# Rules of
Department of Social Services
Division 70—Division of Medical Services
Chapter 15—Hospital Program

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Title 13—DEPARTMENT OF SOCIAL SERVICES
Division 70—Division of Medical Services
Chapter 15—Hospital Program

13 CSR 70-15.010 Inpatient Hospital Services Reimbursement Plan; Outpatient Hospital Services Reimbursement Methodology

PURPOSE: This rule establishes the legal basis for the administration of the state agency’s plan for reimbursement of covered inpatient hospital services in accordance with the principles and provisions described in this rule and also establishes the legal basis for the state agency’s methodology employed for reimbursement of covered outpatient hospital services.

PUBLISHER’S NOTE: The secretary of state has determined that the publication of the entire text of the material which is incorporated by reference as a portion of this rule would be unduly cumbersome or expensive. Therefore, the material which is so incorporated is on file with the agency who filed this rule, and with the Office of the Secretary of State. Any interested person may view this material at either agency’s headquarters or the same will be made available at the Office of the Secretary of State at a cost not to exceed actual cost of copy reproduction. The entire text of the rule is printed here. This note refers only to the incorporated by reference material.

(1) General Reimbursement Principles.

(A) For inpatient hospital services provided for an individual entitled to Medicare Part A inpatient hospital benefits and eligible for Medicaid, reimbursement from the Missouri Medicaid Program will be available only when Medicaid’s applicable payment schedule amount exceeds the amount paid by Medicare. Medicaid’s payment will be limited to the lower of the deductible and coinsurance amounts or the amount the Medicaid applicable payment schedule amount exceeds the Medicare payments. For all other Medicaid recipients, unless otherwise limited by rule, reimbursement will be based solely on the individual recipient’s days of care (within benefit limitations) multiplied by the individual hospital’s Title XIX per diem rate. As described in paragraph (5)(D)(2), of this rule, as part of each hospital’s fiscal year-end cost settlement determination, a comparison of total Medicaid-covered aggregate charges and total Medicaid payments will be made and any hospital whose aggregate Medicaid per diem payments exceed aggregate Medicaid charges will be subject to a retroactive adjustment.

(B) The Title XIX reimbursement for hospitals located outside Missouri and for federally-operated hospitals in Missouri will be determined as stated in section (14) of this plan.

(C) The Title XIX reimbursement for hospitals, excluding those located outside Missouri and in-state federal hospitals, shall include per diem payments, outpatient payments, disproportionate share payments; various Medicaid Add-On payments, as described in this rule; or a safety net adjustment, paid in lieu of Direct Medicaid Payments described in section (15) and Uninsured Add-Ons described in subsection (18)(B). Reimbursement shall be subject to availability of federal financial participation (FFP).

1. Per diem reimbursement—The per diem rate is established in accordance with section (3).

2. Outpatient reimbursement is described in section (13).

3. Disproportionate share reimbursement—The disproportionate share payments described in section (16), and subsection (18)(B) include both the federally mandated reimbursement for hospitals which meet the federal requirements listed in section (6) and the discretionary disproportionate share payments which are allowable but not mandated under federal regulation. A Safety Net Adjustment, section (16), and Uninsured Add-Ons, subsection (18)(B), are subject to federal limitation described in Omnibus Reconciliation Act of 1993 (OBRA 93) and section (17) of this regulation.

4. Medicaid Add-Ons—Medicaid Add-Ons are described in sections (15), (19) and (21) and are in addition to Medicaid per diem payments. These payments are subject to the federal Medicare Upper Limit test.

5. Safety Net Adjustment—The payments described in subsection (16)(A) are paid in lieu of Direct Medicaid Payments described in section (15) and Uninsured Add-Ons described in subsection (18)(B).

(2) Definitions.

(A) Allowable costs. Allowable costs are those related to covered Medicaid services defined as allowable in 42 CFR chapter IV, part 413, except as specifically excluded or restricted in 13 CSR 70-15.010 or the Missouri Medicaid hospital provider manual and detailed on the desk-reviewed Medicaid cost report. Penalties or incentive payments as a result of Medicare target rate calculations shall not be considered allowable costs. Implicit in any definition of allowable cost is that this cost is allowable only to the extent that it relates to patient care; is reasonable, ordinary and necessary; and is not in excess of what a prudent and cost-conscious buyer pays for the given service or item.

