

2022 Private Fee-For-Service plan

Reimbursement guide

Billing for services

To bill for services rendered to UnitedHealthcare® MedicareDirect members, please use the same claim forms, billing codes and coding methodology used for Medicare.

Checking the status of your claims

You can check the status of a UnitedHealthcare MedicareDirect claim one of 2 ways:

- **Online:** To submit claims using the UnitedHealthcare Provider Portal, go to UHCprovider.com and click on the Sign In button in the top-right corner
- **Phone:** Call Provider Services at **877-842-3210**, 7 a.m.–7 p.m. CT, Monday–Friday

The following chart contains an overview of the reimbursement methodologies we use for various service categories. You can refer to this chart to understand how we reimburse for services rendered to UnitedHealthcare MedicareDirect members.

Service category	Reimbursement methodology
Acute Care Hospital – Inpatient Services	<p>This payment system is referred to as the Inpatient Prospective Payment System (IPPS). Under the IPPS, each case is categorized into a Diagnosis-Related Group (DRG). Each DRG has a payment weight assigned to it based on the average resources used to treat Medicare patients in that DRG. The base payment rate is divided into a labor-related and non-labor share. The labor-related share is adjusted by the wage index applicable to the area where the hospital is located. If the hospital is located in Alaska or Hawaii, the non-labor share is adjusted by a cost-of-living adjustment factor. This base payment rate is multiplied by the DRG relative weight.</p> <p>If the hospital treats a high percentage of low-income patients, it receives a percentage add-on payment applied to the DRG-adjusted base payment rate. This add-on, known as the disproportionate share hospital (DSH) adjustment, provides a percentage increase in Medicare payment for hospitals that qualify under one of 2 statutory formulas designed to identify hospitals that serve a disproportionate share of low-income patients. For qualifying hospitals, the amount of this adjustment may vary based on the outcome of the statutory calculation.</p> <p>If the hospital is an approved teaching hospital, it receives a percentage add-on payment for each case paid through IPPS. This add-on, known as the indirect medical education (IME) adjustment, varies depending on the residents-to-beds ratio under the IPPS for operating costs and according to the residents-to-average daily census ratio under the IPPS for capital costs.</p> <p>For particular cases that are unusually costly, known as outlier cases, the IPPS payment is increased. This additional payment is designed to protect the hospital from large financial losses due to unusually expensive cases.</p>

Service category	Reimbursement methodology
Acute Care Hospital – Inpatient Services (cont.)	<p>Any outlier payment due is added to the DRG-adjusted base payment rate, plus any DSH or IME adjustments.</p> <p>For more information about reimbursement for acute care hospital inpatient stays, click here.</p>
Acute Care Hospital – Inpatient Outliers	<p>The actual determination of whether a case qualifies for an outlier payment takes into account both operating and capital costs and DRG payments. That is, the combined operating and capital costs of a case must exceed the fixed-loss-outlier threshold to qualify for an outlier payment. The operating and capital costs are computed separately by multiplying the total covered charges by the operating and capital cost-to-charge ratios. The estimated operating and capital costs are compared with the fixed-loss threshold after dividing that threshold into an operating portion and a capital portion (by first summing the operating and capital ratios, and then determining the proportion of that total comprised by the operating and capital ratios and applying these percentages to the fixed-loss threshold). The thresholds are also adjusted by the area wage index (and capital geographic adjustment factor) before being compared to the operating and capital costs of the case. The outlier payment is based on a marginal cost factor equal to 80% of the combined operating and capital costs in excess of the fixed-loss threshold (90% for burn DRGs).</p> <p>For more information about outlier payments, click here.</p>
Acute Care Hospital – Value-Based Purchasing (VBP)	<p>The hospital VBP program is funded by reducing participating hospitals' base fiscal year (FY) 2018 operating Medicare Severity Diagnosis-Related Group (MS-DRG) payments by 2%. Any leftover funds are redistributed to hospitals based on their Total Performance Scores (TPS). The amount hospitals earn depends on the range and distribution of all eligible/participating hospitals' TPS scores for a FY. It's possible for a hospital to earn back a value-based incentive payment percentage that is less than, equal to or more than the applicable reduction for that FY.</p> <p>For more information about the hospital VBP program, click here.</p>
Acute Care Hospital – Outpatient Services	<p>The Outpatient Prospective Payment System (OPPS) applies to all hospital outpatient departments except for: hospitals that provide Medicare Part B-only services to their inpatients; Critical Access Hospitals (CAHs); Indian Health Service hospitals; hospitals located in American Samoa, Guam and Saipan; and hospitals located in the Virgin Islands. The OPPS also applies to partial hospitalization services furnished by Community Mental Health Centers (CMHCs).</p> <p>Certain hospitals in Maryland that are paid under Maryland waiver provisions are also excluded from payment under OPPS, but not from reporting Healthcare Common Procedure Coding System (HCPCS) and line-item dates of service.</p> <p>For more information about OPPS, click here.</p>
Ambulance	<p>These services are reimbursed at the lesser of billed charges or 100% of the Medicare Ambulance Fee Schedule.</p>

