NETWORK	PROVIDER COMPENSATION	1/1/2015

Alignetworks

Align Networks will reimburse at the lesser of 85% of applicable workers compensation fee schedule, up to a maximum of $92 per daily visit/session or 100% of Participating Provider's billed charges. Initial evaluations (CPT Codes 97001-97003) are excluded from daily maximum reimbursement.

Allowed specialties to participate in this Work Comp Network: **Chiropractic, Occupational Therapist, Physical Therapist and Speech Therapist**

The following services are not applied to the daily maximum discussed above

Code	Align Reimbursement
97750-FC	$42.00 per unit (24 unit cap)
97545	$160.00
97546	$50.00
97001	15% off Montana Workers' Comp Fee Schedule
97003	15% off Montana Workers' Comp Fee Schedule
As Billed	15% off

*****NO SHOW FEE - less than 24 hours notice $175.00*****

Allegiance Provider Direct, LLC

Providers shall be reimbursed on the lesser of billed charges or the Allegiance Provider Direct Fee Schedule. Allegiance Fee Schedule will be a fixed schedule based on the following:

2013 RBRVS as periodically updated, with a $55.35 Conversion Factor

HCPCS "J" codes for injectables and vaccinations will be paid at the ASP, industry standard.

A, L, G, and Q codes will be reimbursed at 85% of billed charge
All procedure codes not given a relative value in Ingenix will be reimbursed at 85% of billed charge

Anesthesia: based on ASA schedule with a $59.00 Conversion Factor per unit

Non-physician medical professional specialties, including but not limited to Physician Assistants, Surgical Assistants, Nurse Practitioners, Nurse Mid-Wives, Physical Therapy, Speech Therapy, Chiropractors and Audiology are paid at 85% of physician allowable.

Psychologists and Optometrists will be 75% of the physician allowable.
LCPC and SW will be 65% of the physician allowable.

America's Choice Provider Network

Providers are reimbursed at 95% of billed charges

Banner Health System

Physician services will be reimbursed at 85% of physician billed charges less co-payments, co-insurance and deductibles.

Chiropractors are paid according to benefit design. Please call Banner Health System to verify benefits.

BCBS - Manage Care Product

MDs are paid according to the lesser of Non-Discounted Billed Charges or the current BCBS schedule.

HCFA Codes are reimbursed at the following:
Relative Value 2013 (RVU)* Conversion Factor = Allowance

Anesthesia	No less than $59.00
Other Physician	No less than $55.35
Clinical Lab	No less than 150% of Medicare

HCPCS Codes are paid at non-discounted billed charges. Exceptions include:

NETWORK	PROVIDER COMPENSATION
BCBS - Manage Care Product - Cont'd	DME: 75% of Medicare allowable for supplies 100% of Medicare allowable for oxygen codes E0431-E0444, E1390 and all orthotic and prosthetic codes with Medicare allowable. HCPCS "J" Codes - Please see BCBS Drug Compensation Policy - www.bcbsmt.com Non-physician medical professional specialties, including Physical Therapists, Speech Therapists, Audiologists, Nurse Midwives, Nurse Practitioners, Physician Assistants, Non-RN Midwives, Clinical Nurse Specialist, OB/GYN Nurses are paid at 85% of physician allowances. Optometrists and Psychologists are paid at 85% of physician allowable Chiropractors are paid according to benefit design. Please call BCBS to verify benefits. LCPC and SW are paid at 65% of allowable. LAC are paid at 60% of allowable.
BCBS - Medicare Advantage Plan	Provider shall accept as payment in full from Plan the amounts set forth in the Medicare Benefit Program Agreement. Provider shall not bill any Medicare Members of Plan for any amounts except any Copayments and charges for services not covered under the Medicare Benefit Contract.
Community Health Network/CHN	Providers shall be reimbursed on the lesser of billed charges or the CHN Fee Schedule. CHN Fee Schedule will be a fixed schedule based on the following: 2013 RBRVS as periodically updated, with a $55.35 Conversion Factor applied 6/1/13 All Medicare accepted modifiers will be allowed J codes will be reimbursed at AWP + 15% A codes, L codes, G codes and Q codes will be reimbursed at 85% of billed Anesthesia: based on ASA schedule with a $59.00 Conversion Factor per unit effective 6/1/13 Non-physician medical professional specialties, including Physical Therapists, Speech Therapists, Audiologists, Nurse Midwives, Nurse Practitioners, Physician Assistants, Surgical Assistants, Podiatry, Optometry are paid at 85% of physician allowances. Chiropractic is 85% of the physician allowances. Mental Health is 85% of the physician allowances. Mental Health is 85% of the physician allowances.
EBMS - "SELECTCARE"	Network Provider shall accept payment as set forth below as payment in full for Covered Services rendered, less coinsurance, copayments, deductibles, and non-covered or ineligilbe charges that the Enrollee is responsible for paying according to the terms of his or her Health Benefit Plan. The professional rate schedule for Selectcare **shall be the lesser of 85% of the Provider's billed charge**, or the RBRVS schedule. The schedule is based on the current year's Medicare Resource Based Value System (RBRVS-2013) - updated annually - using the following Conversion Factors.

