One Hospital Drive
Huntsville, AL 35801
(56) 429-4000

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 at the following rates at the effective date of discharge:

Type of Hospitalization	Per Diem
Inpatient, Days 1 & 2	$1,900.00
Inpatient, Days 3 & up	$1,900.00

***Stop-Loss**: If the total per diem reimbursement is less than 52% of the total charges, then payment shall be 52% of total charges (or 80% of the DOL stop-loss rate of 65%).

Medical devices listed under revenue codes 274, 275, 276, or 278 for inpatient and outpatient services shall be paid additionally at a rate of 35% of billed charges.

II. **Outpatient Services Not Covered in Paragraphs III, IV, V, VI or VII below:** For all services, treatments, supplies, expenses, or other charges, Hospital will be reimbursed at a rate equal to 50% of billed charges.

Medical devices listed under revenue codes 274, 275, 276, or 278 for inpatient and outpatient services shall be paid additionally at a rate of 35% of billed charges.

III. **Emergency Room Services:** For all services, treatments, supplies, expenses, or other charges, Hospital will be reimbursed a global fee of $999.00 per outpatient visit. The global fee is to include all charges related to Hospital services, but not limited to Emergency Room, diagnostics, lab, or other charges. The global fee does not include any physician fees.

IV. **Outpatient Diagnostic Services:** For all services, treatments, supplies, expenses, or other charges, Hospital will be reimbursed at the following rates:

Description	Reimbursement
MRI	
MRI, without contrast	$600.00
MRI, with contrast	$675.00
MRI, with/without contrast	$750.00
CT	
CT, without contrast	$550.00
CT, with contrast	$625.00
CT, with/without contrast	$700.00

V. **Outpatient Rehabilitation Services:** For all services, treatments, supplies, expenses, or other charges related to Physical Therapy, Occupational Therapy, and Speech Therapy, Hospital will be reimbursed for the lesser of billed charges or a rate equal to 90% of the State of Alabama Department of Labor (DOL) workers' compensation fee schedule.

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VI. Hyperbaric Oxygen Therapy: For all services, treatments, supplies, expenses, or other charges, Hospital will be reimbursed at a rate equal to 50% of billed charges.

VII. Pain Management: Provider agrees to accept the following rates as payment in full for services provided: For all services, treatments, supplies, expenses, or other charges, Provider will be reimbursed at the following rates:

CPT Code	Reimbursement
62310 – (Deleted 2017: see new code 62320)	$980.00
62311 – (Deleted 2017: see new code 62322)	$980.00
62320	$980.00
62322	$980.00
64480	$980.00
64483	$980.00
64484	$980.00
64490	$980.00
64491	$980.00
64492	$980.00
64493	$980.00
64495	$980.00
20610	$300.00
62264	$1,130.00
62319 – (Deleted 2017: see new code 62326)	$1,130.00
62326	$1,130.00
64479	$980.00
64510	$980.00
64520	$980.00
64633	$1,900.00
64634	$1,430.00
64635	$2,090.00
64636	$1,920.00
77003	$272.00

****Note:** Effective each anniversary date, all fixed rates will be increased by 6%.