

WMGMA Medicare/Medicaid Workgroup

December 11, 2006

MEDICARE

Wisconsin Medical Society

1. When a patient changes status from acute inpatient to hospice inpatient, what is the proper way to bill the discharge from inpatient and admit to hospital inpatient hospice? Specifically, what codes should providers use for the admit on same day as discharge? Using inpatient admit and discharge codes will result in no payment for the hospice admit.

Answer: WPS Medicare is not able to offer coding advice. Please use the following resources for coding related questions.

For ICD-9 advice use the following resource:

Coding Advice/Central Office on ICD-9

American Hospital Association

One North Franklin

Chicago, IL 60606

Or Email Kayala@aha.org for information in Vols. 1 and 2

World Health Organization Collaborating Center for Classification of Diseases in North America

National Center for Health Statistics

Department of Health and Human Services

6525 Belcrest Road

Hyattsville, MD 20782

Morbidity Classification Branch

National Center for Health Statistics

Department of Health and Human Services

6525 Belcrest Road

Hyattsville, MD 20782

Center for Medicare & Medicaid Services (CMS)

Division of Prospective Payment

Mail Stop C5-06-27

7500 Security Blvd.

Baltimore, MD 21244-1850

For CPT Coding advice use the following resource:

Email the American Medical Association (AMA) at <http://www.ama-assn.org>

Call the CPT Information Services (CPTIS) at 1-800-634-6922

Visit the CMS Website General HCPCS Coding Questions section at http://www.cms.hhs.gov/MedHCPCSGeninfo/20_HCPCS_Coding_Questions.asp

Gundersen Lutheran

2. Code 0056T is a category III code in CPT 2006. At this time all claims come back denied. Does Medicare/Medical Assistance have any plans to review payment policies for this procedure?

Answer: Since Category III codes were first introduced in 2003, many services have been analyzed by the American Medical Association, by the Centers for Medicare & Medicaid Services, by various insurance companies, and by Medicare carriers. A number of these codes have been replaced by category I codes (the “typical” five-digit CPT codes). Others have not had their clinical efficacy and safety established. Thus, they still remain T-codes.

WPS normally pays for the professional component of T-codes when these services are performed in an approved Investigational Device Exception (IDE) trial. If, in time, a given Tcode proves to be safe and effective based on clinical trials, it will be paid with minimal medical review after a decision to cover the procedure has been made. However, under all other circumstances, claims for T-codes (category III) will be denied as experimental/investigative and, therefore, not medically necessary. Under federal law, [Title XVIII of the Social Security Act section 1862 (a) (1) (A)] coverage and payment are only allowed for those services that are considered medically reasonable and necessary.

Mile Bluff

3. Did I read someplace that if Average Sale Price is more than 5% less than the market price that Medicare will pay us more for the drug? If yes, how will we be paid?

Answer: WPS Medicare has no information to support this theory. Medicare pays 106% of the ASP.

Marshfield Clinic

For the next two questions, WPS Medicare has a reconsideration process whereby providers can request a reevaluation of a policy and add new conditions. The provider must request a change providing the scientific evidence for us to consider. The following Website will provide the information necessary to create the request:

http://www.wpsmedicare.com/policies/lmrp_recon.shtml

4. Flow Cytometry - Prior to the October 2006 Communique update for the "Flow 1. 1. Cytometry Policy - PATH-016" the whole range of codes 288.0-288.9 "Diseases of White Blood Cells" was payable. In the September Communique you added all the new codes within the range making the payable range 288.00-288.9. Now in the October Communique and on the website, it looks like the covered range of diagnoses has been removed and only one code 288.09, "Other neutropenia" remains as a covered diagnosis. Is this correct?

Answer: The codes changed for 2007, and after review, a decision followed that not all the expanded white cell codes fit into the general category: Primary immunodeficiencies. If there is evidence to prove otherwise we would be glad to consider it.

5. The policy PHYS-041 Nutritional Training Benefits provides the coverage guidelines for DSMT and MNT. We have a number of patients that have been diagnosed with diabetes secondary to pancreatectomy, 251.3, or diabetes secondary to pancreatitis, 251.8. In a current example, the patient's diagnosis is stated, "Diabetes, insulin requiring, secondary to pancreatitis and absolute insulin deficiency". ICD-9 coding requires us to code to the highest level of specificity. The policy seems to indicate patients with these diagnoses would not be covered for MNT/DSMT because the payable range is 250.00-250.93. However, as a newly diagnosed diabetics requiring insulin, it would seem the patients would be good candidates for MNT/DSMT. Does Medicare intend to exclude these patients from coverage?