Service category	Reimbursement methodology
Ambulatory Surgery Center (ASC)	The payment rates for most covered ASC surgical procedures and covered ancillary services are established prospectively based on a percentage of the OPPS payment rates. For more information about where to locate these prospective payment rates, see Chapter 14, §30.1 of the Medicare Claims Processing Manual .
Anesthesia – Physician Performed	Reimbursement for these services is based on the Medicare anesthesia dollar conversion factor by locality, multiplied by the sum of uniform base units, plus time units.
Anesthesia – Physician Medical Direction of 2 or More Nurse Anesthetists Concurrently	Reimbursement for these services is based on the Medicare anesthesia conversion factor by locality, multiplied by the sum of uniform base units, plus time units and reduced by 50% of the allowance for the service performed by the physician.
Assistant Surgeon (Physician)	Reimbursement for these services is based on the lesser of the billed charge or 16% of the amount applicable for global surgery under the Medicare Fee Schedule.
Assistant Surgeon (Physician Assistant)	Reimbursement for these services is based on the lesser of the billed charge or 85% multiplied by 16% of the amount paid to a physician who serves as an assistant at the time of surgery.
Bad Debts (Facilities)	We will only pay for bad debt on copayments and coinsurance that the member is directly responsible to pay. Bad debt reimbursement will only occur after a facility has made reasonable attempts to collect from the member. Bad debt reimbursement will occur if 120 days have elapsed since the date of service without collection of the member’s copayment or coinsurance. No less than 120 days from the date the member received the first bill for the claim in question, and up to 12 months after that, the facility may submit a copy of a bill demonstrating an outstanding balance and 120 days’ delinquency. Hospitals receive 70% of bad debt; other facilities receive 100% of bad debt, including skilled nursing facilities (SNFs), rural health clinics (RHCs), federally qualified health centers (FQHCs), community mental health clinics and end-stage renal disease (ESRD) facilities. Bad debts are capped so the reimbursement does not exceed the facility’s costs.
Blood	Billing and payment for blood, blood products and stem cells and related services under the hospital Outpatient Prospective Payment System (OPPS): Section 6011 of Public Law (P.L.) 101-239 amended §1886(a)(4) of the Social Security Act to provide that Prospective Payment System (PPS) hospitals receive an additional payment for the costs of administering blood clotting factor to Medicare beneficiaries who have hemophilia and are hospital inpatients. For more information, see Chapter 3 , Chapter 4 and Chapter 17 of the Medicare Claims Process Manual.
Braces	Braces are covered when furnished incident to a physician’s services or on a physician’s order. Reimbursement is at the Medicare allowable charge on the Medicare Durable Medical Equipment, Prosthetic, Orthotic and Supplies (DMEPOS) Fee Schedule.
Cancer Hospitals – Inpatient	These services are exempt from the Inpatient Prospective Payment System (IPPS). The cost-based Tax Equity and Fiscal Responsibility Act (TEFRA) reimbursement is paid on a per-day basis for routine and ancillary services and based on the most recent cost report data. Payment is applicable to Medicare-approved services only.

