Title 13—DEPARTMENT OF SOCIAL SERVICES
Division 70—MO HealthNet Division
Chapter 15—Hospital Program

PROPOSED AMENDMENT

13 CSR 70-15.160 Outpatient Hospital Services Reimbursement Methodology. The division is removing sections (1)-(4), renumbering as necessary, and amending new section (1).

PURPOSE: This proposed amendment updates all documents incorporated by reference and used to create the outpatient simplified fee schedule.

(1) *[Prospective Outpatient Hospital Services Reimbursement Percentage for Hospitals Located Within Missouri.*

(A) Outpatient hospital services shall be reimbursed on a prospective outpatient payment percentage effective July 1, 2002, except for services identified in subsection (1)(C). The prospective outpatient payment percentage will be calculated using the Medicaid overall outpatient cost-to-charge ratio from the fourth, fifth, and sixth prior base year cost reports regressed to the current State Fiscal Year (SFY). (If the current SFY is 2003, the fourth, fifth, and sixth prior year cost reports would be the cost report filed in calendar year 1997, 1998, and 1999.) As part of the regression analysis, a facility's outpatient payment percentage is limited to a downward adjustment of fifteen percent (15%) from the previous year with no limit on the upward swing, unless the facility chose the lower upward and downward swing option. For SFYs 2007–2010, the lower upward and downward swing option was three percent (3%) and beginning with SFY 2011 the lower upward and downward swing option is six percent (6%). Once a facility has chosen an option, it shall be fixed and applied beginning with the year it is selected. If a facility has not chosen an option, the default is the downward adjustment of fifteen percent (15%) from the previous year with no limit on the upward swing. The prospective outpatient payment percentage shall not exceed one hundred percent (100%) and shall not be less than twenty percent (20%).

(B) Outpatient cost-to-charge ratios will be as determined in the desk review of the base year cost reports. If adjustments are not made during the desk review, adjustments will be made to remove the cost and charges for services reimbursed on a fee schedule when calculating the cost-to-charge ratios used to determine the outpatient percentage rate.

1. Costs and charges for laboratory and radiology services reimbursed on a fee schedule shall be excluded when calculating the outpatient cost-to-charge ratios used to determine outpatient percentage rates.

2. Costs and charges for outpatient surgical procedures reimbursed on a fee schedule shall be excluded when calculating the outpatient cost-to-charge ratios used to determine outpatient percentage rates. Adjustments shall be made by the division starting with the calculation of the outpatient percentage rate for the SFY after the surgical procedures are moved to a fee schedule.

A. Exception. A hospital may request a revised calculation of the outpatient percentage rate prior to the adjustment made by the division in paragraph (1)(B)2. of this regulation. The hospital must provide the charges and cost-to-charge ratios by cost center for both Medicaid and Total (i.e., all payor types). The hospital must provide a breakdown of the amounts reimbursed on a fee schedule using a template developed by the division and available upon request. The template must be submitted to the division by April 1 of the current SFY for which the revised calculation of the outpatient percentage rate is requested. The hospital may be notified in writing of the revised outpatient percentage rate within sixty (60) days of receipt of the hospital's written request or within sixty (60) days of receipt of any additional documentation or clarification which may be required. If an adjustment is not otherwise limited or prohibited, the effective date of the change in the hospital's outpatient percentage rate shall be the first day of the month following the date of the division's final determination.

3. Costs and charges for the telehealth originating site fee reimbursed on a fee schedule shall be excluded when calculating the outpatient cost-to-charge ratios used to determine outpatient percentage rates starting with the calculation of the outpatient percentage rate for the SFY after the telehealth originating site fee is moved to a fee schedule.

4. Costs and charges for outpatient drugs reimbursed in accordance with the methodology described in 13 CSR 70-20.070 shall be excluded when calculating the outpatient cost-to-charge ratios used to determine outpatient percentage rates beginning February 1, 2019.

(C) Outpatient Hospital Services Reimbursement Limited by Rule.