Answer: WPS Medicare has operationalized this national benefit with ICD-9 codes, and does not have a restriction on adding codes 251.3 and/or, 251.8 to the claim. The codes should be in addition to the most appropriate codes from the ones listed in the document.

6. At the March meeting we asked the following: A Medicare patient is scheduled for chemotherapy and we prepare two bags of drugs for the patient, but during the administration of the first bag, the patient has a reaction. We understand that Medicare would intend to cover the remainder of the first bag because it is "wasted" and cannot be reused for another patient. Does Medicare also intend to cover the second bag, which has not been used during the chemo administration, but was mixed specifically for the patient and can't be used for anyone else? After group discussion, we were told the question would be reviewed again because they did not take into consideration that these drugs are not usually mixed in the physician's office. We were told this question would be forwarded to CMS for input. Is there an update?

Answer: The policy department has discussed this question and thinks that the second drug is not billable to Medicare. This is basically a non-rendered service. The beneficiary should not be charged for the second bag as it was not infused.

7. In March we submitted the following question: The Medicare Carrier's Manual contains a section regarding the Electronic Data Interchange enrollment form that indicates that by signing the EDI enrollment form the provider agrees that it will ensure that every electronic entry can be readily associated with the original source document. It goes on to indicate that the Secretary of Health and human Services or his/her designee or the contractor has the right to audit and confirm information submitted by the provider and shall have access to the original source documents and medical records related to the provider's submission, including the beneficiary's authorization and signature. Since the government is promoting conversion to EMR and other electronic media, can you tell me if they allow providers to use scanned documents to satisfy the "original source document" requirements? You indicated you had forwarded this question to CMS for consideration. Is there any update available?

Answer: There is no update at this time.

UW Health – UW Medical Foundation

8. On occasion, providers meet with patient proxies to review cases and discuss treatment options without the patient present. These proxies are acting on behalf of patients who are not able to participate in this aspect of their own care for one reason or another. Please explain whether the provider may be reimbursed for the services in the following examples:
- A) Patient living out-of state asks daughter to obtain second opinion on treatment options for tongue cancer. Daughter presents (without patient) with the patient's medical records, including imaging studies and photos. Physician reviews all patient materials and counsels daughter on patient's options. Counseling time is documented.
 - B) Son and daughter of demented patient who has been diagnosed with breast cancer present (without patient) to review the case and discuss treatment options. They have POA for patient and make treatment decisions on the patient's behalf. Patient's medical history is documented, as well as the complexity of medical decision making.
 - C) Mother of developmentally delayed group home resident presents (without patient) to discuss patient's GYN issues. Discussion is documented including, birth control, need for Pap smears and possible sterilization.

Answer: The only time this type of visit can be reimbursed by Medicare is if the patient is an inpatient. There is no accommodation for this in any other setting.

9. We continue to have trouble with the "multiple like services" issue. It is difficult to discern any pattern that would help us choose between multiple units or multiple lines when more than one service was performed under a single procedure code. One of our staff recently contacted customer service regarding code 90761 which was reported on two lines with one denied as a duplicate. When asked whether this should be submitted as two units on a single line, or do we need to add a 76 modifier to the denied service, we were told that Medicare doesn't pay for duplicate services... Would it be possible to use a remark code to assist providers in determining whether a multiple is being denied because of the unpublished submission "guideline"? Isn't Customer Service staff supposed to disclose the multiple unit guidelines for specific codes if we ask? If so, could they get a refresher on this concept?

Answer: 90761 can be quantity billed. You are correct, Customer Service should help you with the quantity billed information for specific codes you inquire about. We have relayed this concern to management. Typically, remark code M52 will set if the denial reason is for a code that is quantity billed that system does not allow to be quantity billed.

