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SECTION 12-REIMBURSEMENT METHODOLOGY

12.1 THE BASIS FOR ESTABLISHING A RATE OF PAYMENT

The MO HealthNet Division 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 participants 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 participants 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 MO HealthNet *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.

12.2 AMBULATORY SURGICAL CENTER SERVICES

Reimbursement for ambulatory surgical center (ASC) services is made on a fee-for-service basis. The maximum allowable fee for a unit of service has been determined by the MO HealthNet Division 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.

MO HealthNet allows payment of a facility charge for those procedures listed in Section 19 and identified by Medicare as ASC procedures, and that are performed in a Certified Ambulatory Surgical Center facility. The facility charge includes all ancillary and overhead costs associated with



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performing the procedure in the ASC facility, that is, equipment, supplies (medical, surgical, anesthetic, casting), nursing and paramedical personnel, materials, utilities and building costs, laundry, etc. It does *not* include the professional services of the operating/performing physician (surgeon, assistant surgeon, anesthesiologist, etc.) or dentist. All such services *must* be separately billed.

Certain Radiology and EKG services as listed in Section 19 that are specifically ordered by a professional and provided on-site may be separately claimed and reimbursed as ancillary to the all-inclusive procedure fee. Reimbursement to the ASC for these radiology services is based on a maximum allowable fee for the total service (facility and professional component).

There is no current provision for an individual provider retrospective cost-settlement activity.

12.3 DETERMINING A FEE

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

In determining what this fee should be, the MO HealthNet Division 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; and
- 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 MO HealthNet Division then determines a maximum allowable fee for the service based upon the recommendations, charge information reviewed and current appropriated funds.

A facility fee has been established for the procedures listed in Section 19, when provided in a free standing ASC facility place of service 24. Payment does *not* include professional services.

12.3.A ON-LINE FEE SCHEDULE

MO HealthNet fee schedules through the MO HealthNet Division are available at <http://dss.missouri.gov/mhd/>. The on-line Fee Schedule identifies covered and non-covered procedure codes, restrictions, allowed units and the MO HealthNet allowable fee per unit. The on-line Fee Schedule is updated quarterly and is intended as a reference *not* a guarantee for payment.



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The on-line Fee Schedule allows for the downloading of individual files or the search for a specific fee schedule. Some procedure codes may be billed by multiple provider types. Categories within the Fee Schedule are set up by the service rendered and are *not* necessarily provider specific.

Refer to Section 13 for program specific benefits and limitations.

12.4 MEDICARE/MO HEALTHNET REIMBURSEMENT (CROSSOVER CLAIMS)

For MO HealthNet participants who are also Medicare beneficiaries and receive services covered by the Medicare Program, MO HealthNet pays the deductible and coinsurance amounts otherwise charged to the participant by the provider. See Section 16 for a detailed explanation of these claims.

12.5 PARTICIPANT COPAY

Certain MO HealthNet services are subject to participant copay. The copay amount is paid by the participant at the time services are rendered. Services of the Ambulatory Surgical Center Program described in this manual are *not* subject to a copay amount. The provider *must* accept in full the amounts paid by the state agency.

12.6 A MANAGED HEALTH CARE DELIVERY SYSTEM METHOD OF REIMBURSEMENT

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

Ambulatory surgical center services are included as a plan benefit in the MO HealthNet Managed Care program.

12.6.A MO HEALTHNET MANAGED HEALTH CARE

Under a Managed Care health plan, a basic set of services is provided either directly or through subcontractors. Managed Care health plans are reimbursed at an established rate per member per month. Reimbursement is based on predicted need for health care and is paid for each participant for each month of coverage. Rather than setting a reimbursement rate for each unit of service, the total reimbursement for all enrollees for the month *must* provide for all needed health care to all participants in the group covered.

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The health plan is at risk for staying within the *overall* budget—that is, within the negotiated rate per member per month multiplied by the number of participants covered. Some individual cases exceed the negotiated rate per member per month but many more cases cost less than the negotiated rate.

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

12.7 PRIOR CONTENTS NO LONGER APPLICABLE

12.8 DIRECT DEPOSIT OPTION

The MO HealthNet Program offers providers the option of having their MO HealthNet 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.

Providers electing to participate in direct deposit *must* complete the Application for Provider Direct Deposit form. Direct deposit begins following a submission of a properly completed application form to the MO HealthNet Division, the successful processing of a test transaction through the banking system and the authorization of the Division to make payment using the direct deposit option. The state conducts direct deposit through the automated clearing house system, utilizing an originating depository financial institution. The rules of the National Clearing House Association and its member local Automated Clearing House Association shall apply, as limited or modified by law.

The Application for Provider Direct Deposit form provides instructions for completing the form on the reverse side. This form *must* also be used if providers wish to change an account number or cancel their election to participate. Exact copies of the form may be used. One form *must* be completed for each provider number. Providers may obtain additional forms by contacting the Provider Enrollment Unit of the MO HealthNet Division at P.O. Box 6500, 615 Howerton Court, Jefferson City, MO 65102-6500. The provider may also download these forms from this website: <http://www.dss.mo.gov/mhd/providers/index.htm>. *Please read the form and instructions carefully*; Section C contains statements regarding legal obligations.

The MO HealthNet Division will terminate or suspend the direct deposit for administrative or legal actions, including but not limited to: ownership change, duly executed liens or levies, legal judgments, notice of bankruptcy, administrative sanctions for the purpose of ensuring program compliance, death of a provider, and closure or abandonment of an account.

All payments are direct deposited or mailed. Providers and their representatives are *not* permitted to accept delivery of MO HealthNet checks in person.



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The MO HealthNet Remittance Advice may be downloaded to the provider from the MO HealthNet billing site at www.emomed.com or in some instances is mailed separately.

END OF SECTION

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