



Sample Contract Matrices

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Insurance Company	Effective Date	Termination Date	Inpatient Services			Outpatient Services				
			8/1/2004	8/1/2005	8/1/2006	8/1/2004	8/1/2005	8/1/2006		
Payor 1A	8/1/2004	Evergreen	ICU/CCU (a)	\$ 2,200	\$ 2,310	\$ 2,425	Amb Surgery(n,u,v)	65%	65%	65%
			Stepdown/Telemetry (b)	\$ 1,800	\$ 1,890	\$ 1,984	NTE	\$ 2,500	\$ 2,625	\$ 2,756
			Med/Surg (d)	\$ 1,650	\$ 1,732	\$ 1,819	ER (RC 450-452, 459)	64%	64%	64%
			Rehab (e)	\$ 1,125	\$ 1,181	\$ 1,240	NTE	\$ 2,000	\$ 2,100	\$ 2,205
(a) RC 200, 201, 202, 203, 207, 208, 209, 210, 211, 212, 231, 219			Nursery Level 1 (f)	\$ 750	\$ 787	\$ 826	Chemo (O)	130%FS	130%FS	137%FS
			Nursery Lvl II, III (g)	\$ 1,500	\$ 1,575	\$ 1,654	Lab (p)	100%FS	100%FS	105%FS
			Nursery LVL 4 (RC 174)	\$ 1,500	\$ 1,575	\$ 1,654	Radiology (q)	130%FS	130%FS	137%FS
(b) Rev Codes 206, 214,			Sub Acute (lvl 3 & 4)(h)	\$ 450	\$ 472	\$ 496	Sleep Studies (s)	100%FS	100%FS	105%FS
			Skilled Care (lvl 1 & 2)(i)	\$ 650	\$ 682	\$ 716	PT/OI/ST (t)	100%FS	100%FS	105%FS
(d) RC 100, 101, 110, 111, 112, 113, 117, 119, 120, 121, 122, 123, 127, 129, 130, 131, 132, 133, 137, 139, 140, 141, 142, 143, 147, 149, 150, 151, 152, 153, 157, 159, 160, 164, 167, 169			Psychiatric Care (j),(ff)	\$ 625	\$ 656	\$ 689	All Other outpatient	64%	64%	64%
			Detox (k), (ff)	\$ 625	\$ 656	\$ 689	New Outpatient Svcs	65%	65%	65%
			Maternity (includes newborn charges for level 1 Nursery)				Urgent Care Center			
			Vaginal Delivery (L)	\$ 3,500	\$ 3,675	\$ 3,859	Urgent Care (S9083)	125%FS	125%FS	125%FS
			C-Section (m)	\$ 5,500	\$ 5,775	\$ 6,064				
(e) RC 118, 128, 138, 148, 158			Maternity addl days	\$ 550	\$ 577	\$ 606				
			Exclusions (each code must meet threshold)							
(f) RC 170, 171, 179			RC 274, 275, 278 >\$800	65%	65%	65%				
			RC 636 >\$800	65%	65%	65%				
(g) RC 172, 173			Case Rates (Devices and High Cost Drugs pay in addition)							
			DRG 104	\$ 30,975	\$ 32,524	\$ 34,150				
(h) RC 193, 194			DRG 105	\$ 30,975	\$ 32,524	\$ 34,150				
			DRG 106	\$ 30,975	\$ 32,524	\$ 34,150				
(i) RC 190, 191, 192, 199			DRG 107(w) 547, 548	\$ 30,975	\$ 32,524	\$ 34,150				
			DRG 108	\$ 30,975	\$ 32,524	\$ 34,150				
(j) 114, 124, 134, 144, 154, 204			DRG 109 (x), 549, 550	\$ 30,975	\$ 32,524	\$ 34,150				
			DRG 525	\$ 42,000	\$ 44,100	\$ 46,305				
(k) 116, 126, 136, 146, 156			DRG 110	\$ 19,950	\$ 20,947	\$ 21,995				
			DRG 111	\$ 19,950	\$ 20,947	\$ 21,995				
(L) 100, 101, 110, 111, 112, 120, 121, 122, 130, 131, 132, 140, 141, 142, 150, 151, 152, 160, Px Code of 72.0 - 73.99 or CPT 59400, 59409, 59410, 59610, 59612, 59614. 0-4 day case			DRG 115(y), 551	\$ 19,950	\$ 20,947	\$ 21,995				
			DRG 116 (z), 552	\$ 19,950	\$ 20,947	\$ 21,995				
			DRG 117	\$ 19,950	\$ 20,947	\$ 21,995				
(m) RC 100, 101, 110, 111, 112, 120, 121, 122, 130, 131, 132, 140, 141, 142, 150, 151, 152, 160, Px Code of 74.0 - 74.99 or CPT 59510, 59514, 59515, 59618, 59620, 59622. 0-5 day case			DRG 118	\$ 19,950	\$ 20,947	\$ 21,994				
			DRG 515	\$ 30,000	\$ 31,500	\$ 33,075				
			DRG 516 (aa), 555	\$ 19,950	\$ 20,947	\$ 21,995				
			DRG 517 (bb), 556	\$ 19,950	\$ 20,947	\$ 21,995				
			DRG 518	\$ 19,950	\$ 20,947	\$ 21,995				
			DRG 526 (cc), 557	\$ 19,950	\$ 20,947	\$ 21,995				
			DRG 527 (dd), 558	\$ 19,950	\$ 20,947	\$ 21,995				
(n) all procedures			DRG 535	\$ 41,000	\$ 43,050	\$ 45,202				
			DRG 536	\$ 41,000	\$ 43,050	\$ 45,202				
(O) CPT Codes 51720, 96400 - 96545			DRG 288	\$ 12,000	\$ 12,600	\$ 13,230				
			Stoploss (Second Dollar, Implants and High Cost Drugs Excluded) (ee)							
(p) CPT Codes 80048 - 89356			Threshold	\$ 100,000	\$ 105,000	\$ 110,250				
			Reimburses	64%	64%	64%				
(q) CPT Codes 70010 - 79999			New Inpatient Svcs	med/surg	med/surg	med/surg				
			SNF (Caps @ Charges)							
(s) CPT Codes 95805, 95807, 95808, 95810, 95811			LVL 1 (RC 100-169, 190-192)	\$ 350	\$ 368	\$ 386				
			LVL 2 (RC 1930)	\$ 400	\$ 420	\$ 441				
(t) CPT Codes 92506 -92508, 97001-97546			LVL 3 (RC 194)	\$ 500	\$ 525	\$ 551				