1. Certain clinical diagnostic laboratory procedures will be reimbursed from a Medicaid fee schedule which shall not exceed a national fee limitation.

2. The technical component of outpatient radiology procedures will be reimbursed from a Medicaid fee schedule.

A. Effective for dates of service beginning October 1, 2011, through December 31, 2018, the technical component of outpatient radiology procedures, will be reimbursed according to the outpatient Medicaid fee schedule. These rates are based on one hundred twenty-five percent (125%) of the Medicare Physician fee schedule rate using Missouri Locality 01. The Medicaid outpatient radiology fee schedule for the calendar years of 2016, 2017, and 2018 is published on the MO HealthNet website. This fee schedule is incorporated by reference and made a part of this rule as published by the Department of Social Services, MO HealthNet Division, 615 Howerton Court, Jefferson City, MO 65109, at its website at https://dss.mo.gov/mhd/providers/files/outpatient-hospital-radiology-fee-schedule18.pdf, December 4, 2018. This rule does not incorporate any subsequent amendments or additions.

B. Effective for dates of service beginning January 1, 2019, the technical component of outpatient radiology procedures will be reimbursed according to the outpatient Medicaid fee schedule. These rates are based on ninety percent (90%) of the Medicare Physician fee schedule rate, effective January 1, 2018, using Missouri Locality 01. The Medicaid outpatient radiology fee schedule for the calendar years of 2017, 2018, and 2019 is published on the MO HealthNet website. This fee schedule is incorporated by reference and made a part of this rule as published by the Department of Social Services, MO HealthNet Division, 615 Howerton Court, Jefferson City, MO 65109, at its website at https://dss.mo.gov/mhd/providers/files/outpatient-hospital-radiology-fee-schedule.pdf, December 4, 2018. This rule does not incorporate any subsequent amendments or additions.

3. Effective for dates of service beginning January 1, 2019, outpatient surgical procedures are reimbursed according to the outpatient Medicaid fee schedule. These rates are based on the 2018 Medicare Hospital Prospective Payment System Addendum B. The list of outpatient surgical procedure codes are reimbursed according to the Medicaid fee schedule. This fee schedule is incorporated by reference and made a part of this rule as published by the Department of Social Services, MO HealthNet Division, 615 Howerton Court, Jefferson City, MO 65109, at its website at https://dss.mo.gov/mhd/providers/files/outpatient-hospital-surgical-procedure-fee-schedule.pdf, November 30, 2018. This rule does not incorporate any subsequent amendments or additions.

4. Effective for dates of service beginning January 1, 2019, telehealth originating site fee is paid at the lesser of the billed amount or the outpatient fee schedule amount.

5. Effective for service dates beginning April 1, 2019, outpatient drugs are reimbursed in accordance with the methodology described in 13 CSR 70-20.070.

6. Services of hospital-based physicians and certified registered nurse anesthetists are reimbursed from a Medicaid fee schedule or the billed charge, if less.

7. Outpatient hospital services provided for those recipients having available Medicare benefits shall be reimbursed by Medicaid to the extent of the deductible and coinsurance as imposed by Medicare.

8. Reimbursement of Medicare/Medicaid crossover claims (crossover claims) for Medicare Part B and Medicare Advantage/Part C outpatient hospital services, except for public hospitals operated by the Department of Mental Health (DMH), shall be determined as follows:

A. Crossover claims for Medicare Part B outpatient hospital services in which Medicare was the primary payer and the MO HealthNet Division (MHD) is the payer of last resort for cost-sharing (i.e., coinsurance, copay, and/or deductibles) must meet the following criteria to be eligible for MHD reimbursement:

(I) The crossover claim must be related to Medicare Part B outpatient hospital services that were provided to MO HealthNet participants also having Medicare Part B coverage;

(II) The crossover claim must contain approved outpatient hospital services which MHD is billed for cost-sharing; and

