Rule No. 560-X-35-.09 Payment Methodology for Covered Services

(1) The Medicaid reimbursement for each service provided by a mental health service provider shall be based on a fee-for-service system. Each covered service is identified on a claim by a procedure code.

(2) Providers should bill no more than one month's services on a claim for a recipient. There may be multiple claims in a month, but no single claim may cover services performed in different months. For example, October 15, 1990, to November 15, 1990, would not be allowed. If the submitted claim covers dates of service, part or all of which were covered in a previously paid claim, it will be rejected.

(3) Payment will be based on the number of units of service reported for HCPCS codes.

(4) All claims for services must be submitted within 12 months from the date of service.

(5) Accounting for actual cost and units of services provided during a waiver year must be accomplished on HCFA's form 372. The following accounting definitions will be used to capture reporting data, and the audited figures used in establishing new interim fees:

(a) A waiver year consists of 12 consecutive months starting with the approval date specified in the approved waiver document.

(b) An expenditure occurs when cash or its equivalent is paid in a quarter by a state agency for waiver benefits. For a public/governmental provider, the expenditure is made whenever it is paid or recorded, whichever is earlier. Non-cash payments, such as depreciation, occur when transactions are recorded by the state agency.

(c) The services provided by a direct service provider agency is reported and paid by dates of service. Thus, all services provided during the 12 months of the waiver year will be attributed to that year.

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