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SECTION 12—REIMBURSEMENT METHODOLOGY

12.1 THE BASIS FOR ESTABLISHING A RATE OF PAYMENT

The Division of Medical Services is charged with establishing and administering the rate of payment for those medical services covered by the Missouri Title XIX Program. The Division establishes a rate of payment that meets the following goals:

- Ensures access to quality medical care for all recipients by encouraging a sufficient number of providers;
- Allows for no adverse impact on private-pay patients;
- Assures a reasonable rate to protect the interests of the taxpayers; and
- Provides incentives that encourage efficiency on the part of medical providers.

Funds used to reimburse providers for services rendered to eligible recipients are received in part from federal funds and supplemented by state funds to cover the costs. The amount of funding by the federal government is based on a percentage of the allowable expenditures. The percentage varies from program to program and in some cases different percentages for some services within the same program may apply. Funding from the federal government may be as little as 60% or as much as 90%; depending on the service and/or program. The balance of the allowable, (10-40%) is paid from state General Revenue appropriated funds.

Total expenditures for Medicaid must be within the appropriation limits established by the General Assembly. If the expenditures do not stay within the appropriation limits set by the General Assembly and funds are insufficient to pay the full amount, then the payment for services may be reduced pro rata in proportion to the deficiency.

12.1 A DETERMINING A FEE

Under a fee system each procedure, service, medical supply and equipment covered under a specific program has a maximum allowable fee established.

In determining what this fee should be, the Division of Medical Services (DMS) uses the following guidelines:

- Recommendations from the State Medical Consultant and/or the provider subcommittee of the Medical Advisory Committee;
- Medicare’s allowable reasonable and customary charge payment or cost-related payment, if applicable;
- Charge information obtained from providers in different areas of the state. Charges refer to the usual and customary fees for various services that are charged to the general public. Implicit in the use of charges as the basis for fees is the objective that charges for services be related to the cost of providing the services.
The Division of Medical Services then determines a maximum allowable fee for the service based upon the recommendations, charge information reviewed and current appropriated funds.

12.2 TRANSPLANT SERVICES

Reimbursement for transplant services is made on a fee-for-service basis. The maximum allowable fee for a unit of service has been determined by the State Medicaid Agency to be a reasonable fee, consistent with efficiency, economy, and quality of care. Payment for covered services is the lower of the provider’s actual billed charge (should be the provider’s usual and customary charge to the general public for the service) or the maximum allowable per unit of service.

12.2.A TRANSPLANT MAXIMUMS

Medicaid reimburses authorized transplant services at the following established rates for “reasonable charges” not to exceed:

- $100,000 for heart, lung (double or single), liver, small bowel, and stem cell transplants, including bone marrow, peripheral blood stem cell and cord blood.
- $39,000 for kidney and pancreas transplants.
- for multiple organ transplants involving a covered transplant(s), the maximum allowable amount of the highest coverage for the highest single transplant (e.g., heart/lung $100,000 cap or kidney/pancreas $39,000 cap).

Reimbursement for authorized transplant services is made on a case-by-case basis for transplant services up to the maximums established.

12.3 SERVICES INCLUDED IN MAXIMUM TRANSPLANT REIMBURSEMENT

The following description of services is provided in order to distinguish those charges that are considered by DMS to be a part of the transplant maximum reimbursement.

12.3.A INPATIENT TRANSPLANT SERVICES

Reimbursement of inpatient transplant services is limited to “reasonable charges” for the inpatient surgery charges and post-surgery inpatient hospital charges, including anti-rejection medications and other pharmacy products, and all procurement services. The transplant stay begins with the date of the transplant surgery and follows through the date of discharge, or significant change in diagnosis not related to the transplant.

Inpatient transplant stay/surgery charges must be billed on a single UB-04 claim form accompanied by an itemized statement. Refer to Section 15 for inpatient transplant billing instructions. Inpatient reimbursement does not exceed the maximums established for the
transplant services. The amount billed to Medicaid for the inpatient services may be cut back for non-covered services or services not considered “reasonable” by DMS.

Procurement services paid to the facility or other provider prior to receipt of the inpatient transplant claim reduces the maximum reimbursement allowable for inpatient transplant services.

Reimbursement is made as claims are received and processed. If claims are received after the maximum reimbursement has been reached, the claim(s) are returned to the provider. Claims for procurement services that cannot be reimbursed because the maximum reimbursement has been reached cannot be billed to the recipient. Refer to Section 14 for a description of procurement services.