(III) The Other Payer paid amount field on the claim must contain the actual amount paid by Medicare. The MO HealthNet provider is responsible for accurate and valid reporting of crossover claims submitted to MHD for payment regardless of how the claim is submitted. Providers submitting crossover claims for Medicare Part B outpatient hospital services to MHD must be able to provide documentation that supports the information on the claim upon request. The documentation must match the information on the Medicare Part B plan's remittance advice. Any amounts paid by MHD that are determined to be based on inaccurate data will be subject to recoupment;

B. Crossover claims for Medicare Advantage/Part C (Medicare Advantage) outpatient hospital services in which a Medicare Advantage plan was the primary payer and MHD is the payer of last resort for cost-sharing (i.e., coinsurance, copay, and/or deductibles) must meet the following criteria to be eligible for MHD reimbursement:

(I) The crossover claim must be related to Medicare Advantage outpatient hospital services that were provided to MO HealthNet participants who also are either a Qualified Medicare Beneficiary (QMB Only) or Qualified Medicare Beneficiary Plus (QMB Plus);

(II) The crossover claim must be submitted as a Medicare UB-04 Part C Professional Crossover claim through the MHD online billing system;

(III) The crossover claim must contain approved outpatient hospital services which MHD is billed for cost-sharing; and

(IV) The Other Payer paid amount field on the claim must contain the actual amount paid by the Medicare Advantage plan. The MO HealthNet provider is responsible for accurate and valid reporting of crossover claims submitted to MHD for payment. Providers submitting crossover claims for Medicare Advantage outpatient hospital services to MHD must be able to provide documentation that supports the information on the claim upon request. The documentation must match the information on the Medicare Advantage plan's remittance advice. Any amounts paid by MHD that are determined to be based on inaccurate data will be subject to recoupment;

C. MHD reimbursement for approved outpatient hospital services. MHD will reimburse seventy-five percent (75%) of the allowable cost-sharing amount; and

D. MHD will continue to reimburse one hundred percent (100%) of the allowable cost-sharing amounts for outpatient services provided by public hospitals operated by DMH as set forth above in paragraph (1)(C)4.

(2) Exempt Hospitals. Exempt hospital out-patient payment percent will be set as follows and will include:

(A) New Medicaid providers which do not have a fourth, fifth, and sixth prior year cost report.

1. Interim payment percentage. An interim outpatient payment percentage for new Medicaid hospital providers will be set at seventy-five percent (75%) for the first three (3) state fiscal years in which the hospital operates. The cost reports for these three (3) years will have a cost settlement calculated in accordance with 13 CSR 70-15.040.

2. Outpatient percentage. The outpatient payment percentage for the fourth and fifth year in which the hospital operates will be based on the overall Medicaid cost-to-charge ratio from its fourth prior year cost report.

(B) Hospitals who qualify as nominal charge providers under 42 CFR 413.13(f) or meet the definition of nominal charge provider in subsection (4)(D) shall be reimbursed on an interim basis by Medicaid at the lesser of seventy-five percent (75%) of usual and customary charges as billed by the provider for covered services or one hundred percent (100%) of the facility's Medicaid-allowable outpatient cost-to-charge ratio as determined from the most recent desk-reviewed cost report. Reimbursement at the applicable percentage shall be effective July 1 of each SFY for all providers.

(C) A hospital which had a change-in-ownership or merged its operation with another hospital between January 1, 1997, and June 30, 2002, and does not have a 1997 cost report filed by new owner, shall have the option to delay its entry into prospective outpatient payment methodology or enter the prospective outpatient payment methodology identified in subsection (1)(A) of this regulation. The hospital must notify the division of its decision by March 3, 2003. A hospital which chooses to delay its entry into the prospective outpatient payment methodology will receive an outpatient payment percentage starting July 1, 2002, and may have final settlements calculated in accordance with paragraphs (2)(C)1. and 2. The transfer to the prospective outpatient payment percentage will occur as follows:

1. A hospital which does not have a fourth prior year cost report (for SFY 2003 cost report would be 1999) filed by new owner will have its retrospective outpatient payment percentage based on the overall outpatient cost-to-charge ratio from the most current desk-reviewed cost report, either prior or current owner. All cost reports for prior and current owner ending in the SFY prior to the year the new owner receives a prospective outpatient payment percentage in accordance with paragraph (2)(C)2., will have a final settlement calculated in accordance with 13 CSR 70-15.040; and

2. A hospital which has a fourth prior year cost report filed by current owner will have its prospective outpatient payment percentage based on the overall outpatient cost-to-charge ratio from its fourth prior year cost report for the fourth and fifth SFY after the change-in-ownership or merger which occurred prior to July 1, 2002. For the sixth SFY the hospital's rate will be established in accordance with subsection (1)(A) of this regulation.

Chart for prospective rates for change in ownership or merger:

(D) Hospital Mergers. Hospitals that merge their operations under one (1) Medicare and MO HealthNet provider number shall have their outpatient percentage rate calculated under the surviving hospital's (the hospital whose Medicare and MO HealthNet provider number remains active) MO HealthNet provider number. The outpatient percentage rate of the surviving entity for the remainder of the state fiscal year in which the merger occurred is determined from combining the cost report data for the applicable cost report periods for the merged facilities. The effective date of the merged rate is the date of the merger. The surviving entity's outpatient percentage rate will be calculated for subsequent state fiscal years using the combined cost report data from the appropriate cost report periods for the merged facilities.

(E) A hospital that has failed to file one (1) of the cost reports used to determine their prospective outpatient payment percentage for the year, whether it be the fourth, fifth, or sixth prior year cost report, will have their prospective outpatient payment percentage based on the two (2) cost reports that are on file with the division plus the average of those two (2) cost reports to be used in place of the missing cost report. For example, if the division does not have on file a fourth prior year cost report, but has the fifth and sixth prior year cost reports, an average of the fifth and sixth prior year cost reports would be used in place of the fourth prior year cost report. This average along with the fifth and sixth prior year cost reports would then be used to calculate the prospective outpatient payment percentage.

(3) Closed Facilities. Hospitals which closed after January 1, 1999, but before July 1, 2002, will have final settlements for cost reports ending during this time period calculated in accordance with 13 CSR 70-15.040.

(4) Definitions.

(A) Base cost report. Desk-reviewed Medicare/Medicaid cost report. When a facility has more than one (1) cost report with periods ending in the fourth prior calendar year, the cost report covering a full twelve- (12-) month period will be used. If none of the cost reports covers a full twelve (12) months, the cost report with the latest period will be used. If a hospital's base cost report is less than or greater than a twelve- (12-) month period, the data shall be adjusted, based on the number of months reflected in the base cost report to a twelve- (12-) month period.

(B) Cost report. A cost report details, for purposes of both Medicare and Medicaid reimbursement, the cost of rendering covered services for the fiscal reporting period. The Medicare/Medicaid Uniform Cost Report contains the forms utilized in filing the cost report. The Medicare/Medicaid Cost Report version 2552-96 (CMS 2552-96) shall be used for fiscal years ending on or after September 30, 1996. The Medicare/Medicaid Cost Report version 2552-10 (CMS 2552-10) shall be used for fiscal years beginning on and after May 1, 2010.

(C) Effective date.

1. The plan effective date shall be July 1, 2002.

2. New prospective outpatient payment percentages will be effective July 1 of each SFY.

(D) Nominal charge provider. A nominal charge provider is determined from the fourth prior year desk-reviewed cost report. The hospital must meet the following criteria:

1. An acute care hospital with an unsponsored care ratio of at least sixty-five percent (65%) and is licensed for fifty (50) inpatient beds or more and has an occupancy rate of more than forty percent (40%). The unsponsored care ratio is determined as the sum of bad debts and charity care divided by total net revenue. The hospital must meet one (1) of the federally mandated Disproportionate Share qualifications; or

2. The hospital is a public hospital operated by the Department of Mental Health primarily for the care and treatment of mental disorders.]