Service category	Reimbursement methodology
Cancer Hospitals – Outpatient	Reimbursement for these services is based on the Outpatient Prospective Payment System (OPPS), under Ambulatory Payment Classifications (APCs). Payment for outpatient services rendered by a cancer hospital is based on the higher of the OPPS or the cost-to-charge ratio (as provided in the interim rate letter).
Children’s Hospitals – Inpatient	These services are exempt from the Inpatient Prospective Payment System (IPPS), and reimbursement is cost-based. Routine and ancillary services are reimbursed on a per diem basis. Reimbursement for ancillary services is based on the most recent cost report data.
Children’s Hospitals – Outpatient	Reimbursements for these services are based on the Outpatient Prospective Payment System (OPPS) under Ambulatory Payment Classifications (APCs).
Clinical Nurse Specialist	Reimbursement is at 80% of the lesser charge or 85% of the Medicare allowable charge on the Medicare Physician Fee Schedule (MPFS) for comparable services.
Clinical Psychologist	Reimbursement is at the Medicare allowable charge on the Medicare Physician Fee Schedule (MPFS) or actual charge, whichever is less, for comparable services for administering diagnostic psychological tests and supervising the administration of these tests.
Clinical Social Worker	Reimbursement is 75% of the Medicare allowable charge on the Medicare Physician Fee Schedule (MPFS) for comparable services.
Clinical Trial Services	<p>For clinical trials covered under the Clinical Trials National Coverage Determination (NCD) 310.1 (NCD manual, Pub. 100-03, Part 4, section 310), Original Medicare covers the routine costs of qualifying clinical trials for all Medicare enrollees, including those enrolled in Medicare Advantage plans, as well as reasonable and necessary items and services used to diagnose and treat complications arising from participating in qualifying clinical trials. All other Original Medicare rules apply.</p> <p>For more information, see Chapter 4 of the Medicare Managed Care Manual.</p>
Community Mental Health Centers	Reimbursement for these services is based on the Outpatient Prospective Payment System (OPPS) under Ambulatory Payment Classifications (APCs).
Comprehensive Outpatient Rehabilitation Facility (CORF)	Reimbursement is at the Medicare allowable charge on the Medicare Physician Fee Schedule (MPFS). Vaccines are reimbursed at 95% of the average sale price (ASP) drug payment system.
Correct Coding Initiative	<p>UnitedHealthcare MedicareDirect applies CMS Correct Coding Initiative (CCI) edits to physician claims. This allows claims to be processed according to Medicare’s correct coding guidelines using Medicare’s Column 1/Column 2 and Mutually Exclusive edits.</p> <p>For more information, click here.</p>
Co-Surgeons	Reimbursement for each co-surgeon is 62.5% of the global surgery rate under the Medicare Physician Fee Schedule (MPFS).
Critical Access Hospitals (CAH)	Reimbursement is at 100% of the rate payable under Medicare (101% of billed charges based on a calculated cost-to-charge ratio on the facility’s most recent interim rate letter). The facility should send a copy of its most recent interim rate letter from the Medicare Administrative Contractor (MAC) by faxing UnitedHealthcare MedicareDirect Reimbursement Services at 866-943-9811 or by email at rpi_irl@uhc.com .

Service category	Reimbursement methodology
Diabetic Shoe	The reimbursement rate is at the Medicare allowable charge on the Medicare Durable Medical Equipment, Prosthetic, Orthotic and Supplies (DMEPOS) Fee Schedule.
Drugs	Drugs not paid on a cost or prospective payment basis will be paid under the Medicare average sale price (ASP) drug payment system. For drug Gapfill, RJ Health is used.
Durable Medical Equipment (DME)	These services are reimbursed at the Medicare allowable charge on the Medicare Durable Medical Equipment, Prosthetic, Orthotic and Supplies (DMEPOS) Fee Schedule for those DME suppliers who aren't considered a participating supplier in the Medicare Competitive Bidding Area (CBA) program. For those participating suppliers in the CBA program, reimbursement is made at the rate published for the CBA program for the particular area.
Epoetin (EPO)	Drugs not paid on a cost or prospective payment basis will be paid under the Medicare average sale price (ASP) drug payment system. For drug Gapfill, RJ Health ASP equivalents are used.
End-Stage Renal Disease (ESRD) Facility	Section 153b of the Medicare Improvements for Patients and Providers Act (MIPPA) requires the implementation of an ESRD-bundled Prospective Payment System (ESRD PPS). The ESRD PPS provides a single payment to ESRD facilities that covers all resources used in furnishing an outpatient dialysis treatment, including supplies and equipment used to administer dialysis (in the ESRD facility or at a patient's home), drugs, biologicals, laboratory tests, training and support services. For more information, see Chapter 8 of the Medicare Claims Processing Manual.
Federally Qualified Health Centers (FQHC)	FQHCs are paid under the Prospective Payment System (PPS). Medicare payment is based on the lesser of the FQHC's actual charge or the PPS rate, as determined by the Medicare Administrative Contractor (MAC). The FQHC PPS rate is updated annually, effective Jan. 1, 2016. For more information, see Chapter 9 of the Medicare Claims Processing Manual.
Health Professional Shortage Area (HPSA)	Reimbursement is at the Medicare Physician Fee Schedule (MPFS) plus a 10% bonus for health professionals in a designated HPSA based on the physician's ZIP code. Bonuses are paid on a quarterly settlement basis.
Hemophilia Clotting Factors Billed by the Care Provider (e.g., Hospital, SNF, Home Health Agency)	<p>Blood clotting factors not paid on a cost or Prospective Payment System (PPS) basis are priced as a drug/biological under the drug pricing fee schedule effective for the specific date of service.</p> <p>If a beneficiary is in a covered Part A stay in a PPS hospital, the clotting factors are paid in addition to the DRG/HIPPS payment. For more information, see Chapter 17 of the Medicare Claims Processing Manual.</p>
Hemophilia Clotting Factors Billed by the Supplier (e.g., DME Supplier, Independent Pharmacy, Red Cross)	A Part B blood clotting factor claim from a Part B supplier is processed by the A/B Medicare Administrative Contractor (MAC) (B). For more information, see Chapter 17 of the Medicare Claims Processing Manual.
Home Dialysis Supplies and Equipment	Reimbursement is according to Method I or Method II per Medicare Fee Schedules. For more information, see Chapter 8 of the Medicare Claims Processing Manual.
Home Health Agencies (HHAs)	Under prospective payment, Medicare pays home health agencies (HHAs) a predetermined base payment. The payment is adjusted for the beneficiary's health condition and care needs. The payment is also adjusted for the