RBRVS - Based CPT Codes		**RBRVS Conversion Factor**
Surgery	10000 - 69999	$59.50
Radiology	70000 - 79999	$59.50
Pathology & Laboratory*	80000 - 89999	$59.50
Medicine	90000 - 99999 (except as stated below)	$59.50
Physical Medicine	97000 - 97999	$54.70
E & M	99201 - 99499	$59.50
Anesthesiology**	00100 - 01999	$54.70
Vision	92002, 92004, 92012, 92014, 92015	$40.00
All other RBRVS-based services not listed above		$59.50

NETWORK	PROVIDER COMPENSATION
EBMS - "SELECTCARE" Cont'd	*Pathology & Lab: When no RBRVS/Unit Value is present, the CMS CLAB Fee Schedule will be used as the allowable at 150%. For those codes not listed in RBRVS or CMS CLAB, the allowable will be 85% of billed charges. **Anesthesia: Unit Values (base units) are published by the American Society of Anesthesiologists. Time units will be based on a four-unit clock (15 minutes). Clinical Lab: 150% of current CMS CLAB Fee Schedule Implants/Implantable Devices: All shall be carved out of the above schedule and reimbursed at cost + 10% Injections/Drugs: Drugs administered in the medical office will be allowed at 120% of ASP. Codes without ASP will be allowed at 85% of billed charge. Chemotherapy drugs (J9000-J9999) will be allowed at 135% of ASP. Chemotherapy drugs without ASP will be allowed at 85% of billed charges. DME: 110% of the current CMS Durable Medical Equipment, Prosthetic, Orthotics and Supplies (DMEPOS) Fee Schedule for Montana. Ambulatory Surgery Centers: Reimbursment is allowed at 80% of billed charges. For codes that do not have an established unit, reimbursement will be 85% of billed charge. The above schedule applies to MDs, Dos, Podiatrists and CRNAs only; all other providers will be reimbursed at 80% of the fee schedule.
EBMS - "CITY OF BILLINGS"	Professional Fees: 2011 RBRVS CPT CODES Conversion Factor: Surgery $59.50 — Physical Medicine $44.00 Radiology $59.50 — E & M $59.50 Pathology & Laboratory * — Anesthesiology ** Medicine $59.50 Vision (92002, 92004, 92012, 92014, 92015) $40.00 All other RBRVS-based services not listed above $59.50 *150% of the CMS CLAB Fee Schedule will be used. Codes without CMS CLAB fees, 85% off billed charges will be allowed **Allowable reimbursed shall be 75% of billed charges CPT codes without an established unit value, reimbursement will be allowed at 85% of billed charges Clinical Lab: 150% of the CMS CLAB Fee Schedule Implants & Implantable Devices: Carve-out at cost + 10% Injection/Drugs: Drugs administered in the medical office will be allowed at 128% of ASP. Chemotherapy drugs (J9000-J9999) will be allowed at 135% of ASP. Codes w/out ASP will be allowed at 85% of billed charges. Immunizations and Vaccines will be allowed at 125% of ASP. Codes w/out ASP will be reimbursed at 85% of billed charges. DME: 110% of current DMEPOS (CMS Durable Medical Equipment, Prosthetic, Orthotics and Supplies) Fee Schedule for Montana. Ambulatory Surgery Centers; 75% of billed charges The Professional Fee Schedule applies to MDs, DO, Podiatrists, and CRNAs only; all other providers will be reimbursed at 80% of the state fee schedule.