*[(5)]***(1)** *Outpatient Simplified Fee Schedule* (OSFS) Payment Methodology.

(A) Definitions. The following definitions will be used in administering section *[(5)]* **(1)** of this rule:

1. Ambulatory Payment Classification (APC). Medicare's ambulatory payment classification assignment groups of Current Procedural Terminology (CPT) or Healthcare Common Procedures Coding System (HCPCS) codes. APCs classify and group clinically similar outpatient hospital services that can be expected to consume similar amounts of hospital resources. All services within an APC group have the same relative weight used to calculate the payment rates;

2. APC conversion factor. The unadjusted national conversion factor calculated by Medicare effective January 1 of each year, as published with the Medicare Outpatient Prospective Payment System (OPPS) Final Rule, and used to convert the APC relative weights into a dollar payment. The Medicare OPPS Final Rule is incorporated by reference and made a part of this rule as published by the Centers for Medicare & Medicaid Services, 7500 Security Boulevard, Baltimore, MD 21244, and available at *[https://www.govinfo.gov/content/pkg/FR-2021-11-16/pdf/2021-24011.pdf, November 19, 2021.]* **https://www.govinfo.gov/content/pkg/FR-2022-11-23/pdf/2022-23918.pdf, November 23, 2022.** This rule does not incorporate any subsequent amendments or additions;

3. APC relative weight. The national relative weights calculated by Medicare for the Outpatient Prospective Payment System;

4. Current Procedural Terminology (CPT). A medical code set that is used to report medical, surgical, and diagnostic procedures and services to entities such as physicians, health insurance companies, and accreditation organizations;

5. Dental procedure codes. The procedure codes found in the Code on Dental Procedures and Nomenclature (CDT), a national uniform coding method for dental procedures maintained by the American Dental Association;

6. Federally-Deemed Critical Access Hospital. Hospitals that meet the federal definition found in section 1820(c)(2)(B) of the Social Security Act;

7. HCPCS. The national uniform coding method maintained by the Centers for Medicare & Medicaid Services (CMS) that incorporates the American Medical Association (AMA) Physicians CPT and the three (3) HCPCS unique coding levels, I, II, and III;

8. Medicare Inpatient Prospective Payment System (IPPS) wage index. The wage area index values are calculated annually by Medicare, published as part of the Medicare IPPS Final Rule;

9. Missouri conversion factor. The single, statewide conversion factor used by the MO HealthNet Division (MHD) to determine the APC-based fees, uses a formula based on Medicare OPPS. The formula consists of sixty percent (60%) of the APC conversion factor, as defined in paragraph *[(5)]***(1)**(A)2. multiplied by the St. Louis, MO Medicare IPPS wage index value, plus the remaining forty percent (40%) of the APC conversion factor, with no wage index adjustment;

10. Nominal charge provider. A nominal charge provider is determined from the third prior year audited Medicaid cost report. The hospital must meet the following criteria:

A. A public non-state governmental acute care hospital with a low-income utilization rate (LIUR) of at least forty percent (40%) and a Medicaid inpatient utilization rate (MIUR) greater than one (1) standard deviation from the mean, and is licensed for fifty (50) inpatient beds or more and has an occupancy rate of at least forty percent (40%). The hospital must meet one (1) of the federally mandated Disproportionate Share qualifications; or

B. The hospital is a public hospital operated by the Department of Mental Health primarily for the care and treatment of mental disorders; and

C. A hospital physically located in the *[S]***S**tate of Missouri;

11. Outpatient Prospective Payment System (OPPS). Medicare's hospital outpatient prospective payment system mandated by the Balanced Budget Refinement Act of 1999 (BBRA) and the Medicare, Medicaid, and *[State Children's Health Insurance Program (SCHIP)]* **SCHIP** Benefits Improvement and Protection Act *[(BIPA)]* of 2000 **(BIPA)**; and