(B) Bad debt. Bad debts should include the costs of caring for patients who have insurance but are not covered for the particular services, procedures or treatment rendered. Bad debts shall not include the cost of caring for patients whose insurance covers the given procedures but limits coverage. In addition, bad debts shall not include the cost of caring for patients whose insurance covers the procedure although the total payments to the hospital are less than the actual cost of providing care.

(C) 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.

(D) Charity care. Results from a provider’s policy to provide health care services free of charge or a reduction in charges because of the indigence or medical indigence of the patient.

(E) Contractual allowances. Difference between established rates for covered services and the amount paid by third-party payers under contractual agreements.

(F) 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.

(G) Critical access. Hospitals which meet the federal definition found in section 1820(c)(2)(B) of the Social Security Act. A Missouri expanded definition of critical access shall also include hospitals which meet the federal definitions of both a rural referral center and sole community provider and is adjacent to at least one county that has a Medicaid eligible population of at least thirty percent (30%) of the total population of the county or hospitals which are the sole community hospital located in a county that has a Medicaid population of at least thirty percent (30%) of the total population of the county.

(H) Disproportionate share reimbursement. The disproportionate share payments
described in section (16), and subsection (18)(B) include both the federally mandated reimbursement for hospitals which meet the federal requirements listed in section (6) and the discretionary disproportionate share payments which are allowed but not mandated under federal regulation. A Safety Net Adjustment, section (16), and Uninsured Add-Ons, subsection (18)(B), are subject to federal limitation as described in Omnibus Reconciliation Act of 1993 (OBRA 93) and section (17) of this regulation.

(I) Effective date.
1. The plan effective date shall be October 1, 1981.
2. The adjustment effective date shall be thirty (30) days after notification to the hospital that its reimbursement rate has been changed unless modified by other sections of the plan.

(J) Medicare rate. The Medicare rate is the rate established on the basis of allowable cost as defined by applicable Medicare standards and principles of reimbursement (42 CFR part 405) as determined by the servicing fiscal intermediary based on yearly hospital cost reports.

(K) Nonreimbursable items. For purposes of reimbursement of reasonable cost, the following are not subject to reimbursement:
1. Allowances for return on equity capital;
2. Amounts representing growth allowances in excess of the intensity allowance, profits, efficiency bonuses, or a combination of these;
3. Cost in excess of the principal of reimbursement specified in 42 CFR chapter IV, part 413; and
4. Costs or services or costs and services specifically excluded or restricted in this plan or the Medicaid hospital provider manual.

(L) Per diem rates. The per diem rates shall be determined from the individual hospital cost report in accordance with section (3) of the regulation.

(M) Reasonable cost. The reasonable cost of inpatient hospital services is an individual hospital’s Medicaid per diem cost per day as determined in accordance with the general plan rate calculation from section (3) of this regulation using the base year cost report.

(N) Specialty pediatric hospital. An inpatient pediatric acute care facility which:
1. Is licensed as a hospital by the Missouri Department of Health and Senior Services under Chapter 197 of the Missouri Revised Statutes;
2. Has been granted substantive waivers by the Missouri Department of Health and Senior Services from compliance with material hospital licensure requirements governing a) the establishment and operation of an emergency department, and b) the provision of pathology, radiology, laboratory and central services; and
3. Is not licensed to operate more than sixty (60) inpatient beds.

(O) Trend factor. The trend factor is a measure of the change in costs of goods and services purchased by a hospital during the course of one (1) year.

(P) Children’s hospital. An acute care hospital operated primarily for the care and treatment of children under the age of eighteen (18) and which has designated in its licensure application at least sixty-five percent (65%) of its total licensed beds as a pediatric unit as defined in 19 CSR 30-20.021(4)(F).

(Q) FRA. The Federal Reimbursement Allowance (FRA) is identified in 13 CSR 70-15.110. Effective January 1, 1999, the assessment shall be an allowable cost.