10. On a similar topic, we have had some questions come up regarding serial xrays. That is, the same type of image done more than once on the same day, by one or more of our radiologists. Both the technical and professional services are repeated. When one of our staff recently called CS about a duplicate denial for one of these serial xrays, (two different radiologists, both on our staff, one xray in the morning and the other in the afternoon), we asked and were told that it had hit audit 616 which referenced PHYS-002 and recommended

a “77” modifier if this was truly a repeat service rather than a duplicate billing of the first xray. A 77 modifier was added and the denial appealed, which resulted in payment. I have a previous communication from Provider Outreach telling me that we should be using modifier 76 in these cases, because of the “same specialty/same group” rule. Our question is, are both of these modifiers appropriate, or is one appropriate and the other not for our situation?

Answer: Generally, payment is made for only one interpretation of an EKG or x-ray procedure furnished to an emergency room patient. The second interpretation is generally a quality control service to be taken into account by intermediaries in determining hospital reasonable costs. Hospitals are encouraged to work with their medical staffs to ensure that only one claim per interpretation is submitted. Payment may be made for a second interpretation (which may be identified through the use of modifier-77) only under unusual circumstances (for which documentation is provided) such as a questionable finding for which the physician performing the initial interpretation believes another physician’s expertise is needed or a changed diagnosis resulting from a second interpretation of the results of the procedure.

11. We were recently contacted by Provider Outreach regarding ensuring appropriate filing of claims when an MSP situation exists. Would you please share the issue with our group and facilitate discussion on this topic for us?

Answer: WPS Medicare is attempting lower the amount of voluntary refunds returned due to MSP discrepancies. Provider Outreach & Education has been asked to assist in this effort. Educational calls have been placed to the 5 organizations with the highest amounts of voluntary refunds due to an MSP discrepancy in each of our 4 states. We are attempting to learn what processes are in place at registration desks throughout the jurisdiction. We are also taking this opportunity to share information about the MSP Questionnaire, SNAP and the IVR.

Prevea

12. We have patients that have Medicare Replacement plans and are in hospice. We originally billed the Medicare Replacement plan with GV (hospice) modifier and now receive denials indicating that hospice charges need to be billed to Medicare when the patients have a Medicare Replacement plan. Is that correct to bill Medicare?

Answer: Yes. The following is an excerpt from 100-04 40.2.2 - Claims From Medicare + Choice Organizations (Rev. 1, 10-01-03) B3-4175.3

Federal regulations require that Medicare fee-for-service contractors maintain payment responsibility for managed care enrollees who elect hospice; specifically, regulations at 42 CFR Part 417, Subpart P: 42 CFR 417.585 Special Rules: Hospice Care (b); and 42 CFR 417.531 Hospice Care Services (b).

A - Covered Services:

While a hospice election is in effect, certain types of claims may be submitted by either a hospice provider, a provider treating an illness not related to the terminal condition, or an M+CO to a fee-for-service contractor of CMS, subject to the usual Medicare rules of payment, but only for the following services:

- 1. Hospice services covered under the Medicare hospice benefit if billed by a Medicare hospice;**
- 2. Services of the enrollee's attending physician if the physician is not employed by or under contract to the enrollee's hospice;**
- 3. Services not related to the treatment of the terminal condition while the beneficiary has elected hospice; or**
- 4. Services furnished after the revocation or expiration of the enrollee's hospice election until the full monthly capitation payments begin again. Monthly capitation payments will begin on the first day of the month after the beneficiary has revoked their hospice election.**

B - Billing of Covered Services:

Medicare hospices will bill the RHHI for Medicare beneficiaries who have coverage through managed care just as they do for beneficiaries with fee-for-service coverage, beginning with a notice of election for an initial hospice benefit period, and followed by claims with types of bill 81X and 82X. If the beneficiary later revokes election of the hospice benefit, a final claim indicating revocation, through use of occurrence code 42, should be submitted as soon as possible so that the beneficiary's medical care and payment is not disrupted.

M + C organizations may bill the Medicare carrier for non-hospice services provided to M + C enrollees who elect hospice benefits. These claims should be submitted with a GV or GW (for services not related to the terminal condition) modifier as applicable. Carriers process these claims in accordance with regular claims processing rules. Medicare physicians may also bill such services directly to carriers as long as all current requirements for billing for hospice beneficiaries are met. Revised requirements for such billing were set forth in Transmittal 1728 CR 1910 in Pub. 14-4 (Medicare Carriers Manual) effective April 2002 and specifies use of modifiers –GV and –GW. When these modifiers are used, carriers are instructed to use an override code to assure such claims have been reviewed and should be approved for payment by the Common Working File in Medicare claims processing systems.

