North Carolina State Health Plan Network Master Reimbursement Exhibit

Attachment - Consolidated Reimbursement Exhibit

Unless specifically noted elsewhere in this Agreement, the provisions in this Reimbursement Exhibit will govern the pricing and reimbursement of all services that are provided to State Health Plan Members under this Agreement and for which a pricing methodology is set forth or designated below.

Nothing in this Reimbursement Exhibit will obligate us to make payment to you on a claim for a service or supply that is not covered under the terms of the applicable Benefit Plan. Furthermore, the determination of a code-specific reimbursement rate/pricing methodology does not guarantee payment for the service.

1. GENERAL CLAIM REQUIREMENTS

a. Unless explicitly stated otherwise, all claims filed for items or services provided to State Health Plan Members must comply with all applicable Medicare billing guidelines[1].

2. PROFESSIONAL SERVICES

Unless specifically noted elsewhere in this Agreement, the provisions in this subsection set forth below shall govern the pricing of all professional services provided to State Health Plan Members under this Agreement.

a. General Pricing Principles

i. New Codes Introduced After Effective Date of This Agreement: Fees for services represented by CPT/HCPCS codes that are introduced after the effective date will be determined based on the hierarchy and criteria applicable to the Service Category on the new code.

ii. The Pricing Development and Maintenance Policy (the "Blue Cross NC Pricing Policy"), incorporated herein by reference, provides detailed information on access to the various pricing sources, and the process we use to develop, maintain, and update the reimbursement rates.

iii. Determination of the applicable reimbursement rate/pricing methodology is based on place of service.

iv. Except for services identified by Medicare as CLIA Excluded or CLIA Waiver, In-Office Laboratory Service fees will be limited to those services for which you have provided Blue Cross and Blue Shield of North Carolina with evidence of CLIA certification.

[1] Medicare billing guidelines can be accessed at:
1. https://www.cms.gov/Medicare/Medicare.html
2. https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS018912.html

b. *General Pricing Methodology for HCPCS Level I ("CPT") and Level II Codes*

Unless a service or code is excluded or subject to a different pricing methodology/source below, fees will be determined based upon HCPCS Level I ("CPT") or Level II codes using the following hierarchy and criteria. The first of the following criteria that can be used to establish a price will be the applicable source:

(i) 160% of Current North Carolina Medicare Part B Physician Fee Schedule[2] or if not available:

(ii) 160% of Optum Insight[2] as licensed by Blue Cross and Blue Shield of North Carolina or if none of the above sources contains a price for the applicable code, the Allowed Amount will be based upon:

(iii) Individual Consideration in accordance with the Blue Cross NC Pricing Policy, or if no price can be determined:

(iv) 50% of your Reasonable Charge

c. *Pricing Methodology for Specialty Pharmacy Medications*

i. All specialty pharmacy medications will be priced at 105% of the applicable price set by the Blue Cross and Blue Shield of North Carolina Specialty Pharmacy Drugs pricing hierarchy in the Blue Cross NC Pricing Policy.

d. *Pricing Methodology for Certain Designated Services*

Unless otherwise noted, the following services will be priced in accordance with the designated hierarchy and criteria as set forth in the Blue Cross NC Pricing Policy. The specific codes associated with the services and subject to the designated hierarchy are listed on the CCS/BETOS Fee Schedule Category and Code Listings, which are available through Blue Cross and Blue Shield of North Carolina's website.

BETOS/CCS Service Category	Service Category Description	Hierarchy/Criteria or Fixed Rate
200	Nonoperative Urinary System Measurements	160%
202	Electrocardiogram	160%
203	Electrographic Cardiac Monitoring	160%
205	Arterial Blood Gases	160%
206	Microscopic Examination (Bacterial Smear, Culture, Toxicology)	160%

[2] The "Current North Carolina Medicare Part B Physician Fee Schedule" will be the latest Medicare fee schedule file published as of January 15 by CMS for an effective date of April 1. The Medicare Part B Physician Fee Schedule can be accessed at https://www.cms.gov/apps/physician-fee-schedule/overview.aspx.