(R) Incorporates by Reference. This rule incorporates by reference the following:
1. Institutional Provider Manual; and
2. Worksheet E-3 Part IV from the Medicare cost report (HCFA 2552-96).

(3) Per Diem Reimbursement Rate Computation. Each hospital shall receive a Medicaid per diem rate based on the following computation.

(A) The per diem rate shall be determined from the 1995 base year cost report in accordance with the following formula:

$$\text{Per Diem} = \frac{\text{OC} \times \text{TI} + \text{CMC}}{\text{MPD} + \text{MPDC}}$$

1. OC—The operating component is the hospital’s total allowable cost (TAC) less CMC;
2. CMC—The capital and medical education component of the hospital’s TAC;
3. MPD—Medicaid inpatient days;
4. MPDC-MPD—Medicaid patient days for capital costs as defined in paragraph (3)(A)(3) with a minimum utilization of sixty percent (60%) as described in paragraph (3)(C)(4);
5. TI—Trend indices. The trend indices are applied to the OC of the per diem rate. The trend indices for SFY 1995 is used to adjust the OC to a common fiscal year end of June 30;
6. TAC—Allowable inpatient routine and special care unit expenses, ancillary expenses and graduate medical education costs will be added to determine the hospital’s total allowable cost (TAC);
7. The per diem shall not exceed the average Medicaid inpatient charge per diem as determined from the base year cost report and adjusted by the TI; and
8. The per diem shall be adjusted for rate increases granted in accordance with subsection (5)(F) for allowable costs not included in the base year cost report.

(B) Trend Indices (TI). Trend indices are determined based on the four (4)-quarter average DRI Index for DRI-Type Hospital Market Basket as published in Health Care Costs by DRI/McGraw-Hill for each State Fiscal Year (SFY) 1995 to 1998. Trend indices starting in SFY 1999 will be determined based on CPI Hospital indexed as published in Health Care Costs by DRI/McGraw-Hill for each State Fiscal Year (SFY).

1. The TI are—
   A. SFY 1994—4.6%
   B. SFY 1995—4.45%
   C. SFY 1996—4.575%
   D. SFY 1997—4.05%
   E. SFY 1998—3.1%
   F. SFY 1999—3.8%
   G. SFY 2000—4.0%
   H. SFY 2001—4.6%
   I. SFY 2002—4.8%

2. The TI for SFY 1996 through SFY 1998 are applied as a full percentage to the OC of the per diem rate and for SFY 1999 the OC of the June 30, 1998 rate shall be trended by 1.2% and for SFY 2000 the OC of the June 30, 1999 rate shall be trended by 2.4%. The OC of the June 30, 2000 rate shall be trended by 1.95% for SFY 2001.

3. The per diem rate shall be reduced as necessary to avoid any negative Direct Medicaid Payments computed in accordance with subsection (15)(B).

(4) Per Diem Rate—New Hospitals.

(A) Facilities Reimbursed by Medicare on a Per Diem Basis. In the absence of adequate cost data, a new facility’s Medicare rate may be its most current Medicare rate on file for two (2) fiscal years following the facility’s initial fiscal year as a new facility. The Medicare rate for this third fiscal year will be the lower of the most current Medicare rate on file by review date or the facility’s Medicare rate for its second fiscal year indexed forward by the inflation index for the current fiscal year. The Medicare rate for the facility’s fourth fiscal year will be determined in accordance with sections (1)–(3) of this plan.

(B) Facilities Reimbursed by Medicare on a Diagnosis Related Grouping (DRG) Basis. In the absence of adequate cost data, a new
facility’s Medicaid rate may be one hundred twenty percent (120%) of the average-weighted, statewide per diem rate for two (2) fiscal years following the facility’s initial fiscal year as a new facility. The Medicaid rate for the third fiscal year will be the facility’s Medicaid rate for its second fiscal year indexed forward by the inflation index for the current fiscal year. The Medicaid rate for the facility’s fourth fiscal year will be determined in accordance with sections (1)–(3) of this plan.

