in the Federal Register under Office Of Management & Budget-Cost of Hospital & Medical Care & Treatment. Hospital-filed claims — Outpatient: 85% of the total covered charges.
X-ray	100% of the Medicare physician fee schedule (MPFS).

Please note: All Medicare Fee Schedule payments are less the member's cost-sharing amounts.

*The WellCare PFFS 2009 Proxy Payment Reimbursement may change over the plan year. Please check our Web site at www.wellcarepffs.com/provider/claiminformation or contact our Provider Service Center to be sure you have the most recent version.

Reimbursement for dental, vision and hearing providers for non-Medicare-covered services that are covered by WellCare PFFS is based on WellCare PFFS vendors' proprietary fee schedule. For information on how to contact these vendors, please see the member's dental/hearing/vision ID card or the WellCare PFFS Quick Reference Contact Guide located on our Web site or by request from our Provider Service Center.



Provider Service Center
 1-866-235-2770 (TTY/TDD: 1-866-239-6265)
 Monday–Sunday, 7am to 2am Eastern
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