Highmark West Virginia Inc.
Facility Reimbursement Manual

Table of Contents

PURPOSE 4

INPATIENT REIMBURSEMENT 4

Definitions 4

1. Alternative Inpatient Percentage of Charges 4
2. Approved Days 4
3. Approved Program 4
4. Case Mix Index (“CMI”) 4
5. Claim 4
6. Diagnosis Related Group 4
7. Hospital Rate (value of one) 4
8. Inlier 4
9. Inpatient Services 4
10. Inter-Hospital Transfer 4
11. Intra Hospital Transfer 4
12. Med/Surg Per Diem 5
13. Highmark WV Average Length of Stay 5
14. Highmark WV DRG Inlier Trim Point 5
15. Highmark WV DRG Outlier Trim Point 5
16. Highmark WV DRG Weight 5
17. Neonatal Per Diem 5
18. Normal Case 5
19. Per Diem 5
20. Period 5
21. Physical Rehabilitation Per Diem 5
22. Psychiatric Per Diem 5
23. Substance Abuse Per Diem 5
24. Receiving Hospital 5
25. Specialty Services 5
26. Transfer 5
27. Transferring Hospital 5

Regular Inpatient Payments 5
Outlier Payment 5
Inlier Payment 6
Transfer Payments 6
Transferring Hospital 6
Receiving Hospital 6
Reporting of Transfer 6
Special Payment Provisions 6
Preadmission Testing ("PAT")/Same Day Testing ("SDT")/Post Discharge Testing ("PDT") 6
Payment For Specialty Services 6
Organ Transplantation Programs 7
Burn Cases 7
Covered Services Furnished Under Arrangement 7
Fragmentation of Services and Charges 7
Submission of Claims 7
OUTPATIENT REIMBURSEMENT 9
Definitions 9
Payment Provisions 9
Outpatient Prospective Payment System (“OPPS”) 9
Other Outpatient Payment Methodologies 10
Submission of Claims Provisions 11
Rate Inflator Increase for Outpatient Services, Fragmentation 12
Change in Outpatient Reimbursement Methodology 12

PURPOSE

This Facility Reimbursement Manual shall define reimbursement between Highmark WV and Provider for Provider's provision of Covered Services, both inpatient and outpatient services, to Members during the Period as defined in the Provider Agreement, subject to the terms and conditions of this Facility Reimbursement Manual and the Provider Agreement. The definitions set forth in the Provider Agreement shall apply herein, unless otherwise stated herein, or unless the context indicates otherwise, and all provisions in this Facility Reimbursement Manual shall apply to the parties and shall be construed and interpreted in a reasonable manner consistent with the provisions set forth in the Provider Agreement.

INPATIENT REIMBURSEMENT

Definitions

1. **Alternative Inpatient Percentage of Charges**. The rates set forth in the Provider Agreement, which may, upon Notice from Highmark WV to Provider, be used as an alternative method of reimbursement for Inpatient Services provided to Members.
2. **Approved Days**. Days Highmark WV has determined to be Medically Necessary.
3. **Approved Program**. A unit or service within facility or a hospital that is registered, certified or licensed by a West Virginia department or agency having jurisdiction or authority over appropriate governmental unit, department, or agency, and, when appropriate, accredited by the Joint Commission on Accreditation of Healthcare Organizations, the American Osteopathic Association, or other recognized accrediting body or Organizations, the American Osteopathic Association, or other recognized accrediting body or organization.
4. **Case Mix Index ("CMI")**. The weighted average of the Highmark WV DRG Weights for cases of Members at Facility.
5. **Claim**. The UB-04 form, successor form (designated by the National Uniform Billing Committee) or other mutually acceptable billing form submitted by Provider for payment of Covered Services rendered to a Member. All references to the UB-04 form in this Facility Reimbursement Manual shall include any such successor or other mutually acceptable form.
6. **Diagnosis Related Group**. Illnesses, injuries, diseases and disorders grouped into medically meaningful ("DRG") categories (as developed by the Centers for Medicare and Medicaid Services and, where appropriate, revised and adapted by Highmark WV) for all participating providers, and set forth in the DRG Weight file which is distributed to Provider annually and upon request.
7. **Hospital Rate (value of one)**. The payment rate set forth in the Provider Agreement.
8. **Inlier**. A case of a Member with a length of stay that is at or below the Highmark WV Inlier Trim Point.
9. **Inpatient Services**. Covered Services ordinarily furnished by a hospital for the care and treatment of inpatients rendered to a Member who either occupies a registered or licensed hospital bed at 12:01 a.m. or occupies such bed for at least twenty-four (24) consecutive hours.
10. **Inter-Hospital Transfer**. Transfer of a Member between a Transferring Hospital and a Receiving Hospital, which hospitals are not the same.
11. **Intra Hospital Transfer**. Transfer of a Member within Facility between one unit of Provider and another, including: (a) Transfer from Provider's medical/surgical unit to its psychiatric, substance abuse or physical rehabilitation unit, provided each such unit is an Approved Program; or (b) Transfer from one specialty unit of Provider to another, provided each such unit is an Approved Program.