(5) Administrative Actions.
(A) Cost Reports.
1. Each hospital participating in the Missouri Medical Assistance Program shall submit a cost report in the manner prescribed by the state Medicaid agency. The cost report shall be submitted within five (5) calendar months after the close of the reporting period. The period of a cost report is defined in 42 CFR 413.24(f). A single extension, not to exceed thirty (30) days, may be granted upon the request of the hospital and the approval of the Missouri Division of Medical Services when the provider’s operation is significantly affected due to extraordinary circumstances over which the provider had no control such as fire or flood. The request must be in writing and postmarked prior to the first day of the sixth month following the hospital’s fiscal year end.

2. The termination of or by a hospital of participation in the program requires that the hospital submit a cost report for the period ending with the date of termination within five (5) calendar months after the close of the reporting period. No extensions in the submitting of cost reports shall be allowed when a termination of participation has occurred. The payments due the hospital shall be withheld until the cost report for the final reporting period is filed with the Division of Medical Services.

3. All cost reports shall be submitted and certified by an officer or administrator of the provider. Failure to file a cost report, within the period prescribed in this subsection, may result in the imposition of sanctions as described in 13 CSR 70-3.030.

4. Amended cost reports or other supplemental. The division will notify hospital by letter when the desk review of its cost report is completed. Since, this data may be used in the calculation of per diem rates, direct payments, trended costs or uninsured payments unless the hospital requests in writing and receives an extension to file additional information prior to the end of the fifteen (15)-day deadline.

(B) Records.
1. All hospitals are required to maintain financial and statistical records in accordance with 42 CFR 413.20. For purposes of this plan, statistical and financial records shall include beneficiaries’ medical records and patient claim logs separated for inpatient and outpatient services billed to and paid for by Missouri Medicaid (excluding cross-over claims) respectively. Separate logs for inpatient and outpatient services should be maintained for Medicaid recipients covered by managed care (MC+). All records must be available upon request to representatives, employees or contractors of the Missouri Medical Assistance Program, Missouri Department of Social Services, General Accounting Office (GAO) or the United States Department of Health and Human Services (HHS). The content and organization of the inpatient and outpatient logs shall include the following:

A. A separate Medicaid log for each fiscal year must be maintained by either date of service or date of payment by Medicaid for claims and all adjustments of those claims for services provided in the fiscal period. Lengths of stay covering two (2) fiscal periods should be recorded by date of admission. The information from the Medicaid log should be used to complete the Medicaid worksheet in the hospital’s cost report;

B. Data required to be recorded in logs for each claim include:
   (I) Recipient name and Medicaid number;
   (II) Dates of service;
   (III) If inpatient claim, number of days paid for by Medicaid, classified by adults and peds, each subproviders, newborn or specific type of intensive care;
   (IV) Charges for paid inpatient days and inpatient ancillary charges for paid days classified by cost center as reported in the cost report or allowed outpatient services, classified by cost center as reported on cost report;
   (V) Noncovered charges combined under a separate heading;
   (VI) Total charges;
   (VII) Any partial payment made by third-party payers (claims paid equal to or in excess of Medicaid payment rates by third-party payers shall not be included in the log);
   (VIII) Medicaid payment received or the adjustment taken; and

IX. Date of remittance advice upon which paid claim or adjustment appeared;

C. A year-to-date total must appear at the bottom of each log page or after each applicable group total or a summation page of all subtotals for the fiscal year activity must be included with the log; and

D. Not to be included in the outpatient log are claims or line item outpatient charges denied by Medicaid or claims or charges paid from an established Medicaid fee schedule. This would include payments for General Relief (GR) recipients, payments for hospital-based physicians and certified registered nurse anesthetists billed by the hospital on a professional services claim, payments for certain specified clinical diagnostic laboratory services, or payments for services provided by the hospital through enrollment as a Medicaid provider-type other than hospital outpatient.

2. Records of related organizations, as defined by 42 CFR 413.17, must be available upon demand to those individuals or organizations as listed in paragraph (5)(B)1. of this rule.

3. The Missouri Division of Medical Services shall retain all uniform cost reports submitted for a period of at least three (3) years following the date of submission of the reports and will maintain those reports pursuant to the record keeping requirements of 42 CFR 413.20. If an audit by, or on behalf of, the state or federal government has begun but is not completed at the end of the three (3)-year period, or if audit findings have not been resolved at the end of the three (3)-year period, the reports shall be retained until resolution of the audit findings.