Service category	Reimbursement methodology
Home Health Agencies (HHAs) (cont.)	<p>geographic differences in wages for HHAs across the country. The adjustment for the health condition, or clinical characteristics, and service needs of the beneficiary is referred to as the case-mix adjustment. The home health Prospective Payment System (PPS) will provide HHAs with payments for each 30-day episode of care for each beneficiary.</p> <p>For more information, click here.</p>
Home Infusion	<p>Reimbursement is based on the Medicare Durable Medical Equipment, Prosthetic, Orthotic and Supplies (DMEPOS) Fee Schedule for applicable services.</p> <p>For more information, click here.</p>
Hospice	<p>Claims for Medicare-covered hospice services and Medicare-covered, non-hospice services must be submitted directly to the appropriate Medicare Administrative Contractor (MAC). Claims for services covered by non-Medicare, supplemental or value-added benefits should be submitted to UnitedHealthcare MedicareDirect.</p>
Hospital Transfer – Acute to Acute	<p>For transfers between Inpatient Prospective Payment System (IPPS) hospitals, the transferring hospital is paid based on a per diem rate. The transferring hospital may be paid a cost outlier payment. The outlier threshold for the transferring hospital is equal to the outlier threshold for non-transfer cases, divided by the geometric mean length of stay for the Diagnosis-Related Group (DRG) and multiplied by a number equal to the length of stay for the case plus 1 day.</p> <p>The payment to the final discharging hospital is made at the full prospective payment rate. The outlier threshold and payment are calculated the same as any other discharge without a transfer. For more information, see Chapter 3 of the Medicare Claims Processing Manual.</p>
Hospital Transfer – Acute to Post-Acute	<p>For transfers from an IPPS hospital to a hospital or unit excluded from IPPS with a Diagnosis-Related Group (DRG) that is subject to the post-acute care transfer policy, the transferring hospital is paid based upon a per diem rate. The transferring hospital may be paid a cost outlier payment. In general, the outlier threshold for the transferring hospital is equal to the outlier threshold for non-transfer cases, divided by the geometric mean length of stay for the DRG, multiplied by a number equal to the length of stay for the case plus 1 day.</p> <p>For more information, see Chapter 3 of the Medicare Claims Processing Manual.</p>
Immunosuppressive Drugs, Transplant	<p>Reimbursement is according to the Outpatient Prospective Payment System (OPPS) if the member is in the outpatient department of a Medicare-participating hospital. In all other settings, reimbursement is at 85% of the Medicare average sale price (ASP) drug payment system. For drug Gapfill, RJ Health ASP equivalents are used.</p>
Indian Health Service Facility (IHS) – Inpatient Services	<p>Reimbursement to an IHS or Tribal Critical Access Hospital (CAH) for covered inpatient services is based on a facility specific per diem rate that is established on a yearly basis from the most recently filed cost report information.</p> <p>Payment for inpatient IHS or Tribal CAH services is at 100% of the facility-specific per diem rate less applicable deductible and coinsurance. Inpatient services should be billed on an 11X type of bill. IHS or Tribal CAHs are paid 101% of the facility-specific per diem rate. For more information, see Chapter 3 of the Medicare Claims Processing Manual.</p>

