North Carolina State Health Plan Network
Clear Pricing Project Service and Rate Schedule

Unless specifically noted elsewhere in this Amendment, the provisions in this Service and Rate Schedule will govern the pricing and reimbursement of all services that are provided to North Carolina State Health Plan (State Health Plan) Members under the Clear Pricing Project (CPP) Amendment and for which a pricing methodology is set forth or designated below.

Nothing in this Service and Rate Schedule 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

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

a. General Pricing Principles

i. This fee schedule will be updated annually based on the most recent Medicare fee schedule file published by CMS for an effective date of January 1 available when the fee schedule is updated in May. Any updated rates will be effective when fully implemented for the Plan and will not be applied retroactively to claims that have been previously processed.

a. On the effective date of this Plan Policy, all claims submitted on behalf of State Health Plan Members will be priced in accordance with the most current rates implemented for the Plan at that time.

ii. Fees for services represented by CPT/HCPCS codes that are introduced after the effective date will be added quarterly based on the hierarchy and criteria applicable to the Service Category on the new code.

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

[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

iv. When application of the hierarchy and criteria for the determination of contractual allowances results in a fee for a given service based upon a percentage of your charge, you are obligated to ensure that: (1) all charges billed to Company are reasonable; (2) all charges are consistent with your fiduciary duty to your patient and Company; (3) no charges are excessive in any respect; and (4) all charges are no greater than the amount regularly charged to the general public, including those persons without health insurance.

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

Unless otherwise noted, the following services will be priced in accordance with the designated percent of Medicare. The specific codes associated with the services and subject to the designated hierarchy described below are listed on the Aetna CPP Fee Schedule spreadsheet except those that are updated quarterly (LINK). The Aetna CPP Fee Schedule spreadsheet is updated annually in May.

Service Category	**Rate**
All Services Not Otherwise Specified	160% of Current Year Medicare
Visual Aids and Other Optical Supplies	100% of Current Year Medicare (rural)
Hearing devices and audiology supplies	100% of Current Year Medicare (rural)
DME and Supplies	80% of Current Year Medicare (rural)
Immunizations/Vaccinations (Administration)	160% of 2018 Medicare
Immunization Medications	100% of Current Year Medicare updated quarterly
Designated Specialty Medications (codes listed in e. i.)	Aetna CPP Specialty Pharmacy Fee Schedule
Other Pharmacy Medications (Injections, Infusions and Other Forms)	100% of Current Year Medicare updated quarterly
Anesthesia	160% of Current Year Medicare
Chiropractic	160% of Current Year Medicare
Ambulance	160% of Current Year Medicare (rural)

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. Designated percentage of Current North Carolina Medicare Part B Physician Fee Schedule[2] or if not available
ii. 100% of National Aetna Market Fee Schedule[3] or if not available
iii. 50% of the 80th percentile of the Usual & Prevailing (U&P) profile[4] or if not available
iv. 50% of eligible billed charges

c. In-Office Laboratory Services

i. 160% of North Carolina Medicare Clinical Lab Fee Schedule[5] or if not available;
ii. 160% of North Carolina Medicare Part B Physician Fee Schedule or if not available;
iii. 100% of National Aetna Market Fee Schedule (AMFS)
iv. 50% of the 80th percentile of the Usual & Prevailing (U&P) profile4 or if not available
v. In the absence of a profile amount, 50% of eligible billed charges

d. Pricing Methodology for Immunization Medications

i. 100% of Current North Carolina Medicare Part B Drug Fee Schedule[2] or if not available
ii. 100% Average Sales Price (ASP), or if not available
iii. 100% of Average Wholesale Price (AWP)
iv. 50% of eligible billed charges

[2] The "Current North Carolina Medicare Part B Physician Fee Schedule" will be the most recent Medicare fee schedule file published by CMS for an effective date of January 1 available when the fee schedule is updated in May. The Medicare Part B Physician Fee Schedule can be accessed at https://www.cms.gov/apps/physician-fee-schedule/overview.aspx.

[3] Aetna Market Fee Schedule (AMFS) – A fee schedule that is based upon the contracted location where services are performed. Company may periodically update this fee schedule.

