

## **PROVIDER BULLETIN**

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### **OUTPATIENT SIMPLIFIED FEE SCHEDULE**

**EFFECTIVE DATE: July 1, 2021**

**APPLIES TO: ALL HOSPITALS PROVIDING OUTPATIENT SERVICES**

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#### **OUTPATIENT SIMPLIFIED FEE SCHEDULE**

The MO HealthNet Division (MHD) is implementing a new outpatient payment policy. The current outpatient hospital payment method is primarily based on a percent of the hospital's billed charges. The current method also utilizes a fee schedule for certain services (laboratory, radiology, some surgical procedures, and telehealth originating site).

The new method of paying for outpatient hospital services uses a simplified fee schedule based on Medicare's Ambulatory Payment Classifications (APCs). The Outpatient Simplified Fee Schedule (OSFS) is based on, but not identical to Medicare APCs and fee schedules. The new method uses this fee schedule for all outpatient services.

The OSFS will apply to all hospitals enrolled in the MO HealthNet program. Payment to physicians will not be affected.

#### **OUTPATIENT SIMPLIFIED FEE SCHEDULE METHODOLOGY**

Fees for outpatient hospital services covered by the MO HealthNet program will be determined by the CPT/HCPCS code at the line level and the following hierarchy:

1. The APC relative weight or payment rate assigned to the procedure in the Medicare OPPS Addendum B will be used to calculate the fee for the service.
  - a. The fee is calculated using the APC relative weight times the Missouri conversion factor. The Missouri conversion factor is the single statewide conversion factor used to determine the APC-based fees, using a formula based on Medicare OPPS.

- b. The formula consists of: sixty percent (60%) of the APC conversion factor multiplied by St. Louis, MO Medicare IPPS wage index value, plus the remaining forty percent (40%) of the APC conversion factor, with no wage index adjustment. The resulting amount is then multiplied by ninety percent (90%) to derive the OSFS fee.
  - c. For APCs with no assigned relative weight, ninety percent (90%) of the Medicare APC payment rate is used as the fee.
2. If there is no APC relative weight or APC payment rate established in the Medicare OPSS Addendum B for the procedure, the fee will be ninety percent (90%) of the rate listed on other Medicare fee schedules (e.g. Physician Fee Schedule, Clinical Laboratory Fee Schedule, Durable Medical Equipment, Prosthetic, Orthotic, and Supply Fee Schedule).
3. Fees for dental procedure codes in the outpatient hospital setting are calculated based on 38.5% of the 50th percentile fee for Missouri reflected in the 2021 National Dental Advisory Service (NDAS).
4. If there is no APC relative weight, APC payment rate, other Medicare fee schedule rate or NDAS rate established for a covered outpatient hospital service, the fee will be determined using MO HealthNet fee schedules applicable to the service (e.g. Dental fee schedule, Medical fee schedule, Other Medical fee schedule, and MHD Independent Lab – Technical Component fee schedule).

Federally-deemed critical access hospitals (CAHs) and nominal charge hospitals will receive a policy adjustor of an additional percent applied to the OSFS fee for each billed procedure code covered by MHD: forty percent (40%) for CAHs and twenty-five percent (25%) for nominal charge hospitals. Payment will be the lower of the provider's charge or the payment as calculated under the OSFS Payment Methodology.

## **OUTPATIENT SIMPLIFIED FEE SCHEDULE BILLING**

There are several billing requirements that will become increasingly more important under the new payment method.

- **Procedure code billing.** Payment will be based on the procedure code billed by the hospital at the line-level of the outpatient claim.
- **Procedure code units.** Procedure codes will pay the fee times the number of units billed, unless the billed units exceed the allowed units. Hospitals are asked to pay attention to billed units, which must be appropriate for the specific CPT/HCPCS code description. Special attention should be paid to therapy and observation codes.
- **Same-day billing.** Hospitals are expected to bill all outpatient services provided on the same day to the same patient on the same outpatient claim.
- **Visit levels.** In billing for emergency room and clinic visits (e.g., 99281-99285), hospitals are expected to follow the same guidelines as they do for Medicare. Similarly, for clinic

visits (e.g., 99202-99205 and 99211-99215), hospitals should bill G0463 Hospital outpatient clinic visit.

- **National Correct Coding Initiative (NCCI).** NCCI is an initiative of the Centers for Medicare and Medicaid Services to ensure that CPT/HCPCS codes are billed in appropriate combinations. NCCI edits associated with procedures and modifiers will continue to be applied under the new method.
- **Dental services.** With the new payment method, MO HealthNet will accept certain Current Dental Terminology© (CDT) codes (also known as D-codes) for dental services on the hospital claim form. These D-codes will be identified on the OSFS and priced by MHD for payment in the outpatient hospital setting.
- **Observation care.** Continue to report observation using HCPCS G0378 (Hospital observation services, per hour). Report the number of hours in the “units” field. One hour equals one unit of service.
- **Dialysis.** The technical component of dialysis provided in hospital-based dialysis clinics may be billed on the institutional claim using procedure code 90999 (Dialysis procedure).

## **OUTPATIENT SIMPLIFIED FEE SCHEDULE REIMBURSEMENT**

Hospitals will be paid according to the Current Procedural Terminology (CPT)/Healthcare Common Procedure Coding System (HCPCS) procedure code listed on the claim. If a claim line has a procedure code and the service is considered covered, then the payment for that line will equal the fee times the billed units, up to the maximum units allowed. Payment will be the lower of the provider's charge or the payment as calculated under the OSFS Payment Methodology.

A complete fee schedule of outpatient hospital procedure codes with the MO HealthNet allowed amount under the OSFS methodology can be found at <https://dss.mo.gov/mhd/providers/fee-for-service-providers.htm> under Fee Schedule & Rate Lists.

## **APPLICABILITY**

Managed Care enrolled providers should contact their Managed Care Organizations for questions regarding the OSFS.

**Provider Bulletins** are available on the MO HealthNet Division (MHD) website 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 website at <http://dss.mo.gov/mhd/> 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.

The information contained in this bulletin applies to coverage for:

- MO HealthNet Fee-for-Service

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 MO HealthNet card or by calling the Provider Communications Interactive Voice Response (IVR) System at 573-751-2896 and using Option One for the MO HealthNet ID card.

**Provider Communications Hotline**  
**573-751-2896**