(u) **Ambulatory Surgery**-All Default: The primary surgical procedure will be identified as the highest applicable category.

(v) **EFFECTIVE 8/1/2006 - Ambulatory Surgery**- All Default: The primary surgical procedure will be identified as the highest applicable category. The primary procedure will be reimbursed at 100.00% of the contracted rate. **Secondary and subsequent procedures are also reimbursed at 100.00% of the contract rate.**

(w) Effective 10/1/2005 DRG 107 is replaced with DRGs 547 and 548

(y) Effective 10/1/2005 DRG 115 is replaced with DRG 551

(z) Effective 10/1/2005 DRG 116 is replaced with DRG 552

(aa) Effective 10/1/2005 DRG 516 is replaced with 555

(bb) Effective 10/1/2005 DRG 517 is replaced with DRG 556

(cc) Effective 10/1/2005 DRG 526 is replaced with DRG 557

(dd) Effective 10/1/2005 DRG 527 is replaced with DRG 558

(ee) **Stoploss** - Second Dollar reimbursement applies the day after the threshold is met. Exclusions are excluded. (per facility it is based on an average per diem)

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Insurance Company	Effective Date	Termination Date	Inpatient Services	Outpatient Services				
Payor 2B	7/15/2005	Evergreen		7/15/2005	2/15/2006	7/15/2005	2/15/2006	
HMO/PPO/POS			Medical (a)	\$ 1,823	\$ 1,714	Ambulatory Surgery (per case) (L)®	\$ 1,953	\$ 1,836
COB			Surgical (b)	\$ 2,213	\$ 2,081	ER Level (1-3, per visit)(M)	\$ 619	\$ 582
(a)DRG 9 -35,43-48,64-74,78-102,121-145,172-190,202-208, 235-256,271-284,294-301,316-333,346-352,366-369,376, 378-380,382-384,395-399,403-405,409-414,416-423,425-433 444-455,462-467,473,475,487,489,490,492,505,508-511, 521-523,524			All ICU (d)	\$ 3,255	\$ 3,061	Cardiac Cath (per case)(n)	\$ 6,510	\$ 6,122
			Intermediate ICU/CCU (d)	\$ 3,255	\$ 3,061	Gamma Knife (entire bill)(o)	95%	95%
			Gamma Knife (e)	95%		All Other Outpatient (q)	72%	72%
			Maternity			Exclusions		
			Mom Normal Delivery (DRG 372-375)(f)	\$ 1,693	\$ 1,592	RC 274-276, 278, 279	72%	72%
			Mom C-Section (DRG 372-375)(g)	\$ 1,823	\$ 1,714			
(b)DRG 1-8,36-42,49-63,75-77,119,120,146-171,191-20, 209-234,257-270,285-293,302-315,334-345,353-365,374, 375,377,381,392-394,400-402,406-408,415,424,439-443, 461,468-471,476-486,488,491,493-504,506,507,512,513, 519,520,528-534,537-543			Newborn/Boarder/NICU level 1 (RC 170)	\$ 587	\$ 552			
			NICU Levels 2-4 (RC 172, 173, 174)	\$ 3,256	\$ 3,061			
			DRG Case Rates					
			103-106, 108, 109, 525, 535, 536 (h)	\$ 38,409	\$ 36,117			
			110- 118 (i)	\$ 24,738	\$ 23,262			
			514, 515, 516, 518, 526, 527 (j)	\$ 24,738	\$ 23,262			
(d) RC 200, 201, 202, 203, 206, 207, 208, 209, 210, 211, 212, 214, 219			547, 548, 549, 550 (10/1/2005)	\$ 38,409	\$ 36,117			
			551, 552 (10/1/2005)	\$ 24,738	\$ 23,262			
(e)DRG 7 or 8 with ICD-9-CM Px of 92.3, Sterotactic - TBD			517, 555, 556, 557, 558 (10/15/2005)	\$ 24,738	\$ 23,262			
			Exclusions					
(f)112, 122, 132, 142, 152			RC 274-276, 278, 279	72%	72%			
			Stoploss (Applies only to DRG and excludes Exclusions)(k)					