NETWORK	PROVIDER COMPENSATION
FedMed Network	Providers are reimbursed at 85% of billed charges
First Choice of the MidWest	Providers are reimbursed at 85% of billed charges
First Health Network/Coventry	Physician services shall be reimbursed off the 2011 RBRVS with GPCI, gap filled with the following conversion factor: $60.00. Anesthesia : $60.00 per unit, ASA If reimbursement for services is not established based upon the foregoing factors, reimbursement shall be 85% of either the billed amount or the usual and customary fee for the service, as determined by 1st Health. ASP shall mean the Average Sales Price as published by CMS and supplemented by Coventry with such supplements being based on common industry references to average sale prices as reported by drug manufacturers. Hard-coded to 3rd Quarter 2011 ASP +6% backfilled with AWP and will not update annually. The following J codes and Immunization codes are carved out and will be reimbursed at the 3rd Quarter 2011 ASP+50% backfilled with AWP: J0129, J0207, J0640, J0641, J0696, J0718, J1080, J1745, J2150, J2310, J2505, J2930, J2997, J3262, J3420, J3488, J9060, J9065, J9070, J9156, J9185, J9190, J9202, J9206, J9214, J9266, J9293, J9310, J9351, J9370, J9390 Durable Medical Equipment - 100% of 2011 DMERC **First Health Workers' Compensation Payers** Reimbursement shall not exceed the amount allowed for Provider's services under Workers' Compensation laws and regulations. If any state law or regulation establishes rules or guidelines for the payment of health care services, reimbursement shall not exceed 95% of the maximum amount payable under such rules or guidelines. In no case shall reimbursement exceed Provider's usual and customary charge for the service rendered.
Fortified Provider Network, Inc.	Providers are reimbursed at 95% of billed charges
Health InfoNet	Health InfoNet (HIN) Maximum Allowable Fee determined from the Ingenix-St. Anthony's non-facility RBRVS and for anesthesiology services the ASA Relative Value Guide. Physician billed fees will serve as the Maximum whenever such fees are less than the Maximum derived from below factors. Mid-level providers may be paid at 90% of the amounts calculable for physicians under this schedule, and the standard discount rate listed below for services for which Relative Value Units (RVUs) are not available. HIN equity and non-equity contracts identical effective 9/1/12 — Conversion Factor: $54.60 ALL HIN Plans: Anesthesiology (4 units/hour) effective 9/1/12 — Conversion Factor: $54.70 All HIN Plans: Services, supplies and devices for which RVUs or Conversion Factors unavailable will be allowed at 85% of billed charges All HIN Plans: Vaccines and J-codes Drugs depending on HIN and/or Purchaser administrative capabilities, Allowable Fee is either 85% of billed charge or ASP/AWP. (J-code drugs (except J9000-J9999) shall be 115% of the current Average Sale Price (ASP). J9000-J9999 shall be 135% of the ASP. Allowable fees for any J-code drug without an ASP value will be 100% of AWP. ASP and AWP data will be updated at least annually, and more often as feasible. Health InfoNet considers a Chiropractor to be ancillary and the discount for all ancillaries is 15% off billed charges.

NETWORK	PROVIDER COMPENSATION
Humana Medicare Advantage Plan	Provider shall accept as payment in full from Plan the amounts set forth in the Medicare Benefit Program Agreement. Provider shall not bill any Medicare Members of Plan for any amounts except any Copayments and charges for services not covered under the Medicare Benefit Contract.
InterWest	InterWest's Maximum Allowable Fees for professional services billed by physicians (MDs/DOs) are based on relative value units, as published in St. Anthony's 2013 RBRVS and ASA Relative Value Guide, with the following conversion factors. New conversion effective 6/1/13.

	Traditional	PPO
E&M	$58.00	$55.35
Medicine	$58.00	$55.35
Surgery	$58.00	$55.35
Radiology	$58.00	$55.35
Pathology & Lab	$58.00	$55.35
Anesthesia (15 min.unit)	$58.00	$55.35

Vaccines (CPT 90281-90399 and 90476-90749) are paid at 100% of charges. Other CPT codes That don't have a RUV are priced according to InterWest's default payment rate.

CPT codes with modifiers are priced in general accordance with Medicare policy, set forth by Interwest.

HCPCS CODED SERVICES

Maximum Allowable Fees for HCPCS coded services are based on Medicare's DMEPOS fee schedule, as follows:

	Traditional	PPO
HCPC Coded Services	105% of National Medicare Ceiling	100% of National Medicare Ceiling

J codes will be established by the Average Sales Price (ASP). Code allowances for these codes are calucalated using ASP plus 35%.

J-coded drugs and other HCPC coded services that do not have a DMEPOS fee are priced according to InterWest's default payment rate.