12. **Med/Surg Per Diem**. The payment rate for each Approved Day of medical/ surgical care as set forth in the Provider Agreement.
13. **Highmark WV Average Length of Stay**. The average number of days for each DRG set forth in the DRG Weight file.
14. **Highmark WV DRG Inlier Trim Point**. The number of inpatient days, specific to each DRG, at or below which the Inlier payment will be made. See DRG Weight file for specified inlier trim points.
15. **Highmark WV DRG Outlier Trim Point**. The number of inpatient days, specific to each DRG, beyond which the Outlier payment will be made. See DRG Weight file for specific outlier trim points.
16. **Highmark WV DRG Weight**. The value assigned to each DRG set forth on the DRG Weight file.
17. **Neonatal Per Diem**. The payment rate set forth in the Provider Agreement paid for each Approved Day of neonatal care grouped into DRGs 789 through 793 as set forth on the DRG Weight file.
18. **Normal Case**. A case of a Member with a length of stay greater than the Highmark WV DRG Inlier Trim Point and less than or equal to the Highmark WV DRG Outlier Trim Point.
19. **Per Diem**. Any daily rate of payment set forth in the Provider Agreement.
20. **Period**. The effective date of the Provider Agreement through the year or years indicated in the Provider Agreement.
21. **Physical Rehabilitation Per Diem**. The payment rate set forth in the Provider Agreement paid for each Approved Day of physical rehabilitation care (DRG 945 and 946) rendered by a separate and distinct unit of Provider.
22. **Psychiatric Per Diem**. The payment rate set forth in the Provider Agreement paid for each Approved Day of psychiatric care (DRGs 876, 880 through 887), as set forth in the DRG Weight file.
23. **Substance Abuse Per Diem**. The payment rate set forth in the Provider Agreement paid for each Approved Day of substance abuse care (DRGs 894 through 897), as set forth on the DRG Weight file.
24. **Receiving Hospital**. A hospital that receives a Member from a Transferring Hospital or Hospital when it transfers a Member from one unit of Hospital to another in a Transfer.
25. **Specialty Services**. Psychiatric (DRGs 876, 880 - 887), substance abuse (DRGs 894 - 897), neonatal (DRGs 789-793), and physical rehabilitation services rendered by a separate and distinct unit.
26. **Transfer**. An Inter Hospital Transfer or Intra Hospital Transfer.
27. **Transferring Hospital**. The Provider that initially admits and subsequently transfers a Member to a hospital other than itself or to itself in a Transfer.

Regular Inpatient Payments

Highmark WV will pay Provider a regular DRG payment for a Normal Case ("Regular DRG Payment") according to the following formula for Members entitled to benefits under a policy:

$$\text{Regular DRG Payment} = \text{Hospital Rate} \times \text{Highmark WV DRG weight}$$

Special reimbursement calculations are addressed below in this Facility Reimbursement Manual. Applicable PPO/POS Hospital Rate, Per Diems and Alternative Inpatient Percentages of Charges will apply.

Outlier Payment

For Outliers, Highmark WV will pay Provider according to the following formula:

$$\text{Regular DRG Payment} + \frac{\text{Regular DRG Payment}}{\text{Highmark WV Average Length of Stay}}$$

X
0.50 X Approved Days
Beyond the Highmark WV DRG
Outlier Trim Point

Inlier Payment

For cases in which the length of stay is less than or equal to the Highmark WV DRG Inlier Trim Point, Highmark WV will pay the lesser of the Alternative Inpatient Percentage of Charges multiplied by Provider's Charges for Covered Services or the Regular DRG Payment (described in "Regular Inpatient Payments" section above).

Transfer Payments

Transferring Hospital

- Outlier Cases: Highmark WV will pay Transfers according to "Outlier Payment" section above.
- Inlier Cases: Highmark WV will pay Transfers according to "Inlier Payment" section above.
- Normal Cases: Highmark WV will pay for cases (only applicable to Transfer codes 02, 05, 62, 63, 66 and 70) which are not classified as Inliers or Outliers at a pro-rated rate according to the following formula:

$$\text{Pro-rated Rate} = \frac{\text{Regular DRG Payment X Approved Days}}{\text{Highmark WV Average Length of Stay}}$$

Receiving Hospital. Cases which have been transferred will be considered normal admissions unless they meet inlier or outlier criteria.