[4] Usual and Prevailing (U&P) based on Fair Health 80th percentile rates

[5] The "Current North Carolina Medicare Clinical Lab Fee Schedule can be accessed at https://www.cms.gov/medicare/medicare-fee-for-service-payment/clinicallabfeesched.

e. Pricing Methodology for Pharmacy Medications

i. 100% of Aetna CPP Specialty Pharmacy Fee Schedule for designated specialty medications listed below:

J2350, J3241, J3380, J2323, J1745, J1599, J1561, J1303, J1459, J1300, J3357, J1555, J1559, J0129, J1557, J0222, J9332, J1558, J3032, J9039, J1097, J1602

ii. 100% of Current North Carolina Medicare Part B Drug Fee Schedule[2] or if not available

iii. 85% of Average Wholesale Price (AWP)

iv. 50% of eligible billed charges

f. Services Excluded from Pricing under this Service and Rate Schedule

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

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

3. FACILITY SERVICES

Unless specifically noted elsewhere in this Amendment, the provisions in this subsection set forth below shall govern the pricing of all services provided to State Health Plan Members under this Amendment for the provider types designated below.

For purposes of this Service and Rate Schedule and except where expressly stated otherwise, all references to "current" Medicare rates, rate schedules, fee schedules, or otherwise are referring to the applicable rates that have been fully implemented for the Plan at the time a claim is processed.

Service	**Methodology**	Rates
Hospital Inpatient Rural	DRG	200% of Current Year Medicare
Hospital Inpatient Non-Rural	DRG	175% of Current Year Medicare
Outpatient Rural	APC	235% of Current Year Medicare
Outpatient Non-Rural	APC	225% of Current Year Medicare
Ambulatory Surgery Center	ASC	200% of Current Year Medicare
Dialysis Facility	Medicare End State Renal Disease PPS	200% of Current Year Medicare
Home Health	Medicare Home Health PPS	125% of Current Year Medicare
Medical Rehabilitation Inpatient	Medicare Inpatient Rehabilitation Facility PPS	155% of Current Year Medicare
Medical Rehabilitation Outpatient	APC	200% of Current Year Medicare

Service	Methodology	Rates
Psychiatric Hospital Inpatient	Medicare Inpatient Psychiatric Facility PPS	155% of Current Year Medicare
Psychiatric Hospital Outpatient	APC	200% of Current Year Medicare
Psychiatric Partial Hospitalization Program (PHP)	All-inclusive Global Per Diem (Billed under Revenue Codes 912 and 913)	$520.00
Long Term Acute Care Hospital (LTAC)	Medicare Long Term Care Hospital PPS	155% of Current Year Medicare
Skilled Nursing Facility	Medicare Skilled Nursing PPS	155% of Current Year Medicare
Critical Access Hospital (CAH) Inpatient	CAH rate under original Medicare	200% of Current Year Medicare
Critical Access Hospital (CAH) Outpatient	CAH rate under original Medicare	235% of Current Year Medicare
Residential Psychiatric Treatment Centers	Revenue Codes 114, 124, 134, 144, 154, 204 - Psychiatric Admission Per Diem	$840.00
Residential Psychiatric Treatment Centers	Revenue Codes 1001 - Residential Treatment Admission Per Diem	$568.00
Hospice	Revenue Code 651 – Routine Home Care Per Diem	$169.28
Hospice	Revenue Code 652 – Continuous Home Care Hourly Rate (Beginning with 9th Hour)	$35.85
Hospice	Revenue Code 655 – Inpatient Respite Care Per Diem	$156.96
Hospice	Revenue Code 656 – General Inpatient Care Non-Respite Per Diem	$661.02
Private Duty Nursing	Revenue Code 552 – RN Hourly Rate	$55.00
Private Duty Nursing	Revenue Code 559 – LPN Hourly Rate	$52.00
Birthing Centers	Revenue Code 724 & CPT Code 59409 – Birthing Center Inclusive Rate	$3,160
Birthing Centers	Revenue Code 724 & HCPCS Code S4005 – Interim Labor Facility Global	$1,920
Mobile Lithotripsy	Revenue Code 790 & CPT Code 50590	$4,200
Intensive Outpatient Programs	Revenue Code 905 – Intensive Outpatient – Psychiatric Global Per Diem	$266.00
Intensive Outpatient Programs	Revenue Code 906 – Intensive Outpatient – Chemical Dependency Global Per Diem	$245.00
Intensive Outpatient Programs	Revenue Code 912 – Partial Hospitalization Global Per Diem	$520.00