4. The Missouri Division of Medical Services shall maintain any responses received on this plan, subsequent changes to this plan and rates for a period of three (3) years from the date of receipt.

(C) New, Expanded or Terminated Services.

1. A hospital, at times, may offer to the public new or expanded services for the provision of allowable inpatient services which require Certificate of Need (CON) approval or permanently terminate a service. For a state hospital, i.e., one owned or operated by the board of curators as provided for in Chapter 172, RSMo, or one owned or operated by the Department of Mental Health, the state hospital may offer new or expanded inpatient services to the public provided it receives legislative appropriations for the project and the project meets the CON costs threshold. Within six (6) months after this event, the hospital must submit a request for
rate reconsideration with a budget which shall take into consideration new, expanded or terminated services. Since a state hospital is not subject to the CON approval process, a state hospital will have six (6) months after the effective date of this amendment to file a budget for CON type projects completed after its base year cost report and will then have six (6) months after the completion of the new or expanded service is offered to the public. The budgets will be subject to desk review and audit. Upon completion of the desk review, reimbursement rates may be adjusted, if indicated. Failure to submit a request for rate reconsideration and budget within the six (6)-month period shall disqualify the hospital from receiving a rate increase. Failure to submit a request shall not prohibit the division from reducing the rate in the case of a terminated service.

2. Failure to submit a budget concerning terminated services may result in the imposition of sanctions as described in 13 CSR 70-3.030.

3. Rate adjustments due to new or expanded services will be determined as total allowable project cost (i.e., the sum of annual depreciation, annualized interest expense and annual additional operating costs) multiplied by the ratio of total inpatient days to total allowable bed days as submitted on the most recent cost report filed by the agency as of the review date divided by total acute care patient days including all special care units and nursery, but excluding swing bed days.

4. Total acute care patient days (excluding nursery and swing bed days) must be at least sixty percent (60%) of total possible bed days. Total possible bed days will be determined using the number of licensed beds times three hundred sixty-five (365) days. If the days, including neonatal units, are less than sixty percent (60%), the sixty percent (60%) number plus newborn days will be used to determine the rate increase. This computation will apply to capital costs only.

(D) Audits.

1. A comprehensive hospital audit program shall be established in cooperation with the Missouri Medicare fiscal intermediary. Under the terms of the Common Audit Agreement, the Medicare intermediary shall perform the following:
   A. Desk review all hospital cost reports;
   B. Determine the scope and format for on-site audits;
   C. Perform field audits when indicated in accordance with Title XIX principles; and
   D. Submit to the state agency the final Title XVIII cost report with respect to each provider.

2. The state agency shall review audited Medicaid-Medicare cost reports for each hospital’s fiscal year in accordance with 13 CSR 70-15.040.

(E) Adjustments to Rates. The prospectively determined individual hospital’s reimbursement rate may be adjusted only under the following circumstances:

1. When information contained in the cost report is found to be intentionally misrepresented. The adjustment shall be made retroactive to the date of the original rate. This adjustment shall not preclude the Medicare agency from imposing any sanctions authorized by any statute or rule;

2. When rate reconsideration is granted in accordance with subsection (5)(F);

3. When the Medicare per diem rate is changed by the servicing fiscal intermediary based on a new audit finding for the base year. This adjustment may be applied and effective no earlier than the first day of the month following notification by the Division of Medical Services; or

4. When a hospital documents to the Division of Medical Services a change in its status from nonprofit to proprietary, or from proprietary to nonprofit, its direct Medicaid payments for the state fiscal year will be adjusted to take into account any change in its Medicaid inpatient allowable costs due to the change in its property taxes. The Medicaid share of the change in property taxes will be calculated for the state fiscal year in which the change is reported by multiplying the increase or decrease in property taxes applicable to the current state fiscal year by the ratio of allowable Medicaid inpatient hospital costs to total costs of the facility. (For example, if the property taxes are assessed starting January 1 for the calendar year, then one-half (1/2) of the calendar year property taxes will be used to calculate the additional inpatient direct Medicaid payments for the period of January 1 to June 30.)