[3] You may obtain Optum Insight pricing information by contacting Blue Cross NC

212	Diagnostic Physical Therapy	160%
213	Physical Therapy Exercises, Manipulation, And Other Procedures	160%
215	Other Physical Therapy And Rehabilitation	160%
218	Psychological And Psychiatric Evaluation And Therapy	160%
219	Alcohol And Drug Rehabilitation/Detoxification	160%
220	Ophthalmologic And Otologic Diagnosis And Treatment	160%
222	Blood Transfusion	160%
227	Other Diagnostic Procedures (Interview, Evaluation, Consultation)	160%
228	Prophylactic vaccinations and inoculations	North Carolina State Health Plan Pricing Policy
233	Laboratory - Chemistry And Hematology	160%
234	Pathology	160%
235	Other Laboratory	160%
236	Home Health Services	125%
240	Medications (Injections, infusions and other forms)	North Carolina State Health Plan Pricing Policy
241	Visual Aids And Other Optical Supplies	DME Vision Hierarchy
242	Hearing devices and audiology supplies	DME Hearing Hierarchy
243	DME and Supplies	DMEPOS Hierarchy
243V	DME and Supplies – Vendor Only	DMEPOS Hierarchy
O1B	Chiropractic	160%
O1G	Immunizations/Vaccinations (Administration)	2018 Medicare Rates at 160%
T1A	Lab Tests - Routine Venipuncture (Non-Medicare Fee Schedule)	160%

e. *Services Excluded from Pricing under this Reimbursement Exhibit*

The following services and codes are excluded from reimbursement under this Agreement

(i) Routine Vision: CPT Codes 92002, 92004, 92012, S0620, S0621

3. ACUTE CARE HOSPITALS AND AMBULATORY SURGERY CENTERS

Unless specifically noted elsewhere in this Agreement, the provisions in this subsection set forth below shall govern the pricing of all services provided to State Health Plan Members under this Agreement in an acute care hospital or ambulatory surgery center.

a. *Billing Requirements*

i. All services must be billed in accordance with applicable Medicare billing guidelines issued by CMS.

ii. All services must be billed on a UB04 or CMS-1500 or successor claim form, as

applicable, consistent with CMS implementation date and Medicare billing guidelines.

iii. Blue Cross and Blue Shield of North Carolina will update DRG, ICD-10 diagnosis, ICD-10 procedure, revenue, CPT, and HCPCS codes and code categorizations as new codes are created, without requiring amendment to this Agreement. Updates by CMS will be implemented no later than 30 days from their effective date with CMS, and will not result in claims reprocessing.

iv. Hospital billed CRNA services shall be filed on a CMS-1500 or successor claim form according to Medicare billing guidelines with the appropriate modifier(s), and reimbursement will be based on the Medicare CRNA fee schedule.

v. Blue Cross and Blue Shield of North Carolina will recognize and reimburse Level II HCPCS codes that have replaced Level I CPT codes by OPPS.

b. *Inpatient Services*

i. For acute care hospitals that qualify as a "Rural Provider" under the North Carolina State Health Plan Pricing Policy,[3] inpatient services will be priced based on 200% of the then current Medicare rate schedule based on the applicable CMS Medicare Inpatient Prospective Payment (IPPS) rates of Medicare Severity Diagnosis Related Groups (MS-DRGs) published on the CMS website on the date of the Member's discharge geographically adjusted, including associated add-on and outlier payments.

ii. For acute care hospitals that do not qualify as a "Rural Provider" under the North Carolina State Health Plan Pricing Policy, inpatient services will be priced based on 175% of the then current Medicare rate schedule based on the applicable CMS Medicare Inpatient Prospective Payment (IPPS) rates of Medicare Severity Diagnosis Related Groups (MS-DRGs) published on the CMS website on the date of the Member's discharge geographically adjusted, including associated add-on and outlier payments.