Service	Methodology	Rates
Intensive Outpatient Programs	Revenue Code 913 – Partial Hospitalization Global Per Diem	$520.00
Alcohol Rehabilitation	Revenue Code 126 – Inpatient Detox Per Diem	$630.00
Alcohol Rehabilitation	Revenue Code 128 – Inpatient Rehab Per Diem	$498.00
Alcohol Rehabilitation	Revenue Code 1002 – Inpatient Residential Treatment Chemical Dependency Per Diem	$422.00
Alcohol Rehabilitation	Revenue Code 906 – Intensive Outpatient Chemical Dependency Per Diem	$191.00
Alcohol Rehabilitation	Revenue Code 912 – Outpatient Partial Hospitalization Per Diem	$361.00
Residential Chemical Dependency	Revenue Codes 129 – Inpatient Per Diem	$510.00
Residential Chemical Dependency	Revenue Code 949 – Outpatient Rehab Per Diem	$47.50

a. Rural Hospital Designation

For purposes of certain fee calculations, each facility listed on Schedule 1 to this Service and Rate Schedule is deemed a "Rural Hospital." Any facility or other provider that is not listed on Schedule 1 does not qualify for reimbursement as a "Rural Hospital." Schedule 1 will be updated no more than once per year and any such update shall be made prior to November 1 of the calendar year in which it is made for an effective date of January 1st of the following year. For the sake of clarity, if Schedule 1 is updated in 2024, such update will issue prior to November 1, 2024 for an effective date of January 1, 2025.

b. Critical Access Hospitals (CAH)

i. The rates will be adjusted in accordance with the Hospital's periodic cost reports filed with CMS provided Hospital's status as a Critical Access hospital remains unchanged. Hospital agrees to forward to Company a copy of letter from CMS verifying rate change upon Hospital's receipt of such letter and the new rate will become effective within forty-five (45) days after Company's receipt of such letter.

ii. 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.

c. Reference Laboratory Services

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

d. All Other Services

Any service that is not covered by Medicare (but is reimbursable under this Amendment) 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 as applicable.

4. RATE TERMS AND CONDITIONS

All payments are subject to the Policies promulgated by Company pursuant to this Amendment. Moreover, payments will be based on the level of care authorized by Company.

Definitions

"Aetna Market Fee Schedule" (AMFS) – A fee schedule that is based upon the contracted location where services are performed. Company may periodically update this fee schedule.

"Service Groupings" – A grouping of codes (e.g., HCPCS, CPT4, ICD-10 (or successor standard) that are considered similar services and are contracted at one rate under the Services and Rate Schedule.

"Telemedicine" Telemedicine is the delivery of clinical medicine via real-time telecommunications such as telephone, the Internet, or other communications networks or devices that do not involve direct patient contact. For purposes of this Schedule, Telemedicine includes only those services that are included in and provided in compliance with Company Policies.

"Medicare Allowable Payment (Inpatient Services)" – is the current payment as of discharge date that a hospital will receive from Company, subject to the then current Medicare Inpatient Prospective Payments Systems and will be updated in accordance with CMS changes, provided, however, that exempt units for psychiatric, rehabilitation and skilled nursing facility services will be paid in accordance with the applicable Medicare Prospective Payment Systems. These payments are intended to mirror the payment a Medicare Administrative Contractor (MAC) would make to the hospital, less (with respect to DRG-based payments) the payments for Indirect Medical Education (IME), Direct Graduate Medical Education (DGME) and Company payment and processing guidelines. The current Medicare Allowable payment is final and is exclusive of cost settlements, reconciliations, or any other retroactive adjustments as completed by a MAC for both overpayments and underpayments.