Service category	Reimbursement methodology
Indian Health Service Facility (IHS) – Outpatient Services	Reimbursement is excluded from the Outpatient Prospective Payment System (OPPS) and is based on an all-inclusive rate. Outpatient professional services are reimbursed based on their respective fee schedules.
Laboratory	Reimbursement is at the lesser of billed charges or the Medicare allowable charge on the Medicare Clinical Laboratory Fee Schedule.
Local Coverage Determinations (LCD)	<p>UnitedHealthcare MedicareDirect’s claim adjudication system allows claims to be processed according to Medicare local coverage determinations. There are currently thousands of Medicare LCD policies across all states that contain detailed Medicare coverage guidelines specific to each locality.</p> <p>Our claim adjudication system will look at the submitted claim and apply the appropriate LCD policy specific to the care provider’s locality. This process is in effect for all physician claims. Providers can view the LCDs on their Medicare Fee-For-Service Medicare Administrative Contractor’s (MAC) website. This information can also be viewed on the CMS website or through the Medicare Coverage Database located here. However, MAC websites may have more detailed or up-to-date information.</p>
Long-Term Care Hospitals (LTCHs)	The Medicare Prospective Payment System (PPS) for LTCHs applies to hospitals described in section 1886(d)(1)(B)(iv) of the Social Security Act, effective for cost-reporting periods beginning on or after Oct. 1, 2002. Section 1886(d)(1)(B)(iv)(I) of the Act defines a LTCH as “a hospital which has an average inpatient length of stay (as determined by the Secretary of Health and Human Services (the Secretary)) of greater than 25 days.” For more information, click here .
Mammography Screening	Reimbursement is at the Medicare allowable charge on the Medicare Physician Fee Schedule (MPFS).
Maryland Hospitals	Reimbursement is at 94% of approved charges for inpatient and outpatient services.
Medical Nutrition Therapy (Registered Dietitian)	Reimbursement is at the lesser of billed charges or 85% of the Medicare allowable charge on the Medicare Physician Fee Schedule (MPFS).
National Coverage Determinations	<p>A number of processes are in place that allow UnitedHealthcare MedicareDirect to process claims according to Medicare National Coverage Determinations (NCDs) for both facility and physician claims. The NCDs are administered systematically and/or through manual review processes. Documentation may be requested for review in an effort to process some claims according to the national coverage guidelines.</p> <p>Medicare NCDs can be viewed on the CMS website or through the Medicare Coverage Database located here.</p>
Nurse Practitioner	Reimbursement is at 80% of the lesser charge or 85% of the Medicare allowable charge on the Medicare Physician Fee Schedule (MPFS).
Oral Anti-Cancer Drugs	Drugs not paid on a cost or prospective payment basis will be paid under the Medicare average sale price (ASP) drug payment system. For drug Gapfill, RJ Health ASP equivalents are used.
Oral Anti-Nausea Drugs	Drugs not paid on a cost or prospective payment basis will be paid under the Medicare average sale price (ASP) drug payment system. For drug Gapfill, RJ Health ASP equivalents.
Parenteral and Enteral Nutrition (PEN)	Reimbursement is based on the Medicare PEN Fee Schedule.