(F) Rate Reconsideration.

1. Rate reconsideration may be requested under this subsection for changes in allowable costs which occur subsequent to the base period described in subsection (5)(A). The effective date for any increase granted under this subsection shall be no earlier than the first day of the month following the Division of Medical Services’ final determination on rate reconsideration.

2. The following may be subject to review under procedures established by the Medicaid agency:

   A. Substantial changes in or costs due to case mix;
   B. New, expanded or terminated services as detailed in subsection (5)(C);
   C. When the hospital experiences extraordinary circumstances which may include, but are not limited to, an act of God, war or civil disturbance; and
   D. Per diem rate adjustments for critical access and trauma center hospitals.

(I) Critical access hospitals meeting either the federal definition or the Missouri expanded definition may request per diem rate adjustments in accordance with this subsection. The per diem rate increase will result in a corresponding reduction in the Medicaid direct payment.

   (a) Hospitals which meet the federal definition as a critical access hospital may request a per diem rate equal to one hundred percent (100%) of their estimated Medicaid cost per day as determined in section (15).

   (b) Hospitals which meet the Missouri expanded definition as a critical access hospital may request a per diem rate equal to seventy-five percent (75%) of their estimated Medicaid cost per day as determined in section (15).

3. The following will not be subject to review under these procedures:

   A. The use of Medicare standards and reimbursement principles;
   B. The method for determining the trend factor;
   C. The use of all-inclusive prospective reimbursement rates; and
   D. Increased costs for the successor owner, management or leaseholder that result from changes in ownership, management, control, operation or leasehold interests by whatever form for any hospital previously certified at any time for participation in the Medicaid program, except a review may be conducted when a hospital changes from non-profit to proprietary or vice versa to recognize the change in its property taxes, see paragraph (5)(E)4.

4. As a condition of review, the Missouri Division of Medical Services may require the hospital to submit to a comprehensive operational review. The review will be made at the discretion of the state Medicaid agency and may be performed by it or its designee. The findings from any such review may be used to recalculate allowable costs for the hospital.

5. The request for an adjustment must be submitted in writing to the Missouri Division of Medical Services and must specifically and clearly identify the issue and the total dollar amount involved. The total
dollar amount must be supported by generally acceptable accounting principles. The hospital shall demonstrate the adjustment is necessary, proper and consistent with efficient and economical delivery of covered patient care services. The hospital will be notified in writing of the agency’s decision 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, whichever is later. Failure to submit requested information within the sixty (60)-day period shall be grounds for denial of the request. If the state does not receive within the sixty (60)-day period, the request shall be deemed denied.

(G) Sanctions. Sanctions may be imposed against a provider in accordance with 13 CSR 70-3.030 and other applicable state and federal regulations.

(6) Disproportionate Share.

(A) Inpatient hospital providers may qualify as a Disproportionate Share Hospital (DSH) based on the following criteria. Hospitals shall qualify as Disproportionate Share Hospitals for a period of only one (1) state fiscal year and must requalify at the beginning of each state fiscal year to continue their disproportionate share classification—

1. If the facility offered nonemergency obstetric services as of December 21, 1987, there must be at least two (2) obstetricians with staff privileges at the hospital who have agreed to provide obstetric services to individuals entitled to these services under the Missouri Medicaid plan. In the case of a hospital located in a rural area (area outside of a metropolitan statistical area, as defined by the federal Executive Office of Management and Budget), the term obstetrician includes any physician with staff privileges at the hospital to perform nonemergency obstetric procedures. This section does not apply to hospitals either with inpatients predominantly under eighteen (18) years of age or which did not offer nonemergency obstetric services as of December 21, 1987;