"Medicare Physician Fee Schedule (MFS)" – A fee schedule established by Company for use in payment to providers for Covered Services, which is based upon Centers for Medicare & Medicaid Services (CMS) Geographic Pricing Cost Indices (GPCI) and Resource Based Relative Value Scale (RBRVS) Relative Value Units (RVU) [including Outpatient Prospective Payment System (OPPS) cap rates]; the Clinical Laboratory Fee Schedule (CLAB); the Durable Medical Equipment, Prosthetics, Orthotics and Supplies Fee Schedule; including PEN (DMEPOS) and 'Medicare Part B Drug Average Sales Price ASP)'. Coding and fees determined under this schedule will be updated as CMS releases code updates, changes in the MFS relative values, including OPPS cap payments, or the CMS conversion factors. Fee schedule only contains rates published by CMS; rates published by local carrier are not included. Company plans to update the schedule within sixty (60) days of the final rates and/or codes being published by CMS. However, the rates and coding sets for these services do not become effective until updates are completed by Company and payment is considered final and exclusive of any retroactive or retrospective CMS adjustments. Aetna payment policies apply to services paid based upon the Medicare Physician Fee Schedule.

PROFESSIONAL SERVICES

Specialist Services

Specialist will provide services that are within the scope of and appropriate to the Specialist's license and certification to practice. Moreover, Specialist agrees, with respect to all chronic biotherapies administered in Specialist's office to State Health Plan Members, to order the necessary specialty medications from a Participating specialty pharmacy provider. With respect to State Health Plan Members diagnosed with either Crohn's Disease or Immunodeficiency Syndrome or Infused Medications for Psoriasis and needing specialty medications for their conditions, Specialist shall in accordance with a State Health Plan Member's plan and unless prohibited by law, coordinate with State Health Plan Member's Participating specialty pharmacy provider to transition the drug and service authorization, drug distribution, clinical oversight and billing management of the specialty medications treating these conditions to the participating specialty pharmacy.

Anesthesia Services

The rates and services set forth in the Services and Rate Schedule are subject to all Policies and include the complete professional component associated with anesthesia for invasive surgical procedures, acute and chronic pain management services and emergency or consultative critical care services.

Except as set forth below, for all services Physician agrees to accept, as payment in full, an amount equal to the product of (a) the Base Unit Value and (b) the sum of (i) base units for the surgical procedure performed, (ii) time units, and (iii) modifying units where appropriate. The source of anesthesia base units is primarily the American Society of Anesthesiologists (ASA) Relative Value Guide and Crosswalk. Services involving administration of anesthesia include pre and post-operative visits, the anesthesia care during the procedure, the administration of fluids and/or blood, and the usual monitoring services (e.g., ECG, temperature, blood pressure, oximetry, capnography, and/or mass spectrometry). For all anesthesia services, anesthesia time begins when the anesthesiologist begins to prepare the patient for the induction of anesthesia in the operating room or in an equivalent area and ends when the anesthesiologist is no longer in personal attendance.

The standard time factor allowance is based on 15-minute increments, except as noted for obstetric procedures, when applicable. One time unit value equals 15 minutes. If the time is not an equal increment of 15 minutes, Company will use decimals rounded to the nearest tenth. If a processing platform cannot accommodate decimals, Company will round down if the time is 7 minutes or less and round up to the next increment for 8 to 14 minutes.

General

a) For procedures and/or services not specifically listed above, Provider agrees to accept the then current Aetna Market Fee Schedule as payment in full. Rates are inclusive of any applicable State Health

Plan Member Copayment, Coinsurance, Deductible and any applicable tax including but not limited to sales tax.

b) Unless required by Applicable Law, reimbursement for mid-level practitioners and other qualified healthcare professionals may differ, depending on licensure, including applicable behavioral healthcare providers. Such reimbursement will be based on our then current reimbursement policies, as updated from time to time, at Company's discretion.

c) Unless otherwise required by Applicable Law, reimbursement for qualified behavioral healthcare providers and Licensed Master Level Practitioner (e.g., Clinical Psychologist, Psychiatric Nurses, Clinical Social Workers, Licensed Professional Counselors, Marriage/Family Therapists, Psychological Examiner, Drug and Alcohol Counselor, Pastoral Counselor) may differ, based on our then current reimbursement policies, as updated from time to time, at Company's discretion.

d) As of the Effective Date of the Amendment, Company allows charges per standard policy guidelines for the services billed for a non-recognized provider type (unable to practice independently) if the following conditions are met:

   i. the non-recognized provider is employed by and works under the direct supervision of a legally qualified practitioner, and
   ii. the non-recognized provider is licensed and qualified to provide services by either degree or professional credentials, and
   iii. the services are prescribed or recommended by a participating provider, and
   iv. the contract covers the services, and
   v. the services are billed by the non-recognized provider's employer/ supervising practitioner.