Service category	Reimbursement methodology
Physical, Occupational, Speech Therapist	Reimbursement is at the lesser of billed charges or Medicare allowable charge on the Medicare Physician Fee Schedule (MPFS).
Physician Assistant	Reimbursement is at 80% of the lesser charge or 85% of the Medicare allowable charge on the Medicare Physician Fee Schedule (MPFS).
Physician Services – All Categories	Reimbursement is paid using the lesser of billed charges and the Medicare Physician Fee Schedule (MPFS), which is geographically adjusted. The fee schedule for physicians who don't participate in Medicare is 95% of the MPFS. However, UnitedHealthcare MedicareDirect reimburses all providers at 100% of the MPFS.
Physician Services (Audiologist)	Reimbursement is paid using the lesser of billed charges and the Medicare allowable charge on the Medicare Physician Fee Schedule (MPFS).
Physician Services (Chiropractor)	Reimbursement is paid using the lesser of billed charges and the Medicare allowable charge on the Medicare Physician Fee Schedule (MPFS).
Physician Services (Dentist)	Reimbursement is paid using the lesser of billed charges and the Medicare allowable charge on the Medicare Physician Fee Schedule (MPFS).
Physician Services (DO)	Reimbursement is paid using the lesser of billed charges and the Medicare allowable charge on the Medicare Physician Fee Schedule (MPFS).
Physician Services (MD)	Reimbursement is paid using the lesser of billed charges and the Medicare allowable charge on the Medicare Physician Fee Schedule (MPFS).
Physician Services (Optometrist)	Reimbursement is paid using the lesser of billed charges and the Medicare allowable charge on the Medicare Physician Fee Schedule (MPFS).
Physician Services (Oral and Maxillofacial Surgeon)	Reimbursement is paid using the lesser of billed charges and the Medicare allowable charge on the Medicare Physician Fee Schedule (MPFS).
Physician Services (Podiatrist)	Reimbursement is paid using the lesser of billed charges and the Medicare allowable charge on the Medicare Physician Fee Schedule (MPFS).
Prosthetic Devices	Reimbursement is at the Medicare allowable charge on the Medicare Durable Medical Equipment, Prosthetic, Orthotic and Supplies (DMEPOS) Fee Schedule.
Psychiatric Hospitals – Inpatient	<p>Payments to inpatient psychiatric facilities (IPF) under the IPF Prospective Payment System (PPS) are based on a single federal per diem base rate computed from both the inpatient operating and capital-related costs of IPFs (including routine and ancillary services), but not certain pass-through costs (e.g., bad debts, direct graduate medical education, and nursing and allied health education).</p>
	<p>The federal per diem payment under the IPF PPS is comprised of the federal per diem base rate (which is broken into a labor-related share and a non-labor-related share) and applicable patient and facility adjustments that are described in §§190.5 and 190.6. For more information, see Chapter 3 of the Medicare Claims Processing Manual, or click here.</p>
Psychiatric Hospitals – Outpatient	Reimbursement for these services is based on the Outpatient Prospective Payment System (OPPS) under Ambulatory Payment Classifications (APCs). For more information, see Chapter 4 of the Medicare Claims Processing Manual.

Service category	Reimbursement methodology
Radiology	The reimbursement rate is paid using the lesser of billed charges and the Medicare allowable charge on the Medicare Physician Fee Schedule (MPFS), professional and technical.
Registered Dietitian	Reimbursement is paid using the lesser of billed charges or 85% of the Medicare allowable charge on the Medicare Physician Fee Schedule (MPFS).
Rehab Hospital – Inpatient Services	The Inpatient Rehabilitation Facility (IRF) PPS will utilize information from a patient assessment instrument (IRF PAI) to classify patients into distinct groups based on clinical characteristics and expected resource needs. Separate payments are calculated for each group, including the application of case and facility level adjustments. For more information, click here .
Rehab Hospital – Outpatient Services	<p>Section §1834(k)(5) of the Social Security Act requires all claims for outpatient rehabilitation services and comprehensive outpatient rehabilitation facility (CORF) services to be reported using a uniform coding system. CMS chose HCPCS (Healthcare Common Procedure Coding System) as the coding system to be used for the reporting of these services. This coding requirement is effective for all claims for outpatient rehabilitation services and CORF services submitted on or after April 1, 1998.</p> <p>The Act also requires payment under a Prospective Payment System for outpatient rehabilitation services including CORF services. For more information, see Chapter 5 of the Medicare Claims Processing Manual.</p>
Religious Non-Medical Health Care Institutions	Reimbursement is on a reasonable cost basis.
Rural Health Clinics (RHCs)	RHCs are reimbursed 105% of the sum of 80% of the lower of the provider-specific interim rate or the per-visit payment limit, plus 20% of the RHC’s billed charges. The 2022 per-visit limit is \$113.00. 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. UnitedHealthcare MedicareDirect pays the cumulative amount, less any patient cost-sharing (copayment or coinsurance), which is collected by the RHC at the point of service. Some services (e.g., flu vaccinations) are not part of the interim rate and are paid separately under Resource-Based Relative Value Scale (RBRVS). UnitedHealthcare MedicareDirect pays these claims at 100% of the RBRVS rate, less any patient cost-sharing (copayment or coinsurance). UnitedHealthcare MedicareDirect requires an interim rate letter on file for any date span for which services were rendered to a member. Please fax all interim rate letters to UnitedHealthcare MedicareDirect Reimbursement Services at 866-943-9811 or by email at rpi_irl@uhc.com .
Skilled Nursing Facilities (SNF)	<p>SNFs are paid on the basis of a Prospective Payment System (PPS). The PPS payment rates are adjusted for case mix and geographic variation in wages and cover all costs of furnishing-covered SNF services (routine, ancillary and capital-related costs).</p> <p>For more information, click here.</p>
Sole Community Hospital (SCH)	These services are reimbursed according to the Prospective Payment System (PPS), under the Diagnosis-Related Group (DRG) methodology. The PPS rate equals the greater of the federal rate or the applicable hospital-specific rate (based on cost report data). For more information, see Chapter 3 of the Medicare Claims Processing Manual.