As specified above, by regulation, the duration of payment responsibility by fee-for-service contractors extends through the remainder of the month in which hospice is revoked by hospice beneficiaries. Managed care enrollees that have elected hospice may revoke hospice election at any time, but claims will continue to be paid by fee-for-service contractors as if the beneficiary were a fee-for-service beneficiary until the first day of the month following the month in which hospice was revoked.

- 13. In regards to the recent clarification released in the Monday, October 30, 2006 WPS Medicare Evaluation & Management e-News: Regarding a complete Review of Systems (ROS), this communication states "Due to recent clarification from CMS, those systems addressed in the ROS must be individually documented. All systems reviewed should be**

documented, regardless of the findings. It is no longer appropriate to state " all other systems are negative" without specifically listing the systems reviewed. Can you please expand on the source, reason or reference for this clarification?

Answer: CMS clarification states, CMS has not issued a national policy on the issue; therefore "...carriers have the discretion to develop new and clarify existing coverage, billing and documentation requirements to ensure that medical services paid by Medicare are medically necessary, reasonable and appropriate." The statement allows for WPS Medicare to require this change in documentation.

14. Exception from the Therapy Cap. Is there an easy way to find out when patients exceed the cap for PT services? When we call the patient may have 9-10 claims pending but we do not know if the services are for PT or other medical visits. Also, the appeals always end in denials. It is well documented the need for continued therapy. The letters received indicate the beneficiary does not meet the medical necessity requirements Medicare has established for granting an exception for these services. Is there something more Medicare is looking for in documentation?

Answer: The best way to learn the patients cap status is to call the IVR. It will tell you how much of the cap amount has been used in each category (The combined category of Physical Therapy and Speech Language Pathology and secondly Occupational Therapy.)

There are automatic exception situations that do not require a manual request at all. These automatic exception situations are outlined in CR 4364. If your patient meets any of the automatic exception criteria then you can automatically file your claims with the KX modifier.

Next, when you say appeals I am assuming you mean the manual requests for exception. If the patient does not meet the automatic exception criteria you will need to request additional visits using the manual exception request process. Each request should not exceed 15 visits. (If you need to request more than 15 you will have to send 2 requests and send the treatment plan in with both of those requests.)

The documentation submitted must be sufficient to support medical necessity of those additional treatment days. The submitted documentation, along with request for cap exception must be in accordance with CMS IOM Pub. 100-02, chapter 15, section 220.3 and CMS IOM Pub. 100-04, chapter 5, sections 102 and 20. Required documentation must include the current evaluation or reevaluation and current plan of care, treatment encounter notes, and interval progress reports sufficient to explain the beneficiary's current functional status and need for continued therapy.

Once you have received approval to your manual request you can bill claims with the KX modifier. Documentation does not need to be sent along with the claim to use the KX modifier.

MEDICAID

Gundersen Lutheran

1. Code 0056T is a category III code in CPT 2006. At this time all claims come back denied. Does Medicare/Medical Assistance have any plans to review payment polices for this procedure?

Answer: Category III CPT procedure codes represent emerging technologies. For the most part they are considered investigational by Medicaid and not covered until they either become regular CPT or HCPCS codes or are recognized by Medicare and other payers. Code 0056T remained a Category III code in CPT 2007.

Mile Bluff

2. Can you update us on the timeline of your rollout of your new computer system?

Answer: There is no official date set yet for implementation of the new computer system. It will not be January 1, 2007. Providers will receive formal notification prior to final implementation.

Agnesian Healthcare

3. The FPWP needs help!!!! According to the minutes from the last meeting, a new schedule was supposed to be ready in September. Listed below are some of our issues:
 - We continue to receive denials for code 90772, IM/Subq administration when used for the administration of Depo-Provera injections. This code is still not listed on the fee schedule; it became effective 1/1/06.

Answer: 90772 is on the Family Planning Waiver, effective 1/1/06. It must be billed on the same claim form as the Depo procedure code. If you need clarification on why a claim is denied, please contact Mari Ruetten at (608) 264-6724 or RuettML@dhfs.state.wi.us.

- We also continue to receive payment for E/M services completely unrelated to GYN or contraceptive diagnoses, i.e. joint pain for an E/M service provided by an Orthopedic physician, URI for a E/M service provided by an ENT physician, etc. We are constantly refunding money for incorrect payments.