e) Consistent with Amendment, Provider agrees to comply with Company Policies, including, but not limited, those contained in the Provider Manual, as modified by Company from time to time. If a change in a Company Policy would materially and adversely affect Provider's administration or rates under this Amendment, Company will send Provider at least ninety (90) days advance written notice of the Policy change. Provider understands that Policy changes will automatically take effect on the date specified, unless an earlier date is required by Applicable Law. Provider is encouraged to contact Company to discuss any questions or concerns with Company Policies or Policy changes

f) For those Plans, the rates for covered Telemedicine services will be as set forth in this Schedule, unless other rates are required by applicable law and/or Company's then-current Policies. The list of applicable services that may be provided through Telemedicine will be listed in Company Policies. Telemedicine services must be provided in accordance with Company Policies (including, but not limited to the Participation Criteria) and there will be no coverage for Telemedicine services not provided in accordance with Company Policies.

g) The parties acknowledge that payments (including, but not limited to, those based on a percentage of

Medicare) will not reflect CMS Quality Payment Program adjustment factors or incentive payments (e.g., MIPS, APM).

h) CPT-4 codes included in the Professional Component of this Amendment apply to the services rendered and are not limited to the specialty of the performing provider

Billing

a) Specialist/Provider must designate the codes set forth above when billing.

b) When modifier QX (Certified Registered Nurse Anesthetist) is billed, payment will be 50% of the contracted rate for services. The supervising physician will receive the balance of the contracted rate for the same services upon submission of a claim.

FACILITY SERVICES

Hospital Inpatient Services

DRG:

All services identified by MS-DRGs are subject to verification by Company using the MEDICARE PROSPECTIVE PAYMENT GROUPER version of grouping software in use by Company on the date of discharge. MS-DRGs submitted by the Hospital that do not coincide with the MS-DRG assigned by Company's grouping software will be paid at the applicable rate for the assigned MS-DRG.

Psychiatric services will be paid in accordance with the Inpatient Psychiatric Facility Prospective Payment System (IPF PPS).

Skilled Nursing services will be paid in accordance with the Skilled Nursing Facility Prospective Payment System (SNF PPS).

Hospital Outpatient Services

APC:

Services identified by the Ambulatory Payment Classifications (APCs), which are part of the Medicare Outpatient Prospective Payment System (OPPS), are subject to verification by Company using the MEDICARE OUTPATIENT PROSPECTIVE PAYMENT GROUPER. Payment will be based on the version of the software and the applicable Medicare rate file in use by Company on the date of service.

Hospital Outpatient Services

A. Services or procedures payable pursuant to:

The Outpatient Prospective Payment System (OPPS), where applicable payment for these services is geographically adjusted using the providers specific wage index; or;

The Medicare Allowable payment is subject to Company's payment and processing guidelines and is final and will not be impacted by cost settlements, reconciliations or any other retroactive adjustments performed by a Medicare Administrative Contractor (MAC) for both overpayments and underpayments.

Pursuant to CMS rules, specific revenue codes are packaged when billed without HCPCS codes. Payment for these dependent, ancillary, supportive, and adjunctive items and services is packaged into payment for the primary independent service reported with an applicable HCPCS codes. Therefore, separate payment will not be made for claims reported with these packaged revenue codes when billed without HCPCS codes. Consistent with this, Company will not make separate payment(s) for packaged revenue codes. Company will follow the OPPS payment updates as published annually by CMS in the OPPS final rule.

B. Dialysis Services: Payment for these services is based on CMS's ESRD Prospective Payment System (PPS) and, shall be for dialysis treatment and related services regardless of the underlying patient diagnosis or condition. CMS's ESRD PPS provides a case-mix adjusted single payment to ESRD facilities for most renal dialysis services provided in an ESRD facility or beneficiary's home. Hospital represents and warrants that it is a CMS certified Renal Dialysis Center or Renal Dialysis Facility. For ESRD-related dialysis and services and to the extent applicable to other dialysis and related services, provider is required to submit based on CMS ESRD billing guidelines to include using bill type '72x' and using taxonomy code 261QE0700X for ESRD providers. http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ESRDpayment/index.html

C. Home Health Care Services: Payment is based on CMS Home Health prospective payment system (PPS). Notice of Admission (NOA) - The NOA is a onetime submission to establish the home health period of care and covers contiguous 30-day periods of care until the individual is discharged from Medicare home health services. NOA submission criteria will require the Home Health Agency (HHA) having a verbal or written order from the physician that contains the services required for the initial visit, and that the HHA has conducted an initial visit at the start of care.