12.3.B ORGAN PROCUREMENT SERVICES

The established maximum reimbursement rate for the transplant procedure includes coverage of the procurement costs associated with all approved heart, lung, liver, kidney, pancreas, small bowel and multiple organ transplants. The associated costs invoiced from the organ procurement agency are included on the inpatient claim for the transplant stay, as well as any costs associated with the organ transport after retrieval.

12.3.B(1) Excision Surgeon

The services of the excision surgeon for cadaveric transplants are manually priced and reimbursed directly by Missouri Medicaid only if the services are not included on the inpatient bill as part of the organ procurement charge billed on the organ procurement organization’s statement of charges or by an invoice submitted to the transplant facility by the excision surgeon.

The amount of reimbursement for the excision surgeon is applied to the maximum allowable reimbursement for the transplant.

12.3.B(2) Donor Physician Services

Reimbursement of the physician services for the stem cell harvest (autologous or allogeneic) or the living related kidney, lung or liver donor excision is reimbursed on a fee for service basis or billed to the facility and included on the hospital claim as an invoiced amount.

The amount of reimbursement is applied to the maximum allowable reimbursement for the transplant.

Physician charges for the search of a related donor are covered and are not applied to the maximum allowable reimbursement for the transplant, regardless of recipient age. However, if the search is for a non-related bone marrow/stem cell transplant donor, the service is not covered by Medicaid unless the transplant recipient is under age 21.
12.3.B(3) Donor Anesthesia Services

Reimbursement of anesthesia services for the bone marrow/stem cell or living related solid organ donor is based on minutes of use, the anesthesia relative value, and the base rate for the anesthesiologist or CRNA.

The reimbursement for anesthesia services associated with the bone marrow/stem cell harvest or living related solid organ donor is applied to the maximum allowable reimbursement for the transplant.

12.3.B(4) Cryopreservation

The cost of autologous stem cell cryopreservation may be billed as a separate service. In the event an autologous transplant is performed, the transplant facility may show the cost of cryopreservation on the inpatient bill associated with the stem cell transplant or the service may be billed separately when performed on an outpatient basis.

The Medicaid maximum allowable amount for cryopreservation reimbursement is $1,150.00 initial storage and maintenance cost.

The costs of cryopreservation are considered part of the procurement services rendered and are applied to the maximum allowable amount.

12.3.B(5) Inpatient Donor Costs

Inpatient stem cell donor (including autologous) or living related solid organ donor charges for the services associated with the bone marrow/stem cell harvest, kidney, lung or liver retrieval are limited to “reasonable charges." Inpatient donor costs must be billed on a separate UB-04 claim form.

The amount of reimbursement is applied to the maximum allowable reimbursement for the transplant.

12.3.B(6) Outpatient Donor Costs for Autologous or Related Donor

Outpatient claims for stem cell donor services (actual donor) or living related solid organ donor services are reimbursed at the Medicaid rate on file for the procedure. Lab services included on these claims are paid according to the lab fee schedule on file.

The amount of reimbursement is applied to the maximum allowable reimbursement for the transplant.
12.3.B(7) Bone Marrow/Stem Cell/Cord Blood Donor Search (Match)

The DR and MLC lab studies (search) for the individual who is finally determined to be a suitable donor (Match) are covered for adults and children and may be submitted to DMS for consideration of reimbursement. Missouri Medicaid does not reimburse the costs associated with locating a non-related bone marrow/stem cell donor for a transplant candidate who is 21 years of age or older.

The amount of reimbursement for these DR and MLC lab tests are applied to the maximum allowable reimbursement for the transplant.

12.3.B(8) Bone Marrow/Stem Cell/Cord Blood Donor Search (Non-Match)

For those candidates who are under the age of 21, the Healthy Children and Youth (HCY) Program reimburses the lower of the billed amount or the maximum fee-for-service amount, or the amount remaining after insurance payment is deducted from the Medicaid allowable amount. This HCY benefit covers the donor search tests and other reasonable services for individuals who are not chosen as the final matched donor. Charges for these services may be submitted to the Missouri Medicaid HCY Program. The reimbursement does not apply to the maximum allowable for the transplant.

12.3.B(9) Bone Marrow/Stem Cell/Cord Blood Donor Service Claims

Once a related or non-related donor has been established according to the above guidelines, reimbursement is allowed for coverage of the donor’s stem cell harvesting expenses including inpatient services. The charges associated with the acquisition of the stem cells from the actual donor must be billed separately. These charges must be billed on the appropriate claim form.