Reporting of Transfer

- The Transferring Hospital shall identify Transfers through use of appropriate codes in the proper field of the Claim to report transfers between acute care hospitals or transfers between an acute care hospital and a specialty care hospital or for Transfers between specialty care hospitals.
- The Receiving Hospital shall identify Transfers through use of the appropriate codes in the proper field of the Claim to report transfers from an acute care hospital or Transfers from a health care facility other than an acute care facility or from a skilled nursing facility.

Special Payment Provisions

Preadmission Testing ("PAT")/Same Day Testing ("SDT")/Post Discharge Testing ("PDT")

Provider will not bill and Highmark WV will not separately pay for outpatient billing for PAT, SDT and PDT since payment for these services has been included in the Provider Rate.

As it applies to this clause, PAT is defined as testing as it relates to an admission performed up to 72 hours before the Member is admitted to Provider. Testing performed 72 hours or earlier before the admission will be billed to Highmark WV as an outpatient claim, and will be paid in accordance with the Outpatient Reimbursement section of this Facility Reimbursement Manual. PDT is defined as testing performed up to 24 hours after discharge and related to discharge.

Payment For Specialty Services

Highmark WV will pay Claims for Specialty Services according to the following Formula:

Specialty Service Per Diem
X
Approved Days

Per Diems for Specialty Services Claims are set forth in the Provider Agreement. Highmark WV payment will be made according to the negotiated Specialty Service Per Diem.

Hospitals lacking an Approved Program for the appropriate Specialty Service must transfer Members with such specialty diagnosis to a hospital with an appropriate Approved Program within one day (or the next business day if a weekend or legal holiday and no threat is posed to the patient's safety) from the time of admission.

Organ Transplantation Programs
Highmark WV payment rate for transplant cases (including, without limitation, DRGs 001,002, 005,006, 007, 008, 010, 014, 016, 017and 652 will be reimbursed based upon a negotiated rate.

Burn Cases
Provider will transfer all cases grouping into DRGs 927 through 929 and 933 through 935 , Burns, as soon as medically feasible to a burn unit that is an Approved Program. Highmark WV's payment is the DRG reimbursement methodology.

Covered Services Furnished Under Arrangement
Provider may furnish Covered Services under arrangement with outside suppliers, including other hospitals. The amount charged by the supplying organization shall be paid directly by Provider. The Covered Service shall appear as a line item on any claim submitted to Highmark WV and Highmark WV's payment to Provider for such Covered Service shall be based on Provider's negotiated rate as specified in the Provider Agreement for such Covered Service. Covered Services furnished under arrangement shall be treated in all respects as though such services were furnished directly by Provider. Highmark WV will not reimburse Provider or the outside supplier for any Covered Services for which Provider is not in compliance with the provisions of this paragraph (unless agreed to by the parties on a case-specific basis).

Fragmentation of Services and Charges
Provider shall not fragment any line item Charge existing as the effective date of the Agreement into components without providing Highmark WV with thirty (30) days advance Notice and such fragmentation shall not be effective until thirty (30) days from the date of Notice. Upon receipt of Notice, Highmark WV will determine the impact of such fragmentation and adjust the Hospital Rate by the amount by which the reimbursement for the fragmented components exceeds the sum of the reimbursement for the previous single line item. Such fragmentation includes changes in Provider's employment or billing relationship with Facility-based Physicians.

Submission of Claims
Claims submitted by Provider to Highmark WV will include all necessary diagnostic and demographic information under ICD-10-CM or successor coding of the physician's medical record documentation. Claims with insufficient ICD-10-CM or successor information to allow appropriate DRG grouping or those Claims grouping into DRG 999 will be returned by Highmark WV to Provider for recoding.

Provider will identify any case in which the patient left "against medical advice" (AMA).

Provider shall not submit any interim billing to Highmark WV. Claims received by Highmark WV indicating an interim bill, will be returned by Highmark WV to Provider.

Provider will submit a combined bill for the mother's and infant's care or Highmark WV may require that separate bills be submitted concurrently for certain accounts. Highmark WV requires the separation of charges for services received by an infant during any period when the mother is not a patient.

Provider will identify "leave of absence" (LOA) instances on the billing form.

Provider will combine all readmissions within thirty (30) days that are of the same DRG.