All services related to the treatment of a State Health Plan Member, even services obtained from another provider must be billed by the Home Health Agency through consolidated billing. Payment for services subject to consolidated billing is made to the Home Health Agency and suppliers of these services must be aware that separate Medicare payment will not be made to them. When there is an overpaid episode, an overpayment will be requested through Company's overpayment recovery process.

D. Other Outpatient Services: Outpatient services or procedures that are: (i) not payable as set forth above; (ii) billed in accordance with CMS guidelines; and (iii) not considered packaged, composite or

concurrent services, are payable at the Aetna Market Fee Schedule Hospital, as defined below.

E. Services and Supplies not able to be paid as set forth in A and B above: Outpatient services and supplies that are (i) billed in accordance with CMS guidelines; and (ii) that are not considered packaged, composite or concurrent services, and (iii) and not payable at the Aetna Market Fee Schedule Hospital, are payable at 50% billed charges.

F. Certain Facility Fees Excluded: The following codes and code combinations are excluded from reimbursement/payment under this Amendment:

1. Procedure codes G0463, 99201-99205 and 99211-99215 when billed in combination with revenue codes 0280, 0480, 0760-0769 or 0960-0989
2. Services billed with the revenue codes 0510-0529

General

A. Hospital Services shall include all programs, services, facilities, and equipment necessary for care. Rates are inclusive of any applicable Member Copayment, Coinsurance, Deductible and any applicable tax including but not limited to sales tax, pre-procedure testing and other services as may be expressly included in the contracted rates. Any equipment and/or services provided by an alternate facility during the course of an admission shall be the financial responsibility of the Hospital and will be considered to be included in the rates noted in this rate schedule. The rate applied will be the applicable Amendment rate in effect on the date of discharge.

B. All claims will be handled in accordance with Company payment and processing guidelines.

C. Company will update all Medicare grouper software (IPPS, OPPS, IPF PPS, SNF PPS, ESRD PPS, Home Health PPS, etc.) within 60 days of the later to occur of (i) the CMS effective date; or (ii) CMS release date. Until updated in Company's systems, Company will pay based upon the prior versions of the Medicare grouper software.

D. Personal comfort and convenience items are not eligible for payment.

E. All professional services billed, including services billed by Participating Providers, under the Hospital’s federal tax identification number on a UB-04 (or its equivalent in the event UB-04s are no longer the standard billing form) billing form are not eligible for payment. All professional services billed, including services billed by Participating Providers, under the Hospital’s tax identification number on a CMS 1500 or equivalent form shall be paid at the Aetna Market Fee Schedule or applicable contracted rates.

F. Not all hospitals participate in the Institutes of Excellence transplant program (IOE) program; unless hospital has executed a separate transplant services agreement or a transplant services amendment/addendum with company and/or its affiliates for participation in the IOE program ("transplant agreement"), and continues to meet company's IOE criteria, hospital is not a participating provider for Members in the IOE program.

   Except as specifically outlined in a current transplant agreement, nothing in this schedule applies to transplant services provided under the IOE program. Any references herein to transplant services apply only to non-IOE transplant services, unless specifically noted otherwise in the transplant services agreement.

G. The parties acknowledge that payments (including, but not limited to, those based on a percentage of Medicare) will not reflect CMS Quality Payment Program adjustment factors or incentive payments (e.g., MIPS, APM).

Billing

A. Providers must submit claims using the same coding rules as traditional Medicare. Providers must follow all Medicare billing guidelines for claims submission. Providers must include all claims information required by traditional Medicare.

B. The parties acknowledge that payments (including, but not limited to, those based on a percentage of Medicare) will not reflect CMS Quality Payment Program adjustment factors or incentive payments (e.g., MIPS, APM).