Answer: The question on our part is why are non-covered services provided to FPWP enrollees being billed to Medicaid? The provider is responsible for knowing which services are covered by the FPWP and for checking the eligibility of the recipient, including any limitations or restrictions. Services that are not covered should not be billed to the Waiver Program, but rather to the patient or other insurance. Please remember that a patient may only be billed if she was notified prior to the delivery of the service that she would be responsible for payment.

- On the other hand, we have not been paid for services that should be paid, i.e. code 58100, endometrial biopsy, a code listed on the Family Planning Clinic Maximum Allowable Fee Schedule. Per Karen Gordon, this fee schedule applies only to family planning clinics (Planned Parenthood). It does not apply to physician offices. A physician/provider in a medical office can only receive payment for codes listed on the original schedule that was published in December, 2002.

A new fee schedule needs to be published that applies to all providers who provide FPWP services. Edits should be in place to allow payment only for family planning diagnoses. A process should be in place to update the fee schedule and diagnostic code list annually, shortly after the new codes are effective. This program is creating a lot of work for your staff and our staff because of all of the denials.

Answer: Karen is correct that the Family Planning Clinic maximum allowable fee schedule only relates to family planning clinics. The services listed on the schedule are unrelated to the services covered by the FPWP. Reimbursement under the FPWP is based on the fee schedule applicable to the provider of the service (e.g., physician, family planning clinic, nurse midwife, etc.).

Procedure code 59100 is not covered service under FPWP. All procedures that are covered by the Waiver are detailed in Wisconsin Medicaid/BadgerCare Updates. Please see 2002-68 and 2003-68. An updated listing will be published in December.

Marshfield Clinic

4. Telehealth Facility Fees – WI Medicaid has indicated an intent to provide coverage for the originating site facility fee for telehealth services (CPT Q3014). However, as we understand it, the current processing system isn't set up to process the charge unless it is submitted with a line-item provider number. Since there is no "presenter" required to be with the patient, there is no individual provider at that site. We have been asked to use the name of the consulting provider at the distant site, but this creates a whole new set of problems. Claims would have to incorrectly indicate that this provider was at two different locations at the same time. Commercial insurers primary to Medicaid would not be able to process claims submitted in this manner.

How can this be resolved so that we can appropriately submit our services for consideration?

Answer: The original intention was to allow Q3014 in any place of service and for any provider. Unfortunately, the legacy claims processing system has firm rules regarding the use of billing provider numbers in the performing provider field. For CT 20 (physician claims), Medicaid will not accept a billing number in that field if a different billing number is in the billing number field. The system is set to auto-deny. This is not something that can be easily fixed, nor will it be under the current claims processing system.

In the interim, we suggest that you put a performer (e.g., doctor, etc.) in that field and document what really occurred. It's not clean, but is necessary in the current system.

We are planning to issue an Update to explain this to providers.

5. Is there any new information available on the Family Planning Waiver Program?

Answer: A covered services update should be published in December. We are awaiting management approval.

6. Is there any information available on the new Medicaid processing system?

Answer: See response to #2 above.

UW Health – UW Medical Foundation

8. On occasion, providers meet with patient proxies to review cases and discuss treatment options without the patient present. These proxies are acting on behalf of patients who are not able to participate in this aspect of their own care for one reason or another. Please explain whether the provider may be reimbursed for the services in the following examples:

- A) Patient living out-of state asks daughter to obtain second opinion on treatment options for tongue cancer. Daughter presents (without patient) with the patient's medical records, including imaging studies and photos. Physician reviews all patient materials and counsels daughter on patient's options. Counseling time is documented.

Answer: If the mother is the patient and the daughter is getting a second opinion from a provider other than the patient's own physician, the service is not reimbursable - the second physician doesn't know the patient and has never seen her. He/she is offering an opinion.

- B) Son and daughter of demented patient who has been diagnosed with breast cancer present (without patient) to review the case and discuss treatment options. They have POA for patient and make treatment decisions on the patient's behalf. Patient's medical history is documented, as well as the complexity of medical decision making.

Answer: If the counseling was requested by the provider in order to make treatment decisions for the patient the service is reimbursable. If the counseling was done for the convenience and informing the relatives, at their request, the service is not reimbursable – it's part of patient care.

- C) Mother of developmentally delayed group home resident presents (without patient) to discuss patient's GYN issues. Discussion is documented including, birth control, need for Pap smears and possible sterilization.