(g)112, 122, 132, 142, 152			Threshold	\$ 75,000	\$ 75,000			
			Reimburses	72%	72%			
(h)Effective 10/1/2005 DRG 107 is replace with DRGs 547 and 548, DRG 109 is replaced with 549 and 550								
(i) Effective 10/1/2005 DRG 115 is replaced with DRG 551 and DRG 116 is replaced with DRG 552								
(j) Effective 10/1/2005 DRG 516 is replaced with DRG 555, DRG 526 is replaced with DRG 557 and DRG 527 is replaced with DRG 558								
(L) 10000-36414, 36417-69999								
(M) 99281-99282, 99283, 99284-99285								
(n) CPT 93501-93533 RC 481 plus RC 274-276, 278, 278 A 72% of charges								

(k) Stoploss - Second Dollar reimbursement applies the day after the threshold is met. Exclusions are excluded. Claims must be received with the IBILL within 365 days.

(q) In no event shall payment for services for rapid treatment or observatin care exceed the cost of an inpatient medical per diem.

Payor 4E	11/1/2001	Evergreen					
COB			Med/Surg/ Peds per diem	\$1,155	OP Surgery		
			Cardiac Angio Plasty	85%	ASPG groups 1-9 per case	\$1,985	
			Cardiac Surg per diem	\$4,635	ASPG group 10	80%	
			Cardiac Care Unit per diem	\$2,935	All Other OP	80%	
Reimbursement will be lesser of contracted rates or 90% of billed charges			Step Down/DOU per diem	\$1,545			
			ICU/PICU/NICU per diem	\$3,195			
			Normal Delivery per diem	\$2,660			
In no way will payer reimburse less than 60% of chgs			C-Section per diem	\$5,575			
			Psych/ Behavioral Hlth per diem	\$815			
			Boarder Baby per diem	\$390			
			Cardiac Cath	85%			
			Litho (RC 790)	90%			
			Stop Loss: 2nd \$ (exclds all items reimbursed at X% of BC)				
			Nothing else followed on rate sheet				

Payor 5F	12/1/2006	Evergreen					
Lesser of - The payment rate will be the lesser of the negotiated rate or 90% of billed charges. Excludes percent of payment and exclusions.			Cardiac Angio	85%	Ambulatory Surgery (a)		
			Cardiac Surgery	85%	Category 1 - 9 (per case)	\$ 3,650	
			CCU	\$ 4,015	Category 10 (All Other Outpatient)	80%	
			Step Down (DOU)	90%	Exclusions		
			NICU (b)	\$ 3,670	RC 790 Extra-Corporeal Shock Wave	90%	
(a) The ambulatory Surgery Payment Group is defined as 1) the 2004 Medicare CPT codes and categories 2) the 57 additional CPT codes contained in the amendment.			ICU/PICU	\$ 5,640			
			Normal / C-Section Delivery	\$ 2,240			
			Psych/Behav./Chem. Dep	\$ 1,420			
			Sick/Boarder Baby	\$ 1,200			
Facility Stay -the day or consecutive days of stay for which a patient occupies and inpatient acute care bed or is assigned to an observation be for the period of 24 hours, provided that if the patient is discharged and readmitted for treatment for the same condition which occasioned the origi- nal visit or a complication arising there from, the days of stay before discharge and following readmission until			MED/SURG/PEDS	\$ 2,000			
			Cardiac Cath	85%			
			All Other inpatient	90%			
			Stoploss(1st Dollar, excludes % of charges payment & RC Excls)				
			Threshold	\$ 60,000			
			Reimburses	85%			
			Exclusions				