iii. For services reimbursed under DRG methodology, outlier payments will be included as applicable.

iv. Blue Cross and Blue Shield of North Carolina will reimburse outlier claims consistent with CMS outlier methodology. Blue Cross and Blue Shield of North Carolina reserves the right to conduct retrospective review of claims and make necessary adjustments to such claims if certain services rendered are determined to be non-Covered Services or otherwise non-reimbursable under this Agreement.

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[3] The State Health Plan Pricing Policy can be accessed online at: www.bluecrossnc.com/providers/ncstatehealthplannetwork and in the The Blue BookSM Provider e-Manual available at https://www.bluecrossnc.com/providers/emanuals/provider-blue-book

v. Provider agrees to submit claims but not be compensated for those hospital services that are non-reimbursable as identified in CMS' Hospital-Acquired Conditions and Present on Admission Indicator Reporting program, or successor program, in accordance with CMS payment policies.

vi. Blue Cross and Blue Shield of North Carolina will reimburse acute and post-acute transfer cases consistent with CMS methodology.

vii. Interim billing will not be payable under this Agreement.

viii. After an initial claim is submitted, replacement claims will be accepted, but separate claims for items or services that should have been billed on the initial claim, but were not, will not be accepted.

ix. Claim level lesser of logic does not apply to claims payment

c. *Outpatient Services*

i. For acute care hospitals that qualify as a "Rural Provider" under the North Carolina State Health Plan Pricing Policy, outpatient services identified by CMS Outpatient Prospective Payment System (OPPS) Status codes will be priced based on 235% of the then current Medicare APC allowable rates, geographically adjusted.

ii. For acute care hospitals that do not qualify as a "Rural Provider" under the North Carolina State Health Plan Pricing Policy, outpatient services identified by CMS Outpatient Prospective Payment System (OPPS) Status codes will be priced based on 225% of the then current Medicare APC allowable rates, geographically adjusted.

iii. Payment for outpatient services will follow CMS packaging rules and discounting policies.

iv. Outpatient payment rates under the APC reimbursement will be consistent with CMS reimbursement levels for the same outpatient services. Outpatient services included in APC Status code A will be reimbursed per the applicable Medicare fee schedule unless specified otherwise above.

v. For services reimbursed under APC methodology, outlier payments will be included as applicable.

vi. Blue Cross and Blue Shield of North Carolina will reimburse outlier claims consistent with CMS outlier methodology. Blue Cross and Blue Shield of North Carolina reserves the right to conduct retrospective review of claims and make necessary adjustments to such claims if certain services rendered are determined to be non-Covered Services or otherwise non-reimbursable under this Agreement.

vii. Interim billing will not be payable under this Agreement.

viii. After an initial claim is submitted, replacement claims will be accepted, but separate claims for items or services that should have been billed on the initial claim, but were not, will not be accepted.

ix. Claim level lesser of logic does not apply to payment. Line level lesser of logic will apply for items reimbursed under the Medicare fee schedule for a specific claim.

d. *Ambulatory Surgery Centers*

All outpatient services provided in an ambulatory surgery center will be priced based on 200% of the then current Medicare ASC allowable rates, geographically adjusted.

e. *Certain Facility Fees Excluded*

i. The following codes and code combinations are excluded from reimbursement/payment under this Agreement:

(i) Procedure codes G0463, 99201-99205 and 99211-99215 when billed in combination with revenue codes 0280, 0480, 0760-0769 or 0960-0989.

(ii) Services billed with the revenue codes 0510-0529

4. DIALYSIS FACILITIES

Unless specifically noted elsewhere in this Agreement, the provisions in this subsection set forth below shall govern the pricing of all services provided to State Health Plan Members under this Agreement in a dialysis facility.

a. 200% of current rate under the Medicare End State Renal Disease Prospective Payment System.