Answer: Again, if the provider requested the counseling in order to make treatment decisions, then the counseling is reimbursable. If the counseling was requested by the mother merely to become better informed about the patient's

status and possible future health care needs it is part of patient care not separately reimbursable.

9. Please explain the current testing plan for NPI. Also, when will you be ready for dual use (NPI and legacy identifier) reporting?

Answer: Decisions on NPI are still pending. You will be notified of NPI requirements in a separate Medicaid Update.

Prevea

10. PT code 96110:developmental testing; limited (e.g. Developmental Screening Test II, Early language Milestone Screen) with interpretation and report. What documentation would support interpretation and report? Is it sufficient for the provider to state, Denver questionnaire given to pt's mother and the child passed.

Answer: According to our auditors, it is not sufficient to simply state that the person took a test and passed. Interpretation requires a written report of sufficient detail to enable the auditor to determine the results and work involved in the interpretation.

11. Is there a set methodology that drives Medicaid rates?

Answer: Wisconsin Medicaid does not have a single uniform method of establishing reimbursement rates. Physicians are reimbursed using a fee schedule but that schedule has been established over the years using a variety of methodologies. Wisconsin Medicaid does not use the RVRBS (Resource Based Relative Value System) to establish physician reimbursement.

The following methods are used now to establish physician reimbursement rates:

- ***Medicare rates as a Cap*** – Required by federal directive for clinical laboratory services, this is also used for radiology services. By law, Medicaid's rates for clinical laboratory cannot exceed Medicare's. These are revised annually based on Medicare data.
- ***Medicare Rate or Percentage of Medicare*** – For new codes or pricing existing codes that have no max fee, we often adopt the Medicare rate or a percentage thereof (typically 90%). To the extent that Medicare rates are RVRBS based, these rates reflect RVRBS. However, we do not use RVUs or coefficients to set these rates. In January 2005, we revised reimbursement for cardiology procedures to set all rates at 90% of Medicare.
- ***Historical Rates*** - Some codes have been on file for many years. Their rates will likely set based upon either the average of billed amounts or a comparison to similar codes. The rates have changed largely through legislatively mandated increases.

- ***Provider-Specific Rates*** – Physician assistants and nurse midwives get 90% of the physician rate for covered services. Occasionally the legislature will target certain specialties for rate increases.
- ***Incentive Payments*** – Established by the legislature, Medicaid pays a 20% bonus for primary care services and 50% bonus for obstetric services, if either the provider practices in or the recipient lives in a health professional shortage area. The legislature also established a pediatric bonus for office visits and emergency room visits. The pediatric bonus can be combined with the HPSA bonus.
- ***Cost Based Rates*** – Used primarily for physician-administered drug pricing, the max fee for an injection procedure is set at average wholesale price of the medication minus a percentage (currently 13%). Reimbursement for vaccines is based on CDC pricing or AWP but includes the administration fees. Vaccines available through the Vaccines for Children program are paid administration only.
- ***Anesthesia Pricing*** – The only set of codes that use RVUs (actually base units established by the American Society of Anesthesiologists), anesthesia pricing is based on the sum of the RVU and the number of 15-minute time units multiplied by a coefficient. The coefficient varies depending upon the type of provider performing the service (anesthesiologist vs. CRNA) and the level of medical direction involved.
- ***Age-Based Rates*** – When influenza vaccine was made available through the Vaccines for Children program, we set rates to pay only administration fee of \$3.28 when the vaccine is given to children and the cost of the drug plus administration when given to adults. There are also pediatric bonuses for office visits and emergency room visits.
- ***Manual Pricing*** – Used for codes that are non-specific or for services for which prices have not yet been established. These are priced by a consultant or through consultant approved adjudication directives, usually as a percentage of billed or of Medicare.
- ***Legislatively Mandated Changes*** – Last occurring in SFY 2003, we increased rates by 1.095% across the board. An additional 1.095% was allocated for increases to services for which Medicaid paid less than 50% of billed. Increases were made to obstetric reimbursement that year, based on a percentage of Medicare rates.

Rates for other services are based on a variety of methodologies, including contracted rates (e.g., rehabilitation agencies), DRGs and rates per day (e.g., hospitals, nursing homes), and cost-based settlements (e.g., RHCs, FQHCs).