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Cardiac Angioplasty - includes admissions for which the PRIMARY procedure is the performance of cardiac angioplasty. Reimbursement applies to the ENTIRE stay				

Cardiac Surgery -Excludes admissions for which the primary procedure is the performance of a cardiac catheterization or heart transplant and admissions for the treatment of wounds of the heart and great vessels or thoracic aortic aneurysms. Reimbursement applies to the ENTIRE facility.

Step down/DOU - Excludes any days of care received either prior to or following hospitalization in a step down/DOU bed.

(b)NICU- Excludes any day of service received either prior to or following hospitalization in a neonatal critical care unit and Neonatal levels 1 and 2 which are included under the sick/boarder baby heading.

ER Admits - If a patient is admitted to the facility after having received Emergency Room treatment, all ER services will be included in the first day of the facility stay.

Mother and Baby charges - The per diem includes both mother and baby.

Multiple Procedures - When multiple procedures are performed during a single outpatient surgical encounter the primary procedure (the one with the highest charge) will be reimbursed at 100% of the negotiated rate. The secondary procedure (the second highest rate) will be reimbursed at 50% of the negotiated rate, no other payment will be made.

Categories - If a claim is categorized into any group and Group 10, the claim will be paid at the group 10 rate.

Payor 6G	1/15/2008	Evergreen		
Caps @ Charges / COB				
(a) Except DRGs 469, 302, 480, 481, 495, 512, 513			DRG reimbursement (a)(b) (base rate)	\$ 12,932
			Outlier	
			Threshold Days	20
(b) Covered services rendered to a mother and her baby will be paid as separate admissions.			Reimburses thereafter per day	\$ 2,120
			Rule out Myocardial (d) per case	\$ 4,500
			False Labor (e) per case	\$ 2,364
			Observation (f) per case (RC 762)	\$ 2,364
			Emergency Room (g)(h) (per case)	
			Level 1 (CPT 99281, 99282)	\$ 663
			Level 2 (CPT 99283)	\$ 996
			Level 3 (CPT 99284, 99285)	\$ 2,480
			Level 4 (CPT 99291)	\$ 4,982
			Urgent Care (RC 456) (i)(per case)	\$ 159
			Oncology Treatment (RC 280, 289)	\$ 1,272
			Laboratory (j)	90%
			Pathology (RC 310-312, 314, 319)	90%
			Services below are PER VISIT	
			Other Diagnostic (RC 320-324, 329)(per visit)	\$ 302
			Radiation Therapy (RC 330, 333, 339)(per visit)	\$ 1,272
			Chemo (RC 331, 332, 335)(per visit)	\$ 636
			Pathology (RC 0310, 0311, 0312, 0314, 0319)	85%
			Other Diagnostic Radiology (RC 0320-0324, 0329)	\$ 302
			Nuclear Medicine (RC: 0340-0342, 0349)	\$ 1,961
			(CT) Scan (RC: 0350-0352, 0359)	\$ 1,908
			Imaging Services (RC0400, 0409)	\$ 371
			Diagnostic/Screening Mammography (RC 401, 403)	\$ 95
			Ultrasound Imaging (RC: 0402)	\$ 498
			PET(RC 0404)	\$ 5,215
			Respiratory Services (RC: 0410, 0412, 0419)	\$ 551
			Hyperbaric (RC: 0413)	\$ 1,590
			Physical Therapy (RC 0420-0424, 0429)	\$ 186
			Occupational Therapy (RC 0430-0434, 0439)	\$ 186
			Speech Therapy (RC 0440-0444, 0449)	\$ 191
			Cardiology (RC 480, 489)	\$ 530
			Cardiac Stress Test (RC 482)	\$ 498
			Echocardiology (RC 483)	\$ 848
			Ambulance land (RC 540, 542, 543, 546-549)	\$ 1,060
			Ambulance Air (RC 545)	\$ 4,240
			MRI(RC 610-612, 614-616, 618, 619)	\$ 2,099
			Labor Room/Delivery (k)	\$ 1,060
			EKG/ECG (RC 730, 739)	\$ 223
			Holter Monitor/ Tele (RC 731, 732)	\$ 440
			EEG (RC 740, 749)	\$ 1,463
			Hemodialysis (RC 820-825, 829)	\$ 731
			Peritoneal Dialysis, CAPD, CCPD (L)	\$ 186
			Neuro Psych Test/Feedback (m)	\$ 424
			Other Diagnostic (RC 920, 929, W/O CPT 95805-95811)	\$ 392
			Sleep Studies (RC 920, 929 w/ CPT 95805-95811)	\$ 1,060
			Peripheral Vascular labn (RC 921)	\$ 657
			EMG (RC 922)	\$ 514
			Other Therapeutic (940, 949)	\$ 212
			Allergy Testing (RC 924)	\$ 101
			Education and Training (RC 942)	\$ 106
			Cardiac Rehab (RC 943)	\$ 148
			Outpatient Procedure Groupers (n)(per case)	
			Group 0	\$ 456

