Provider: Wiregrass Medical Center & Nursing Home
TIN: 63-6004474
Effective: 01/03/2017

1200 W. Maple Ave
Geneva, AL 36340
(334) 684-3655

Hospital agrees to accept the following rates as payment in full for services provided:

I. **Inpatient Services:** For all services, treatments, supplies, expenses, or other charges, Hospital will be reimbursed for the lesser of billed charges or a rate equal to 95% of the State of Alabama Department of Labor (DOL) workers' compensation fee schedule in effect at the date of discharge. The calculation for the AlaMed inpatient rate shall be inclusive of all methods of calculation in the Hospital's inpatient state fee schedule, including but not limited to the stop-loss provisions in the event the state fee schedule includes a stop-loss.*

Medical devices listed under revenue codes 274, 275, 276, or 278 shall be paid additionally at a rate of cost + 20% and Hospital will include the invoice with its bill.

II. **Outpatient Services not covered in Paragraphs III, IV, or V below:** For all services, treatments, supplies, expenses, or other charges, Hospital will be reimbursed for the lesser of billed charges or a rate equal to 85% of the State of Alabama Department of Labor (DOL) workers' compensation fee schedule in effect at the date of discharge.*

Medical devices listed under revenue codes 274, 275, 276, or 278 shall be paid additionally at a rate of cost + 20% and Hospital will include the invoice with its bill.

III. **Physician Services:** For all physician services, treatments, supplies, expenses, or other charges for which the Hospital bills, Hospital will be reimbursed for the lesser of billed charges or a rate equal to 85% of the State of Alabama Department of Labor (DOL) workers' compensation fee schedule.

IV. **Outpatient Physical Therapy:** For all services, treatments, supplies, expenses, or other charges, Hospital will be reimbursed for the lesser of billed charges or a rate equal to 85% of the State of Alabama Department of Labor (DOL) workers' compensation fee schedule.

V. **Outpatient Diagnostics:** For all services, treatments, supplies, expenses, or other charges, Hospital will be reimbursed for the lesser of billed charges or a rate equal to the following:

Description	Rate
MRI	
MRI, without contrast	$600.00
MRI, with contrast	$650.00
MRI, with/without contrast	$750.00
CT	
CT, without contrast	$350.00
CT, with contrast	$400.00
CT, with/without contrast	$500.00

*Note: To calculate the AlaMed rate, first calculate the state rate and then apply the applicable discount.