12. Payment level adjustment. The percentage applied to the Medicare fee to derive the OSFS fee.

(B) Effective for dates of service beginning July 20, 2021, outpatient hospital services shall be reimbursed on a predetermined fee-for-service basis using an OSFS based on the APC groups and fees under the Medicare Hospital OPPS. When service coverage and payment policy differences exist between Medicare OPPS and Medicaid, MHD policies and fee schedules are used. The fee schedule will be updated as follows:

1. MHD will review and adjust the OSFS annually on July 1 based on the payment method described in subsection *[(5)]***(1)**(D); and

2. The OSFS is incorporated by reference and made a part of this rule as published by the Department of Social Services, MO HealthNet Division, 615 Howerton Court, Jefferson City, MO 65109, at its website at *[https://dss.mo.gov/mhd/providers/fee-for-service-providers.htm, August 10, 2022]* **https://dss.mo.gov/mhd/providers/pages/cptagree.htm, July 13, 2023.** This rule does not incorporate any subsequent amendments or additions.

(C) Payment will be the lower of the provider's charge or the payment as calculated in subsection *[(5)]***(1)**(D).

(D) Fee schedule methodology. Fees for outpatient hospital services covered by the MO HealthNet program are determined by the HCPCS procedure 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* is used to calculate the fee for the service, with the exception of the hospital observation per hour fee which is calculated based on the method described in subparagraph *[(5)]* **(1)**(D)1.B. Fees derived from APC weights and payment rates are established using the Medicare OPPS *Addendum B* effective as of January 1 of each year as published by the CMS for Medicare OPPS. The Medicare OPPS *Addendum B* is incorporated by reference and made a part of this rule as published by the Centers for Medicare & Medicaid Services, 7500 Security Boulevard, Baltimore, MD 21244, and available at *[https://www.cms.gov/medicaremedicare-fee-service-paymenthospitaloutpatientppsaddendum-and-addendum-b-updates/january-2022-0, January 18, 2022.]* **https://www.cms.gov/medicare/medicare-fee-service-payment/hospitaloutpatientpps/addendum-and-addendum-b-updates/january-2023, January 20, 2023.** This rule does not incorporate any subsequent amendments or additions.

A. The fee is calculated using the APC relative weight times the Missouri conversion factor. The resulting amount is then multiplied by the payment level adjustment of ninety percent (90%) to derive the OSFS fee.

B. The hourly fee for observation is calculated based on the relative weight for the Medicare APC (using the Medicare OPPS *Addendum A* effective as of January 1 of each year as published by the CMS for Medicare OPPS), which corresponds with comprehensive observation services multiplied by the Missouri conversion factor divided by forty (40), the maximum payable hours by Medicare. The resulting amount is then multiplied by the payment level adjustment of ninety percent (90%) to derive the OSFS fee. The Medicare OPPS *Addendum A* is incorporated by reference and made a part of this rule as published by the Centers for Medicare & Medicaid Services, 7500 Security Boulevard, Baltimore, MD 21244, and available at [*https://www.cms.gov/medicaremedicare-fee-service-paymenthospitaloutpatientppsaddendum-and-addendum-b-updates/january-2022, January 18, 2022]* **https://www.cms.gov/medicare/medicare-fee-service-payment/hospitaloutpatientpps/addendum-and-addendum-b-updates/january-2023-0, January 20, 2023**. This rule does not incorporate any subsequent amendments or additions.

C. For those 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 for a particular service in the Medicare OPPS *Addendum B*, then the MHD approved fee will be ninety percent (90%) of the rate listed on other Medicare fee schedules, effective as of January 1 of each year: Clinical Laboratory Fee Schedule; Physician Fee Schedule; and Durable Medical Equipment Prosthetics/Orthotics and Supplies Fee Schedule, applicable to the outpatient hospital service.