(d) Revenue Code 0762 with Principal ICD-9-CM Diagnosis Codes: 411.0-411.89, 413.0-413.9, 414.00-414.05, 786.50-786.59, V71.7

If an Admission of a Customer for the same diagnosis occurs the same or next two calendar days of the rendering of emergency Covered Services, urgent care, Observation, rule out myocardial infarction or false labor services, charges for such Covered Services shall not be billed by Facility separately and will not be paid by Payer or by the Customer but shall be included in the contract rate for the Admission.

(e)Revenue Codes: 0720, 0721, 0722, 0724, 0729 with Principal ICD-9-CM Diagnosis Codes 644.10-644.13 (1)

If an Admission of a Customer for the same diagnosis occurs the same or next two calendar days of the rendering of emergency Covered Services, urgent care, Observation, rule out myocardial infarction or false labor services, charges for such Covered Services shall not be billed by Facility separately and will not be paid by Payer or by the Customer but shall be included in the contract rate for the Admission.

(f)If an Admission of a Customer for the same diagnosis occurs the same or next two calendar days of the rendering of emergency

Covered Services, urgent care, Observation, rule out myocardial infarction or false labor services, charges for such Covered Services shall not be billed by Facility separately and will not be paid by Payer or by the Customer but shall be included in the contract rate for the Admission.

(g)Revenue Codes 0450, 0451, 0452, 0459 with CPT 99281, 99282, 99283, 99284, 99285, 99291

If an Admission of a Customer for the same diagnosis occurs the same or next two calendar days of the rendering of emergency Covered Services, urgent care, Observation, rule out myocardial infarction or false labor services, charges for such Covered Services shall not be billed by Facility separately and will not be paid by Payer or by the Customer but shall be included in the contract rate for the Admission.

(i)If an Admission of a Customer for the same diagnosis occurs the same or next two calendar days of the rendering of emergency

Covered Services, urgent care, Observation, rule out myocardial infarction or false labor services, charges for such Covered Services shall not be billed by Facility separately and will not be paid by Payer or by the Customer but shall be included in the contract rate for the Admission.

(j)Revenue Code: 0300, 0301, 0302, 0303, 0304, 0305, 0306, 0307, 0309, 0923, 0925

(k)Revenue Code: 0720, 0721, 0722, 0724, 0729 without Principal ICD-9-CM Diagnosis Codes 644.10-644.13

(L)Continuous Ambulatory Peritoneal Dialysis and Continuous Cycling Peritoneal Dialysis) (Revenue Code: 0830-0835, 0839, 0840-0845, 0849, 0850-0855, 0859

(m) NON-PSYCHIATRIC disorders only RC 900, 917, 918

(n)Revenue Codes 0360, 0361, 0369, 0481, 0490, 0499, 0750, 0759, 0790, 0799 and appropriate CPT or HCPCS Codes See Exhibit 2 for Revenue Code and CPT or HCPCS code criteria.

Claim Filing - Claims must be filed within 180 days from the date of discharge or the date outpatient services were rendered.

Claim Payment - Payor will pay clean claims within 30 days.

Underpayments/Overpayments - Either party may seek correction of the payment by giving the other party notice within 12 months after the payment was initially made. Undisputed underpayments will be repaid within 45 days of notice of the underpayment.

