

PROVIDER BULLETIN

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MO HEALTHNET REIMBURSEMENT OF OUTPATIENT HOSPITAL MEDICARE CROSSOVER CLAIMS

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- **Overview of the change in reimbursement methodology for Medicare Part B and Medicare Advantage Plan/Part C Outpatient Hospital Crossover Claims.**
- **Example of a Medicare Part B Crossover Claim under new methodology.**

The MO HealthNet Division (MHD) has filed an Emergency Amendment to the Outpatient Hospital Regulation 13 CSR 70-15.060 to implement a change in the reimbursement of Medicare/Medicaid outpatient hospital crossover claims (crossover claims) for Medicare Part B and Medicare Advantage/Part C outpatient hospital services. The change in reimbursement methodology will not impact outpatient hospital crossover claims submitted by public hospitals operated by the Department of Mental Health (DMH).

Effective for payment dates beginning October 1, 2010 with dates of service on or after January 1, 2010, MHD will no longer automatically reimburse the cost sharing amount determined by Medicare or the Medicare Advantage Plan for outpatient hospital services. MHD will now determine the MO HealthNet reimbursement for the cost sharing amount as seventy-five percent (75%) of the allowable cost sharing amount. The claims will continue to process in the MMIS system as they currently do, applying MHD adjustments & edits, and the 75% will be applied to the MHD total allowable cost sharing amount to determine the new reimbursement. This methodology results in payment which is comparable to the fee-for-service (FFS) amount that would be paid by MHD for those same services.

The example of this methodology related to a Medicare Part B crossover claim is included at the end of this bulletin for educational purposes only and does not represent actual claims data or all scenarios.

The MO HealthNet Division expects a portion of the cost to the hospitals for nonpayment of the cost sharing amount for Medicare Part B to be recovered through Medicare's bad debt reimbursement policies as set forth in 42 CFR §413.89 and the Medicare Provider Reimbursement Manual. Bad debts associated with services paid under a reasonable charge-based methodology (such as ambulance services) or a fee schedule (such as therapies or lab) are not reimbursable by Medicare. Allowable bad debt for critical access hospitals is eligible to be reimbursed at one hundred percent (100%) and all other hospitals are eligible to be reimbursed at seventy percent (70%). The bad debts associated with nonpayment of the cost

sharing amount for Medicare Part C claims related to QMB or QMB plus participants are not eligible for reimbursement from Medicare. However, based on an analysis of hospital outpatient crossover claim expenditures for SFY 2010, the Medicare Part C crossover claims only represent eleven ten-thousandths percent (0.0011%) of the total outpatient hospital crossover claims or approximately seven hundred and fifty eight dollars (\$758). Hospitals will be responsible for properly reporting the allowable bad debt relating to the cost sharing amount for Medicare Part B not paid by the MO HealthNet Division on their Medicare cost report to receive Medicare reimbursement. If the allowable bad debt is not properly reported on the Medicare cost report, the hospitals may not receive reimbursement from Medicare.

During the initial year of implementation, hospitals may experience a delay of approximately eighteen (18) months in receiving the reimbursement from Medicare for the allowable bad debt depending on cost reporting deadlines and the hospital's fiscal year end. After the initial implementation period, the increased cost of the bad debts will be reflected in the Medicare Administrative Contractor bi-weekly interim payments for allowable Medicare bad debts in accordance with the Medicare Provider Reimbursement Manual Section §2405.2 and 42 CFR §412.116.

This change in reimbursement of Medicare Part B and Medicare Advantage/Part C cost sharing amounts will be automatically implemented by the MO HealthNet Division (MHD) and requires no action on the part of the hospitals to comply with this change in methodology. However, the hospitals will be required to properly report the allowable bad debt on their Medicare cost report to receive reimbursement from Medicare. This change falls within the normal scope of Medicare reporting and therefore, no additional staff should be needed.

To assist hospitals with identifying the amounts they can report as bad debt for Medicare reporting purposes, MHD will utilize an adjustment reason code of OA45 and a remark code of N59 which will be reflected on the hospital's remittance advice (RA).

**Example of MHD Payment for a Medicare Part B Crossover Claim
Using New Reimbursement Methodology**

The below example demonstrates that the claims will continue to process in the MMIS system as they currently do, applying MHD adjustments & edits, and the 75% will be applied to the MHD total allowable cost sharing amount to determine the new payment.

Line # on Claim	Medicare Billed Amt	Medicare Adjustment Reason / Amount				Medicare Paid Amt	Total Cost Sharing Billed to MHD	MHD Adjustments		MHD Payment Using Current Reimb. Method.
		CO Code	CO Amt	PR Code	PR Amt			Other Insurance/ Spenddown	Denied By MHD	
1	\$161.65	45	\$87.29			\$74.36				\$0.00
2	\$73.50	45	\$39.69			\$33.81				\$0.00
3	\$1,466.00	45	\$791.64	2	\$293.20	\$381.16	\$293.20			\$293.20
4	\$1,565.00	45	\$845.10	2	\$313.00	\$406.90	\$313.00			\$313.00
5	\$192.00	45	\$103.68	2	\$38.40	\$49.92	\$38.40		\$38.40	\$0.00
6	\$169.00			2	\$21.84	\$87.38	\$21.84			\$21.84
7	\$46.50	45	\$22.56	2	\$4.79	\$19.15	\$4.79			\$4.79
8	\$40.52	97	\$40.52			\$0.00				\$0.00
9	\$9.06	45	\$7.38	2	\$0.34	\$1.34	\$0.34			\$0.34
10	\$43.50	94	(\$102.89)	2	\$29.28	\$117.11	\$29.28			\$29.28
11	\$3.50	96	\$3.50			\$0.00				\$0.00
12	\$1,336.00	45	\$669.45	2	\$133.31	\$533.24	\$133.31	\$133.31		\$0.00
Total	\$5,106.23		\$2,507.92		\$834.16	\$1,704.37	\$834.16	\$133.31	\$38.40	\$662.45

New Reimbursement Payment % 75%

MHD payment applying new reimbursement methodology \$496.83

Calculation of Bad Debt for Medicare Reporting Purposes

MHD payment using current reimbursement methodology	\$662.45
Less the MHD payment applying the new reimbursement methodology	\$496.83
Amt. of bad debt for Medicare reporting purposes (indicated on the RA as codes OA45 / N59)	\$165.62

Provider Bulletins are available on the MO HealthNet Division (MHD) (Formerly the Division of Medical Services) Web site at <http://dss.mo.gov/mhd/providers/pages/bulletins.htm>. Bulletins will remain on the Provider Bulletins page only until incorporated into the [provider manuals](#) as appropriate, then moved to the Archived Bulletin page.

MO HealthNet News: Providers and other interested parties are urged to go to the MHD Web site at <http://dss.missouri.gov/mhd/global/pages/mednewssubscribe.htm> to subscribe to the electronic mailing list to receive automatic notifications of provider bulletins, provider manual updates, and other official MO HealthNet communications via E-mail.

MO HealthNet Managed Care: The information contained in this bulletin applies to coverage for:

- MO HealthNet Fee-for-Service
- Services not included in MO HealthNet Managed Care

Questions regarding MO HealthNet Managed Care benefits should be directed to the patient's MO HealthNet Managed Care health plan. Before delivering a service, please check the patient's eligibility status by swiping the red MO HealthNet card or by calling the Interactive Voice Response (IVR) System at 573-635-8908 and using Option One for the red or white card.

Provider Communications Hotline
573-751-2896