MVP and its participating facility providers use industry standard billing formats allowing for efficient claims processing and an expedited adjudication of cleanly submitted claims. Facility providers should refer to the rate sheet documents contained in their most current MVP agreement for the methodologies specific to that facility provider's reimbursement.

Inpatient Hospital Services Program

The Inpatient Hospital Services Program identifies the different types of inpatient stays to help facilitate billing and payment procedures. The following represent the majority of inpatient stay categories for which payment rates may be distinguished:

- Medical/surgical
- ICU/CCU
- Obstetrical delivery
- Obstetrical-related care; non-delivery
- Newborn
- Neonatal intensive care
- Licensed, hospital-based skilled nursing facility
- Tertiary care exclusions
- Skilled nursing level
- Physical rehab
- Sub-acute level

Note: Payment rates are "all inclusive" meaning that all services provided during the inpatient stay, including all pre-admission testing, will be paid at one rate. Except as defined in the Agreement, MVP does not reimburse hospitals separately for any service provided during the inpatient stay. The hospital may elect to include the physician component in the inpatient per diem or case rates. The effective date of a hospital's rates is indicated on its rate sheet. Newborn reimbursement includes payment for the New York State required newborn hearing screening testing.

Per Diem services that overlap contract periods will be paid based on the rate effective on the applicable date of service. DRG and case rates will be paid based on the member's admission date. MVP considers the member's inpatient hospital admission date to be the date and time the physician writes the order to admit to an inpatient level of care. MVP, in conjunction with facilities that have rate agreements, has reimbursement methodologies in place to process and pay different levels of inpatient care, as appropriate, within a hospital stay.

DRG Reimbursement Payment Methodology

DRG Reimbursement is a payment methodology which reimburses select hospitals a lump sum payment for the entire admission to the facility. Facility pre-admission testing or outpatient services provided three (3) or more days immediately preceding and including the date of admission are included in the inpatient payment. MVP utilizes the NYS Department of Health All Payor Revised DRG reimbursement rules and methodologies as outlined in the hospital's rate sheet documents. If members require hospital services during the covered admission which are not available at the hospital, hospital will be responsible for all costs of covered services provided at other facilities including transportation to those facilities unless the member is discharged from the hospital prior to treatment. A hospital must notify MVP of all member admissions within 24 hours of each admission or the first business day after each admission if the admission takes

place on a weekend or MVP recognized holiday (see *Concurrent Review* in Section 5 for more details).

Outpatient Hospital Services Program

The Outpatient Hospital Services Program identifies the variety of services provided to members on an outpatient hospital basis. The following are examples of outpatient service types for which payment rates may be distinguished:

- Ambulatory surgery/major
- Ambulatory surgery/minor
- Laparoscopic surgery
- Scope procedures
- Angioplasty
- Cardiac catheterization
- Observation stays
- Emergency room
- Electrophysiology studies
- Sleep studies
- Physical, occupational, & speech therapy
- Non-capitated lab services
- Non-capitated radiology services
- MRI/MRA
- PET and PET/CT
- Lithotripsy
- Hyperbaric chamber
- Wound care
- Other special case rates
- Other referred ambulatory services
- Other referred ambulatory services without CPT or HCPCS procedure codes

"Per Visit" Outpatient Service Format

Like the inpatient all-inclusive rate, all surgeries, scope procedures, cardiac catheterization, lithotripsy, emergency room, observation bed, PT/OT/ST, sleep study services and other services are subject to a "per visit" payment methodology. This methodology assumes that the payment rates are all-inclusive, defined as all services provided during the outpatient visit are included in one case rate, including preadmission testing. Except as defined in the Agreement, MVP will not reimburse hospitals separately for any service provided during the outpatient visit. The hospital may elect to include the physician component in the "per visit" rates.

Hospital Based Ambulatory Surgery

Hospital based ambulatory surgery services are determined by the principal CPT procedure code detailed on the UB04 claim form or the Standard EDI Transaction (ANSI 837). CPT and HCPCS codes designated as ambulatory surgery are updated annually with new codes added and deleted codes removed.