A. The Medicare *Clinical Laboratory Fee Schedule* is incorporated by reference and made a part of this rule as published by the Centers for Medicare & Medicaid Services, 7500 Security Boulevard, Baltimore, MD 21244, and available at *[https://www.cms.gov/medicaremedicare-fee-service-paymentclinicallabfeeschedclinical-laboratory-fee-schedule-files/22clabq1, December 29, 2021]* **https://www.cms.gov/medicare/medicare-fee-service-payment/clinicallabfeesched/clinical-laboratory-fee-schedule-files/23clabq1, January 12, 2023**. This rule does not incorporate any subsequent amendments or additions.

B. The Medicare *Physician Fee Schedule* is incorporated by reference and made a part of this rule as published by the Centers for Medicare & Medicaid Services, 7500 Security Boulevard, Baltimore, MD 21244, and available at [*https://www.cms.gov/medicaremedicare-fee-service-paymentphysicianfeeschedpfs-carrier-specific-files/all-states-1, December 18, 2021]* **https://www.cms.gov/medicaremedicare-fee-service-paymentphysicianfeeschedpfs-carrier-specific-files/all-states-2, January 5, 2023**. This rule does not incorporate any subsequent amendments or additions.

C. The Medicare *Durable Medical Equipment Prosthetics/Orthotics and Supplies Fee Schedule* is incorporated by reference and made a part of this rule as published by the Centers for Medicare & Medicaid Services, 7500 Security Boulevard, Baltimore, MD 21244, and available at *[https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/DMEPOSFeeSched/DMEPOS-Fee-Schedule, December 15, 2021]* **https://www.cms.gov/medicaremedicare-fee-service-paymentdmeposfeescheddmepos-fee-schedule/dme23, December 19, 2022**. This rule does not incorporate any subsequent amendments or additions;

3. Fees for dental procedure codes in the outpatient hospital setting are calculated based on thirty-eight and one half percent (38.5%) of the fiftieth percentile fee for Missouri reflected in the 2022 *National Dental Advisory Service* (NDAS). The 2022 NDAS is incorporated by reference and made a part of this rule as published by Wasserman Medical & Dental at its website at *[https://wasserman-medical.com/product-category/dental/ndas/, and available at the MO HealthNet Division, 615 Howerton Court, Jefferson, City MO 65109, January 31, 2022]* **https://wasserman-medical.com/product-category/dental/ndas/, January 10, 2023** . This rule does not incorporate any subsequent amendments or additions;

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, then a MO HealthNet fee will be determined using the MHD *Dental, Medical, Other Medical or Independent Lab—Technical Component* fee schedules.

A. The MHD *Dental Fee Schedule* is incorporated by reference and made a part of this rule as published by the Department of Social Services, MO HealthNet Division, 615 Howerton Court, Jefferson City, MO 65109, and available at https://dss.mo.gov/mhd/providers/pages/cptagree.htm, *[June 7, 2022]* **March 8, 2023**. This rule does not incorporate any subsequent amendments or additions.

B. The MHD *Medical Fee Schedule* is incorporated by reference and made a part of this rule as published by the Department of Social Services, MO HealthNet Division, 615 Howerton Court, Jefferson City, MO 65109, and available at https://dss.mo.gov/mhd/providers/pages/cptagree.htm, *[August 8, 2022]* **March 8, 2023**. This rule does not incorporate any subsequent amendments or additions.

C. The MHD *Other Medical Fee Schedule* is incorporated by reference and made a part of this rule as published by the Department of Social Services, MO HealthNet Division, 615 Howerton Court, Jefferson City, MO 65109, and available at https://dss.mo.gov/mhd/providers/pages/cptagree.htm, *[June 7, 2022]* **March 8, 2023**. This rule does not incorporate any subsequent amendments or additions.