North Carolina State Health Plan Pricing Policy

Schedule 1 - Rural Hospitals - Effective 1/1/2025

ADVENTHEALTH HENDERSONVILLE
ALAMANCE REGIONAL MEDICAL CENTER
ALLEGHANY COUNTY MEMORIAL HOSPITAL
ANGEL MEDICAL CENTER
ASHE MEMORIAL HOSPITAL
ATRIUM HEALTH ANSON
ATRIUM HEALTH CLEVELAND
ATRIUM HEALTH KINGS MOUNTAIN
ATRIUM HEALTH LINCOLN
ATRIUM HEALTH STANLY
BETSY JOHNSON REG HOSPITAL
BLADEN COUNTY HOSPITAL
BLUE RIDGE REGIONAL HOSPITAL
BRENNERS CHILDRENS HOSPITAL
CALDWELL MEMORIAL HOSPITAL
CAPE FEAR VALLEY HOKE HOSPITAL
CAROLINAEAST MEDICAL CENTER
CARTERET GENERAL HOSPITAL
CATAWBA VALLEY MEDICAL CENTER
CENTRAL CAROLINA HOSPITAL
CENTRAL HARNETT HOSPITAL
CHARLES A. CANNON, JR. MEMORIAL HOSPITAL
CHATHAM HOSPITAL
COLUMBUS REGIONAL HEALTHCARE SYSTEM
D.L.P. MARIA PARHAM MEDICAL CENTER LLC
DAVIE COUNTY HOSPITAL
DAVIS REGIONAL MEDICAL CENTER
DLP PERSON MEMORIAL HOSPITAL LLC
DOSHER MEMORIAL HOSPITAL
ECU HEALTH BEAUFORT HOSPITAL
ECU HEALTH BERTIE HOSPITAL
ECU HEALTH CHOWAN HOSPITAL
ECU HEALTH DUPLIN HOSPITAL
ECU HEALTH EDGECOMBE HOSPITAL
ECU HEALTH ROANOKE-CHOWAN HOSPITAL
ERLANGER MURPHY MEDICAL CENTER
FIRSTHEALTH MONTGOMERY MEM HOSPITAL
FIRSTHEALTH MOORE REGIONAL
FRYE REGIONAL MEDICAL CENTER
GRANVILLE MEDICAL CENTER
HALIFAX REGIONAL MEDICAL CENTER
HARRIS REGIONAL HOSPITAL
HAYWOOD REGIONAL MEDICAL CENTER
HIGHLANDS-CASHIERS HOSPITAL
HUGH CHATHAM MEMORIAL HOSPITAL
IREDELL MEMORIAL HOSPITAL
LAKE NORMAN REGIONAL MEDICAL CENTER
LENOIR MEMORIAL HOSPITAL
LEXINGTON MEMORIAL HOSPITAL
LIFEBRITE COMMUNITY HOSPITAL OF STOKES
MARG R. PARDEE MEMORIAL HOSPITAL
MARTIN GENERAL HOSPITAL
NASH GENERAL HOSPITAL
NORTHERN REGIONAL HOSPITAL
NOVANT HEALTH BRUNSWICK MEDICAL CENTER
NOVANT HEALTH ROWAN MEDICAL CENTER
NOVANT HEALTH THOMASVILLE MEDICAL
ONSLOW MEMORIAL HOSPITAL
PENDER MEMORIAL HOSPITAL
RANDOLPH HOSPITAL
RUTHERFORD REGIONAL MEDICAL CENTER
SALISBURY VAMC
SAMPSON REGIONAL MED CENTER
SCOTLAND MEMORIAL HOSPITAL
SENTARA ALBEMARLE MEDICAL CENTER
SENTARA CAREPLEX HOSPITAL
SOUTHEASTERN REGIONAL MEDICAL CENTER
ST LUKES HOSPITAL
SWAIN COUNTY HOSPITAL
THE MCDOWELL HOSPITAL
THE OUTER BANKS HOSPITAL, INC.
TRANSYLVANIA REGIONAL HOSPITAL
UNC HEALTH BLUE RIDGE
UNC ROCKINGHAM HEALTH CARE, INC.
WASHINGTON COUNTY HOSPITAL
WATAUGA MEDICAL CENTER, INC.
WAYNE MEMORIAL HOSPITAL
WILKES REGIONAL MEDICAL CENTER
WILSON MEDICAL CENTER