The amount of reimbursement is applied to the maximum allowable reimbursement for the transplant.

12.4 TRANSPLANT SURGEONS

The services of the transplant surgeon are reimbursed to the surgeon on a fee for service basis. The surgeon must enroll with the Missouri Medicaid in order to receive reimbursement. Refer to the Physician Manual for enrollment criteria. The reimbursement is not applied to the maximum reimbursement allowed for the transplant.

12.4.A CO-SURGEON

Refer to Physician's Manual, Section 13.40. Medicaid does not reimburse for the services of an assistant surgeon when a co-surgeon is used.
12.4.B OTHER PHYSICIANS
Reimbursement for other physician services associated with the transplant patient’s care is made using the general policies, reimbursement guidelines and rates established for all Missouri Medicaid providers, as outlined in the Physician's Manual, Section 13.

12.5 PRE-TRANSPLANT INPATIENT DAYS
Reimbursement of the pre-transplant stay is limited to the hospital’s per diem rate subject to the length of stay limitation determined by the final discharge diagnosis. The current out-of-state facility rate is applied to out-of-state transplant facilities for the pre-transplant date(s) of service.

12.5.A MC+ Managed Care Recipients
Reimbursement for any necessary pretransplant inpatient services provided to MC+ managed care recipients is the responsibility of the patient’s health plan. This care must be coordinated with and billed to the recipient’s specific chosen or assigned health plan.

12.6 PRE-SURGERY ASSESSMENT
Inpatient, outpatient, and physician services for the pre-surgery assessment and evaluation of the transplant candidate should be billed according to the service performed. Pre-surgery assessment services are reimbursed according to general policies at regular Medicaid rates.

12.6.A MC+ MANAGED CARE RECIPIENTS
Reimbursement for any necessary presurgery assessment services provided to MC+ managed care recipients is the responsibility of the patient’s health plan. This care must be coordinated with and billed to the recipient’s specific chosen or assigned health plan.

12.7 FOLLOW-UP CARE
Reimbursement for any necessary medical services provided after the discharge for the inpatient transplant stay is made using the general policies, reimbursement guidelines and rates established for all Missouri Medicaid providers, as outlined in Missouri Medicaid Program Manuals.

12.7.A MC+ MANAGED CARE RECIPIENTS
Reimbursement for any necessary medical services provided to MC+ managed care recipients after the discharge for the inpatient transplant stay is the responsibility of the patient’s health plan. This care must be coordinated with and billed to the recipient’s specific chosen or assigned health plan.

12.8 CYCLOSPORIN
The cost of Cyclosporin and/or immunosuppressive drugs administered while the transplant patient is admitted to the hospital (both during the stay for the transplant procedure and during any subsequent admissions) is included in the hospital’s reimbursement for the hospital stay.

Cyclosporin reimbursement after the patient has been discharged must be provided by an approved Missouri Medicaid Pharmacy provider and is subject to the policy and procedures as stated in the Pharmacy Program Manual.

12.8.A MC+ MANAGED CARE RECIPIENTS

Cyclosporin and other immunosuppressive drugs dispensed on an outpatient basis to MC+ managed care recipients is the responsibility of the patient’s chosen or assigned health plan and must be provided by a plan pharmacy.

12.8.B SECOND/THIRD TRANSPLANTS

Reimbursement of a second/third organ transplant due to failure of engraftment or rejection is authorized on a case-by-case basis. Each transplant is treated as a new authorization and subject to the same reimbursement policies as those of the initial transplant. When the second/third transplant is performed during the same course of stay as the initial transplant, the date of the second/third surgery begins a new authorization/reimbursement period subject to the same reimbursement limitations as for the initial transplant. Refer to Section 15 for inpatient billing instructions.

Reimbursement of a second/third stem cell transplant is considered on a case-by-case basis as outlined in Section 13. Each transplant is treated as a new authorization unless otherwise limited, and subject to the same reimbursement policies as those of the initial transplant.

12.8.C CHARGES EXCEEDING REIMBURSEMENT MAXIMUMS

The transplant facility and other providers by virtue of their participation as a Missouri Medicaid provider agree to accept Medicaid’s reimbursement as reimbursement of services in full. No collection for Medicaid covered services in connection with the transplant and related services can be made from the recipient/patient, the recipient's spouse, parent or guardian, relative or anyone else receiving public assistance.

12.8.D OUT-OF-STATE HOSPITAL REIMBURSEMENT RATES—BOTH BORDERING AND NONBORDERING STATES

Reimbursement of inpatient services provided in an out-of-state hospital for recipients 21 years of age and older is the lower of the hospital’s billed charge or the Missouri Title XIX per diem rate times the applicable number of days. Refer to Hospital Manual, Section 12.3 for further information.