The payment rates for hospital based ambulatory surgical procedures are all-inclusive and includes all facility services directly related to the procedure within 24 hours of the surgery.

Reimbursement for hospital based ambulatory surgical procedures is defined by the provider contract. If the patient is admitted following the surgery, the hospital's ambulatory surgery services are inclusive to the payment terms of the inpatient service category.

Observation Status

The purpose of observation beds is to provide facilities for those patients who require a period of observation to determine the need for further treatment or a possible admission to the hospital as an inpatient. If the patient is approved for an inpatient admission or ambulatory surgery, the observation services are inclusive to the payment terms of those service categories. When a patient is admitted from an observation stay, the entire observation period will convert to inpatient benefit days. The facility is required to notify the health plan of the request for conversion to inpatient benefit days. The request is subject to review for medical necessity and will be reviewed when all clinical information is received following the standard UM process for concurrent review.

Emergency Room

Emergency room services are defined by the applicable revenue codes defined as 0450-0459 (excluding 0456). One of MVP's emergency room methodologies is a four-level program based upon diagnosis severity of an ER visit. The principal diagnosis submitted on the UB04 or Standard EDI Transaction (ANSI 837) will determine the ER level and thus the payment rate. The MVP Emergency Room classification system is updated annually to add new codes and remove deleted codes. If a patient is approved for an inpatient admission, ambulatory surgery or observation of the ER services are inclusive to the payment terms of those service categories.

Multiple Surgery Protocol — VT Only

For facility claims in Vermont, MVP will compensate multiple surgical procedure codes by reimbursing the surgical procedure code with the highest allowable reimbursement at 100 percent. Any additional surgical procedures would be subject to reduction logic and reimbursed at 50 percent of the allowed amount. Refer to *Section 15: Payment Policies* for additional information.

Other Referred Ambulatory Procedures

The laboratory, radiology, and other referred ambulatory procedures are defined as referred care not part of a "per visit" service type. MVP will only reimburse these procedures if they are not covered as part of an existing capitation agreement or other contract. It is important that hospitals follow the guidelines for billing and claims submission relative to the contract that is in place for these services. Under a fee schedule agreement, if a laboratory, radiology, or other referred ambulatory procedure is not covered as part of an existing contract, these procedures are to be reimbursed on a fee max-based system. The fee max-based system is based upon the resource-based relative value scale (RBRVS) for physician payment format. The RBRVS uses the federal system that assigns a relative value unit to CPT or HCPCS procedure codes multiplied by a negotiated "conversion factor" dollar amount. The RBRVS RVUs MVP uses as well as the Clinical Lab Fee Schedule can be accessed at National Physician Fee Schedule Relative Value File from Medicare at **www.cms.gov**. In the event that Medicare has not published an RVU for a given code, MVP will pay these codes at the all other referred ambulatory rates without CPT/HCPCS code at reasonable charges. Please refer

to your rate agreement for further details. Under a fee max-based system, the amount allowed shall not exceed billed charges.

On or about January 1st of each year hereunder, MVP will update the MVP Fee Schedule to be consistent with the regionally or nationally adjusted Medicare Fee Schedule most recently updated during the immediately preceding calendar year. Such updates shall not be retroactive. For a copy of the RVUs, please contact the MVP Contracts Department at **518-388-2351**. Rochester providers, please contact the Customer Care Center for Provider Services at **1-800-999-3920**.

Free-Standing Ambulatory Surgical Centers

Services provided at free-standing ambulatory surgical centers are determined by the principal CPT procedure code detailed on the CMS-1500 claim form or the Standard EDI Transaction (ANSI 837). CPT and HCPCS codes designated as ambulatory surgery are updated annually with new codes added and deleted codes removed.

Reimbursement for free-standing ambulatory surgical center procedures is defined by the provider contract. Unless specifically contracted, reimbursement for professional services is not included in the reimbursement for free-standing ambulatory surgical center services.

Urgent Care Centers

Services provided at urgent care centers are determined by the place of service code detailed on the CMS-1500 claim form or the Standard EDI Transaction (ANSI 837). CPT and HCPCS codes are updated annually with new codes added and deleted codes removed.

Reimbursement for urgent care center procedures is defined by the provider contract.