2. As determined from the fourth prior year desk-reviewed cost report, the facility must have either—

   A. A Medicaid inpatient utilization rate (MIUR) at least one (1) standard deviation above the state’s mean MIUR for all Missouri hospitals. The MIUR will be expressed as the ratio of total Medicaid days (TMD) provided under a state plan divided by the provider’s total number of inpatient days (TNID). The state’s mean MIUR will be expressed as the ratio of the sum of the total number of the Medicaid days for all Missouri hospitals divided by the sum of the total patient days for the same Missouri hospitals. Data for hospitals no longer participating in the program will be included;

   \[
   \text{MIUR} = \frac{\text{TMD}}{\text{TNID}}
   \]

   or

   B. A low-income utilization rate (LIUR) in excess of twenty-five percent (25%). The LIUR shall be the sum (expressed as a percentage) of the fractions, calculated as follows:

   (I) Total Medicaid patient revenues (TMPR) paid to the hospital for patient services under a state plan plus the amount of the cash subsidies (CS) directly received from state and local governments, divided by the total net revenues (TNR) (charges, minus contractual allowances, discounts and the like) for patient services plus the CS; and

   (II) The total amount of the hospital’s charges for patient services attributable to charity care (CC) (care provided to individuals who have no source of payment, third-party or personal resources) less CS directly received from state and local governments in the same period, divided by the total amount of the hospital’s charges (THC) for patient services. The total patient charges attributed to CC shall not include any contractual allowances and discounts other than for indigent patients not eligible for medical assistance under a state plan;

   \[
   \text{LIUR} = \frac{\text{TMPR} + \text{CS}}{\text{TNR} + \text{CC}} + \frac{\text{CC} - \text{CS}}{\text{THC}}
   \]

3. As determined from the fourth prior year desk-reviewed cost report, the hospital—

   A. Has an unsponsored care ratio of at least ten percent (10%). The unsponsored care ratio is determined as the sum of bad debts and CC divided by TNR and also meets either of the criteria in paragraph (6)(A)2.; or

   B. Ranks in the top fifteen (15) in the number of Medicaid inpatient days provided by that hospital compared to Medicaid patient days provided by all hospitals, and the hospitals also have a Medicaid nursery utilization ratio greater than thirty-five percent (35%) as computed by dividing Title XIX nursing and neonatal days by total nursery and neonatal days; or

   C. Operated a neonatal intensive care unit with a ratio of Missouri Medicaid neonatal patient days to Missouri Medicaid total patient days in excess of nine percent (9%) reported or verified by the division from the fourth prior year cost report;

4. As determined from the fourth prior year desk-reviewed cost report—

   A. The acute care hospital has an unsponsored care ratio of at least sixty-five percent (65%) and is licensed for less than fifty (50) inpatient beds; or

   B. The acute care hospital has 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%); or

   C. The hospital is owned or operated by the Board of Curators as defined in Chapter 172, RSMo and the Missouri Rehabilitation Center created by Chapter 199, RSMo or their successors; or

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

5. As determined from the fourth prior year desk-reviewed cost report, hospitals which annually provide more than five thousand (5,000) Title XIX days of care and whose Title XIX nursery days represent more than fifty percent (50%) of the hospital’s total nursery days.

(B) Those hospitals which meet the criteria established in paragraphs (6)(A)1., (6)(A)2. and (6)(A)4. shall be deemed safety net hospitals. Those hospitals which meet the criteria established in (6)(A)1. and (6)(A)3. shall be deemed first tier Disproportionate Share Hospitals (DSH). Those hospitals which meet only the criteria established in paragraphs (6)(A)1. and (6)(A)2. or (6)(A)1. and (6)(A)5. shall be deemed second tier DSH.

(C) A hospital not meeting the requirements in subsection (6)(A), but has a Medicaid inpatient utilization percentage of at least one percent (1%) for Medicaid-eligible recipients may at the option of the state be deemed a Disproportionate Share Hospital (DSH). These facilities may receive only the DSH payments identified in section (18).

(D) Specialty pediatric hospitals shall not qualify for disproportionate share payments by meeting the state defined requirements. However, they will qualify for disproportionate share payments if they meet the federal requirements as defined in (6)(A)1. and (6)(A)2.

(E) Hospitals shall not send amended cost reports or other data necessary for qualification for disproportionate share classification for purposes of rate reconsideration unless the reports or other necessary data are received within sixty (60) days of the date of the division’s notification of the final determination of the rate.