5. FEDERALLY QUALIFIED HEALTH CENTERS (FQHC)

Unless specifically noted elsewhere in this Agreement, the provisions in this subsection set forth below shall govern the pricing of all services provided to State Health Plan Members under this Agreement in an FQHC.

a. For professional services billed on a CMS-1500 or successor form, 160%, and for technical services billed on a UB-04 form, 200% of current rate under the Medicare FQHC Prospective Payment System.

6. HOME HEALTH

Unless specifically noted elsewhere in this Agreement, the provisions in this subsection set forth below shall govern the pricing of all home health services provided to State Health Plan Members under this Agreement.

a. 125% of current rate under the Medicare Home Health Prospective Payment System.

7. MEDICAL REHABILITATION HOSPITALS AND MEDICAL REHABILITATION DISTINCT PART UNITS

Unless specifically noted elsewhere in this Agreement, the provisions in this subsection set forth below shall govern the pricing of all services provided to State Health Plan Members under this Agreement in medical rehab hospitals and medical rehab distinct part units:

a. *Inpatient Services*

i. 155% of current rate under the Medicare Inpatient Rehabilitation Facility Prospective Payment System.

b. *Outpatient Services at Medical Rehab Hospitals*

i. 200% of the then current Medicare APC allowable rates under the Outpatient Prospective Payment System, geographically adjusted.

8. INPATIENT PSYCHIATRIC HOSPITALS AND PSYCHIATRIC DISTINCT PART UNITS

Unless specifically noted elsewhere in this Agreement, the provisions in this subsection set forth below shall govern the pricing of all services provided to State Health Plan Members under this Agreement in inpatient psychiatric hospitals and psychiatric distinct part units.

a. *Inpatient Services*

i. 155% of current rate under the Medicare Inpatient Psychiatric Facility Prospective Payment System.

b. *Outpatient Services at Inpatient Psychiatric Hospitals*

i. 200% of the then current Medicare APC allowable rates under the Outpatient Prospective Payment System, geographically adjusted.

9. LONG TERM ACUTE CARE HOSPITALS (LTAC)

Unless specifically noted elsewhere in this Agreement, the provisions in this subsection set forth below shall govern the pricing of all services provided to State Health Plan Members under this Agreement in a long term acute care hospital.

a. *Inpatient Services*

i. 155% of current rate under the Medicare Long Term Care Hospital Prospective Payment System.

10. SKILLED NURSING FACILITIES

Unless specifically noted elsewhere in this Agreement, the provisions in this subsection set forth below shall govern the pricing of all services provided to State Health Plan Members under this Agreement in a skilled nursing facility.

a. 155% of current rate under the Medicare Skilled Nursing Prospective Payment System.

11. CRITICAL ACCESS HOSPITALS (CAH)

Unless specifically noted elsewhere in this Agreement, the provisions in this subsection set forth below shall govern the pricing of all services provided to State Health Plan Members under this Agreement in a critical access hospital.

a. For inpatient services, 200%, and for outpatient services, 235% of rate paid to the CAH under original Medicare at the time the claim is processed.

b. Any components of a CAH claim that are priced by Medicare based on 101% of the CAH's "reasonable cost" CAH claims will be paid based solely on the interim rate(s) in effect at the time the claim is processed and will not be subject to a final settlement after the applicable cost reports are filed.

12. REFERENCE LABORATORY SERVICES

Laboratory services billed under Place of Service 81 are not reimbursable under this Agreement.

13. ALL OTHER SERVICES

a. Any service that is not covered by Medicare (but is reimbursable under this Agreement) or is not subject to another pricing methodology or hierarchy as set forth in this Attachment shall be priced based on a percentage of charge, case rate, per diem, fee schedule, per unit price or other applicable methodology specified in the North Carolina State Health Plan Pricing Policy.