D. The MHD *Independent Lab—Technical Component Fee Schedule* is incorporated by reference and made a part of this rule as published by the Department of Social Services, MO HealthNet *Division, 615 Howerton Court, Jefferson City, MO 65109,* and available at https://dss.mo.gov/mhd/providers/pages/cptagree.htm, *[June 7, 2022]* **March 8, 2023**. This rule does not incorporate any subsequent amendments or additions;

5. In-state federally-deemed critical access hospitals will receive an additional forty percent (40%) of the rate as determined in paragraph *[(5)]***(1)**(B)2. for each billed procedure code; and

6. Nominal charge providers will receive an additional twenty-five percent (25%) of the rate as determined in paragraph *[(5)]***(1)**(B)2. for each billed procedure code.

(E) Packaged services. MHD adopts Medicare guidelines for procedure codes identified as "Items and Services Packaged into APC Rates" under Medicare OPPS *Addendum D1*. These procedures are designated as always packaged. Claim lines with packaged procedure codes will be considered paid but with a payment of zero (0). The Medicare OPPS *Addendum D1* is incorporated by reference and made a part of this rule as published by the Centers for Medicare & Medicaid Services, 7500 Security Boulevard, Baltimore, MD 21244, and available at *[https://www.cms.gov/license/ama?file=/files/zip/2022-nfrm-opps-addenda.zip, November 3, 2021]***https://www.cms.gov/license/ama?file=/files/zip/2023-nfrm-opps-addenda.zip, November 22, 2022**. This rule does not incorporate any subsequent amendments or additions.

(F) Inpatient only services. MHD adopts Medicare guidelines for procedure codes identified as "Inpatient Procedures" under Medicare OPPS *Addendum D1*. These procedures are designated as inpatient only (referred to as the inpatient only (IPO) list). Claim lines with inpatient only procedures will not be paid under the OSFS.

(G) Drugs. Effective for dates of service beginning April 1, 2019, outpatient drugs are reimbursed in accordance with the methodology described in 13 CSR 70-20.070.

(H) Payment for outpatient hospital services under this rule will be final, with no cost settlement.

AUTHORITY: sections 208.153, ***208.152,*** *208.201, and 660.017, RSMo****.*** *[2016, and section 208.152, RSMo Supp. 2022.]* Emergency rule filed June 20, 2002, effective July 1, 2002, expired Feb. 27, 2003. Original rule filed June 14, 2002, effective Jan. 30, 2003. Amended: Filed May 3, 2004, effective Oct. 30, 2004. Amended: Filed June 15, 2005, effective Dec. 30, 2005. Emergency amendment filed Sept. 21, 2010, effective Oct. 1, 2010, expired March 29, 2011. Amended: Filed Sept. 30, 2010, effective March 30, 2011. Emergency amendment filed Sept. 20, 2011, effective Oct. 1, 2011, expired March 28, 2012. Amended: Filed July 1, 2011, effective Feb. 29, 2012. Emergency amendment filed June 20, 2012, effective July 1, 2012, expired Dec. 28, 2012. Amended: Filed June 20, 2012, effective Jan. 30, 2013. Amended: Filed July 1, 2013, effective Jan. 30, 2014. Amended: Filed May 1, 2018, effective Jan. 1, 2019. Amended: Filed Jan. 8, 2019, effective July 30, 2019. Amended: Filed April 21, 2021, effective Nov. 30, 2021. Emergency amendment filed June 13, 2022, effective July 1, 2022, expired Feb. 23, 2023. Amended: Filed June 13, 2022, effective Jan. 30, 2023.* ***Amended: Filed July 13, 2023.***

PUBLIC COST: This proposed amendment is estimated to cost the Department of Social Services $17.2 million in SFY 2024. This proposed amendment will not cost other state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars ($500) in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Department of Social Services, Legal Services Division-Rulemaking, P.O. Box 1527, Jefferson City, MO 65102-1527, or by email to Rules.Comment@dss.mo.gov. To be considered, comments must be received within thirty (30) days after publication of this notice in the Missouri Register. A public hearing will not be scheduled.