Default Payment Rate

	Traditional	PPO
Default Payment Rate	92% of Charges	85% of Charges

The following health care professionals will be paid at 85% of Physician Fee Schedule: Audiologists, Certified Surgical Assistants, Chiropractors, Dieticians, Naturopaths, Nurse Anesthetists, Nurse Midwives, Nurse Practitioners, Occupational Therapists, Optometrists, Physical Therapists, Physician Assistants, Psychologists, Registered Nurses, Speech-Language Pathologists.

All other health care professionals not listed above will be reimbursed at the default payment rate.

COMPENSATION FOR PPO DIRECT NETWORK:
PPO Direct Network: Require Enrollees to pay for services in full at time of service. Providers do not submit claims on Enrollees' behalf or comply with any utilization management requirements.

Facility Services: PPO Direct Network: 90% of Charges, based on InterWest's PPO Network
Professional Services: PPO Direct Network : 80% of Charges

NETWORK	PROVIDER COMPENSATION
Montana Health Systems	For any Worker, MHS shall pay to Participating Providers (health facilities, hospitals, clinics, ambulatory surgery centers a sum equal to the lesser of (i) 93.5% of billed charges or (ii) 93.5% of the amount payable under the Montana Workers' Compensation Medical Fee Schedules. If a billed service is not covered by the fee schedule, MHS shall establish a fee to be paid to the Participating Provider based on at least one of, but not limited to, the following: reasonableness, the usual fees of similar providers, the services provided in the specific case, fees for similar services in similar geographic regions, and any extenuating circumstances. Payment will not be approved for disallowed codes as listed in the Montana Health Systems Provider Manual, or for such other reason as set forth in this agreement or the Montana Health Systems Provider Manual.
Montana Health Coop. - EXCHANGE	Effective 1/1/14, reimbursement methodology is based off the 2012 RBRVS units. Conversion factor $55.35 MD/DO. All other providers will be reimbursed at 85% of the MD/DO allowable. Anethesia $59.00 per 15 min unit with CMS/ASA guidelines.
New West Medicare Advantage Plan	Provider shall accept as payment in full from Plan the amounts set forth in the Medicare Benefit Program Agreement. Provider shall not bill any Medicare Members of Plan for any amounts except any Copayments and charges for services not covered under the Medicare Benefit Contract.
PacificSource	Providers shall be reimbursed for providing Covered Services based off a fee schedule: 2011 RBRVS as periodically updated, with a MD/DO Conversion Factor $58.50 Anesthesia - Conversion Factor of $60.00/unit ASA DPM - Conversion Factor $52.65 All Professional Services Midlevel Providers (PA, NP, FNP, CNM, CRNA, PhD, PsyD, OD, PsyR) - Conversion Factor $49.72 All Professional Services for (DC, PT, OT, ST, ND, AUD, RD) - Conversion Factor $48.00 All Professional Services for (LCPC, LCSW) - Conversion Factor $38.02 All Professional Services for (LAC) - Conversion Factor $35.10 Laboratory - 125% of CMS Injectables, Vaccines, Immunizations: HCPCS Services (J0000 - J9999 and Q0000 - Q9999) - 115% of ASP Other vaccines & immunizations - 114% of ASP Other HCPCS Services/Supplies - 110% of CMS allowed by State of Montana All procedure codes not given a unit value will be 85% of billed charges
Preferred One	Providers are paid 85% of billed charges. Preferred One carves out chiropractic service to Health Services Management. To be a provider, please call HSM directly 800-432-3640 to participate. Cigna (a payer under Preferred One) carves out mental health services to Metropolitan Counseling Clinic to participate call 800-333-1687 United Healthcare (a payer under Preferred One) carves out mental health services to United Behavioral Health. Please contact them at 877-564-7505 if you wish to be a provider for this company.
Three Rivers Provider Network (TRPN)	Providers are reimbursed at 95% of billed charges

NETWORK	PROVIDER COMPENSATION
United Healthcare	MDs are paid according at the lesser of Non-Discounted Billed Charges or the current UHC schedule, based off 2010 RBRVS. Optometry benefits go through Spectara. Spectara phone # 877-372-4870. HCFA Codes are reimbursed at the following: Anesthesia $61.00 conversion factor (Anesthesia Rounding Option: Proration) effective 9/1/12 Other Physician $61.00 converter for all PPO/Commercial Options Products effective 9/1/12
Windsor/Sterling Medicare Advantage Plan	Provider shall accept as payment in full from Plan the amounts set forth in the Medicare Benefit Program Agreement. Provider shall not bill any Medicare Members of Plan for any amounts except any Copayments and charges for services not covered under the Medicare Benefit Contract.