OUTPATIENT REIMBURSEMENT

Definitions

1. **Claim**. The UB-04 form, CMS 1500 or successor form (designated by the National Uniform Billing Committee) or other mutually acceptable billing form submitted for payment by Provider for Covered Services rendered to a Member.
2. **CMS**. Centers for Medicare and Medicaid Services.
3. **New Service**. Any service, supply, product or accommodation which Provider offers that was not in effect at least thirty (30) days prior to the effective date of this Agreement and (i) for which a new revenue center is added or (ii) which is projected to generate at least 1% of Provider's total revenue on an annual basis.
4. **Period or Term of Agreement**. As defined in the Provider Agreement.

Payment Provisions

Outpatient Prospective Payment System ("OPPS")

Highmark WV will make payment to Provider for outpatient acute care services provided to Members in accordance with Highmark WV's OPPS based payment methodology (Highmark WV Methodology). This payment system uses the Ambulatory Payment Classification (APC) system to classify and pay hospitals for services to outpatients. The Highmark WV Methodology is based on: 1) the Medicare Hospital Outpatient Prospective Payment System (OPPS) Payment Methodology (Medicare Methodology); and 2) all applicable Medicare guidelines and policies, inclusive of any current updates made in accordance with the process as outlined in the Highmark WV Commercial Hospital Outpatient Billing and Reimbursement Guide. Highmark WV will evaluate such updates on an ongoing basis for applicability to the Highmark WV Methodology. Highmark WV will calculate payment rates by applying the outlined multiplier(s) below to the base Medicare payment determined by the applicable Medicare-based OPPS pricer as published annually by CMS and such updates as applicable by Highmark WV. Payment to Provider will be the lesser of Eligible Charges or an amount based on the contract rate per the Provider Agreement.

Highmark WV may prospectively adjust the base rate, relative weight and/or local wage adjustment factor based on changes to the applicable Medicare APC methodology in accordance with CMS timeframes. Therefore, if CMS updates the Medicare OPPS methodology, Highmark WV may incorporate the CMS modifications to the payment rates as CMS modifications are released.

Highmark WV payment rates to the Provider will be calculated by applying a multiplier(s) to the CMS Medicare payment for the coded service that is effective at the time the service was incurred.

The Highmark WV Methodology is described in greater detail in the *Highmark WV Commercial Hospital Outpatient Billing and Reimbursement Guide* (the "Guide"). The *Guide* is viewable on the Highmark WV Navinet® under the **Resource Center** link on Navinet and chose **Claims, Payment & Reimbursement → Hospital Outpatient Prospective Payment System (OPPS) Based Payment Method →** select relevant **year** and **quarter**.

Durable Medical Equipment

Under the Highmark WV Methodology, determinations with regard to allowable Durable Medical Equipment (DME) services will be made in accordance with Highmark WV's payment policies and product design. Where appropriate, Provider may submit a facility bill to Highmark WV for DME items and will be

paid according to Highmark WV's DME fee schedule. If Provider owns and operates a separate DME organization, a DME Agreement must be executed.

Professional Services

Payment for the services of professional providers is excluded from the Provider's payment rates defined in this Agreement. Provider may establish a separate account or utilize an existing account (with Highmark WV's approval) to bill Highmark WV for service provided by professional providers in accordance with applicable Highmark WV policies and procedures.

Updates

As updates occur to the Medicare Methodology, Highmark WV will evaluate each update to ensure continuity of payment and to determine if further customization of Highmark WV edits or payment criteria is necessary. Examples of such updates to the Medicare Methodology can be found in the *Guide*.

Patient Liability

Actual payment is subject to member eligibility, coverage under the member's contract, Highmark WV medical and reimbursement policy for products, medical necessity determination, timely filing and other billing requirements, and other party liability. All updates are implemented prospectively and retroactive adjustments are not applied.

Other Outpatient Payment Methodologies

Highmark WV will pay for the provision of outpatient Covered Services rendered to Member during the Period, as set forth in the Provider Agreement.

If Highmark WV discovers that a Claim for such services was submitted incorrectly, Highmark WV may deny or adjust payments, as appropriate, as Highmark WV may determine in its reasonable discretion. For purposes of this Facility Reimbursement Manual, Highmark WV may determine, in its reasonable discretion, whether a location removed from Provider shall be deemed to be an Outside Facility.

Provider represents that locations found in the Provider Agreement are a complete list of on-site Clinics that Provider submits Claims as on-site Clinics, and that no other on-site Clinic is or will be submitting Claims for outpatient services furnished under the Provider Agreement. Provider shall update the location exhibit, as necessary, on a quarterly basis, subject to approval of Highmark WV by Notice.