12.9 MEDICARE/MEDICAID REIMBURSEMENT (CROSSOVER CLAIMS)
Section 12 - Reimbursement Methodology

For Medicaid recipients who are also Medicare beneficiaries and receive services covered by the Medicare Program, Missouri Medicaid pays the deductible and coinsurance amounts otherwise charged to the recipient by the provider.

Transplant patients who are eligible for both Medicare and Medicaid are limited to the maximum reimbursement allowed by Medicare and/or Medicaid for the type of transplant being performed.

12.9.A MEDICARE COVERED TRANSPLANTS

Medicare covered transplants are reimbursed by the Medicare carrier or intermediary for applicable services up to Medicare’s maximum allowed amount. The provider may bill Medicaid for the deductible and co-insurance amounts by submitting the Medicare RA/EOMB and a Part A or Part B sticker.

12.9.B NON-MEDICARE COVERED TRANSPLANTS

Transplant services not covered by Medicare but which are covered by Medicaid are reimbursed in accordance with the limits defined for Medicaid covered transplants. The transplant service must be prior authorized and the provider must submit evidence that the service is not a Medicare covered service before Medicaid can reimburse any claims.

12.10 RECIPIENT COST SHARING AND COPAY

Certain Medicaid services are subject to recipient cost sharing or copay. The cost sharing amount is paid by the recipient at the time services are rendered. Services of the Transplant Program are not subject to a cost sharing or copay amount.

12.11 A MANAGED HEALTH CARE DELIVERY SYSTEM METHOD OF REIMBURSEMENT

One method through which Medicaid provides services is a Managed Health Care Delivery System. A basic package of services is offered to the recipient by the health plan; however, some services are not included and are covered by Medicaid on a fee-for-service basis.

The Medicaid Program utilizes the managed care delivery system for certain included eligibles. Refer to Section 1 and Section 11 for a detailed description.

12.11.A HEALTH PLAN TRANSPLANT RESPONSIBILITIES

Claims for the pre-transplant assessment and care are the responsibility of the plan and must be authorized by the health care plan. Unless the patient has been disenrolled from the plan or becomes eligible under another type of assistance after the transplant, the plan is responsible for outpatient follow-up care after the transplant patient’s discharge for the transplant stay. Services must be authorized by the health care plan. Reimbursement of those authorized services is made by the plan.
The Division of Medical Services is responsible for reimbursement of those charges directly related to the transplant including the organ/stem cell procurement costs, actual inpatient transplant surgery costs, and post-surgery inpatient hospital costs associated with the transplant surgery, the primary transplant physician’s charges and other physician services associated with the patient’s transplant.

Refer to Section 11 for additional information regarding MC+ managed health care enrollees.

12.12 GENERAL RELIEF PROGRAM (text del. 2/06)

12.13 DIRECT DEPOSIT OPTION

The Missouri Medicaid Program offers providers the option of having their Medicaid checks automatically deposited into their checking or savings accounts. This option is much quicker than receiving payment through the mail and eliminates the possibility of lost checks. Refer to to the Physician Manual, Section 12.8 and the Hospital Manual, Section 12.9 for further information.

12.14 DONATED FUNDS

The Division of Medical Services acknowledges that many transplant candidates are the subject of community fund raisers to help with the cost of transplant related services. The “trust” agreements established to administer those funds are reviewed by DMS to determine if the funds are subject to any contractual or legal requirement for payment of Medicaid covered services.

If it is determined that the donated funds are legally or contractually available to the Medicaid transplant candidate, the candidates spouse or the candidates parent, the donated funds are treated as a primary source of payment. Subsequently, any amount to be paid by Medicaid for covered services is the amount remaining up to maximum reimbursement allowable after the donated funds have been exhausted.

If the transplant facility receives donated funds that assist in the reimbursement of the cost of the transplant procedure and are not from a contractual or legally binding source, the funds are not applied to reduce the Missouri Medicaid Program’s commitment.

In addition to the Medicaid maximum allowable amount established for the transplant procedure, providers may accept donated funds for reimbursement of non-covered Medicaid services and/or for costs over the maximum amount allowed for the transplant. However, under no circumstances, may the provider bill the transplant patient, the patient's spouse or parent or anyone else receiving public assistance, nor may the provider accept both Medicaid reimbursement and donated funds for reimbursement of the same charges.