Service category	Reimbursement methodology
Surgical Dressings	<p>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 services are reimbursed under Prospective Payment System (PPS) Ambulatory Payment Classifications (APCs). HHA’s payment is bundled into PPS home health resource groups (HHRGs).</p> <p>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.</p>
Swing Beds	<p>Critical access hospital (CAH) swing beds are exempt from the skilled nursing facility (SNF) Prospective Payment System (PPS).</p> <p>Section 4432(a) of the Balanced Budget Act (BBA) of 1997 specifies that swing bed facilities must be incorporated into Part A SNF PPS by the end of the statutory transition period. Effective with cost-reporting periods beginning on or after July 1, 2002, swing bed bills are not paid on the cost-based method, but rather on the basis of the Part A SNF PPS. These payment rates cover all payment for furnishing covered swing bed extended care services (routine, ancillary and capital-related costs) other than approved educational activities as defined in 42 CFR 413.85. For more information, see Chapter 6 of the Medicare Claims Processing Manual.</p>
Veterans Administration (VA) Hospitals	<p>Federal care providers are excluded from participation in the Medicare program. However, federal hospitals, like other non-participating hospitals, may be paid for emergency inpatient and outpatient hospital services. For hospital-filed claims, inpatient services are reimbursed at the lower of actual charges or rates published for federal hospitals in the Federal Register under the Office of Management & Budget – Cost of Hospital & Medical Care & Treatment. Outpatient services are reimbursed at 85% of the total covered charges.</p>

Acronyms used in this document

APC	Ambulatory Payment Classification	IPPS	Inpatient Prospective Payment System
ASC	Ambulatory Surgery Center	IRF	Inpatient Rehabilitation Facility
ASP	Average Sale Price	LCD	Local Coverage Determination
CAH	Critical Access Hospitals	LTCH	Long-Term Care Hospital
CBA	Competitive Bidding Area	MA	Medicare Advantage
CMHC	Community Mental Health Center	MAC	Medicare Administrative Contractor
CMS	Centers for Medicare & Medicaid Services	MIPPA	Medicare Improvements for Patients and Providers Act
CORF	Comprehensive Outpatient Rehabilitation Facility	MPFS	Medicare Physician Fee Schedule
DME	Durable Medical Equipment	MS-DRG	Medicare Severity Diagnosis-Related Group
DMEPOS	Durable Medical Equipment, Prosthetic, Orthotic and Supplies	NCD	National Coverage Determination
DRG	Diagnosis-Related Group	OPPS	Outpatient Prospective Payment System
DSH	Disproportionate Share Hospital	PEN	Parenteral and Enteral Nutrition
EPO	Epoetin	PPS	Prospective Payment System
ESRD	End-Stage Renal Disease	RBRVS	Resource-Based Relative Value Scale
FQHC	Federally Qualified Health Center	RHC	Rural Health Clinic
HCPCS	Healthcare Common Procedure Coding System	SCH	Sole Community Hospital
HHA	Home Health Agency	SNF	Skilled Nursing Facility
HHRG	Home Health Resource Group	TEFRA	Tax Equity and Fiscal Responsibility Act
HPSA	Health Professional Shortage Area	TPS	Total Performance Scores
IHS	Indian Health Service Facility	VBP	Value-Based Purchasing
IME	Indirect Medical Education		