Provider shall furnish to Highmark WV upon request such other information deemed necessary by Highmark WV to evaluate the New Service.

Such New Services shall not qualify as a Covered Service until so determined in writing by Highmark WV. If Provider fails to provide any requested data or information relative to a New Service on a timely basis, and Highmark WV cannot complete its review of the New Service prior to the effective date of implementation, Highmark WV, in its sole discretion, shall determine the effective date for approval of coverage, if any. Until such time, such New Service shall not be considered a Covered hospital Service for the purpose of this Agreement and Provider shall not bill Highmark WV nor any Member for such new Service.

Partial Hospitalization

"Partial Hospitalization" (relating to behavioral medicine) is a time-limited, ambulatory, active treatment

program that offers therapeutically intensive, coordinated, and structured clinical service within a stable therapeutic milieu.

The Highmark WV reimbursement for patients who are admitted for Partial Hospitalization (more than three (3) but less than twenty-four (24) consecutive hours) will be made according to the negotiated Partial Hospitalization per diem listed on the Provider Agreement.

Provider shall bill the beginning and ending dates of service for the entire period reflected on the claim for Partial Hospitalization (excluding physician services) on a UB-04 form, or successor form, using revenue codes 912 through 916 and HCPCS code S0201. Please use the Blue Shield provider number listed in the Provider Agreement when billing for Partial Hospitalization Services.

Provider is required to pre-certify all services for Partial Hospitalization, which may apply to one or more days.

Intensive Outpatient Services

"Intensive Outpatient Services" (relating to behavioral medicine) is a time-limited, ambulatory, active treatment program that offers therapeutically intensive, coordinated, and structured clinical service within a stable therapeutic milieu.

The Highmark WV reimbursement for patients who are admitted for Intensive Outpatient Services (less than three (3) consecutive hours) will be made according to the negotiated Intensive Outpatient per diem listed on in the Provider Agreement.

Provider shall bill on a UB-04 form, or successor form with the use of HCPCS Code S9480 and one (1) unit listed in appropriate unit field. Please use the assigned Blue Shield provider number when billing for Intensive Outpatient Services.

Provider is required to pre-certify all Intensive Outpatient Services. Final determination of the Covered Benefit will be based on the Member's Benefit Plan.

Submission of Claims Provisions

As with Original Medicare, accurate and complete coding of CPT and HCPCS procedure codes, procedure modifiers, revenue codes, and units will maximize your reimbursement and speed the processing of claims.

All applicable fields on the UB-04 form, or successor form, should be completed for outpatient billing.

Provider agrees that it will provide Covered Services to any Member subject to the terms and conditions contained in this Facility Reimbursement Manual and in the applicable policy.

Claims submitted by Provider to Highmark WV will include all necessary diagnostic and demographic information under ICD-10-CM, or successor coding of the physician's medical record documentation. Claims with insufficient information to allow appropriate APC or rate assignment or those Claims assigned claim dispositions from the OCE indicating improper or incomplete coding will be returned by Highmark WV to Provider for recoding. Consistent with Medicare, each line should have a charge submitted.

Provider will identify any case in which the patient left "against medical advice" (AMA).

Provider shall not fragment any line item Charge into components which, when added together, exceed the applicable Charge in effect prior to such fragmentation. Fragmentation includes charges in the billing relationship between Provider and Facility-based physicians.

Rate Inflator Increase for Outpatient Services, Fragmentation

Provider shall provide Highmark WV with sixty (60) days' Notice of any Charge increase. Notice will include the Facility Chargemaster to be used for the provision of outpatient services beginning with the effective date as provided in the Notice.

When it has been determined that the actual or projected outpatient charge per service increase implemented by Provider for Covered Services or aggregate reimbursement increase as described above has or will exceed the allowed percentage of increase, the multiplier(s) included in the Provider Agreement will be adjusted to yield reimbursement for Covered Services at the level consistent with an applied increase equal to or less than the rate determined in accordance with the Provider Agreement.

Change in Outpatient Reimbursement Methodology

Highmark WV shall have the right upon thirty (30) days' Notice to Provider, to revise the reimbursement methodology(s) for some or all Covered Outpatient Services rendered to Members. Such methodology(s) revisions may include, but is not limited to, any such methodology(s) implemented by the CMS, for Medicare reimbursement to the Provider. Such methodology(s) shall supersede the outpatient reimbursement methodologies contained in Section B.1 of this Facility Reimbursement Manual.

Any increase in provider reimbursement is governed in the "Rate Inflator Increase for Outpatient Services, Fragmentation" section above.