(7) Outlier Adjustment.
(A) Effective for admissions beginning on or after July 1, 1991, outlier adjustments for medically necessary inpatient services involving exceptionally high cost or exceptionally long lengths of stay for Missouri Medicaid-eligible children under the age of six (6) will be made to hospitals meeting the disproportionate share requirements in subsection (6)(A) and, for Missouri Medicaid-eligible infants under the age of one (1), will be made to any other Missouri Medicaid hospital except for specialty pediatric hospitals.

1. The following criteria must be met for the services to be eligible for outlier review:

A. The patient must be a Missouri Medicaid-eligible infant under the age of one (1) year, or for disproportionate share hospitals a Missouri Medicaid-eligible child under the age of six (6) years, for all dates of service presented for review;

B. Hospitals requesting outlier review for children one (1) year of age to children under six (6) years of age, must have qualified for disproportionate share status under section (6) of this plan for the state fiscal year corresponding with the fiscal year end of the cost report referred to in paragraph (7)(A)5.; and

C. One (1) of the following conditions must be satisfied:

(I) The total reimbursable charges for dates of service as described in paragraph (7)(A)3. must be at least one hundred fifty percent (150%) of the sum of total third-party liabilities and Medicaid inpatient claim payments for that claim; or

(II) The dates of service must exceed sixty (60) days and less than seventy-five percent (75%) of the total service days was reimbursed by Medicaid.

2. Claims for all dates of service eligible for outlier review must—

A. Have been submitted to the Division of Medical Services fiscal agent or the MC+ health plan in their entirety for routine claims processing, and claim payment must have been made before the claims are submitted to the division for outlier review; and

B. Be submitted for outlier review with all documentation as required by the Division of Medical Services no later than ninety (90) days from the last payment made by the fiscal agent or the MC+ health plan through the normal claims processing system for those dates of service.

3. Claim charges and Medicaid payment data will be determined from claims data, submitted to the Division of Medical Services fiscal agent or MC+ health plan, by the hospital through normal claims processing.

4. The claims may be reviewed for—

A. Medical necessity at an inpatient hospital level-of-care;

B. Appropriateness of services provided in connection with the diagnosis; and

C. Charges that are not permissible per the Division of Medical Services; policies established in the institutional manual and hospital bulletins.

5. After the review, reimbursable costs for each claim will be determined using the following data from the most recent Medicaid hospital cost report filed by June 1 of each year:

A. Average routine (room and board) costs for the general and special care units for all days of the stay eligible per the outlier review;

B. Ancillary cost-to-charge ratios applied to claim ancillary charges determined eligible for reimbursement per the outlier review; and

C. No cost will be calculated for items such as malpractice insurance premiums, interns and residents, professional services or return on equity.

6. Each state fiscal year, outlier adjustment payments for each hospital will be made for all claims submitted before March 1 of the preceding state fiscal year which satisfy all conditions in paragraphs (7)(A)1.–4. The payments will be determined for each hospital as follows:

A. Sum all reimbursable costs per paragraph (7)(A)5. for all applicable outlier claims to equal total reimbursable costs;

B. Subtract third-party payments and Medicaid payments for those claims from total reimbursable costs to equal excess cost; and

C. Multiply excess costs by fifty percent (50%).

(B) Effective for admissions beginning on or after July 1, 1997, outlier adjustments shall also be made for Missouri Medicaid recipients enrolled in MC+. All criteria listed under subsection (7)(A) applies to MC+ outlier submissions.

8. Payment Assurance.

(A) The state will pay each hospital, which furnishes the services in accordance with the requirements of the state plan, the amount determined for services furnished by the hospital according to the standards and methods set forth in the rules implementing the Hospital Reimbursement Program.

(B) Where third-party payment is involved, Medicaid will be the payor of last resort with the exception of state programs, such as Vocational Rehabilitation and the Missouri Crippled Children’s Service. Procedures for remitting third-party payments are provided in the Missouri Medical Assistance Program provider manuals.

(C) Regardless of changes of ownership, management, control, operation, leasehold interests by whatever form for any hospital previously certified for participation in the Medicaid program, the department will continue to make all Title XIX payments directly to the entity with the hospital’s current provider number and hold the entity with the current provider number responsible for all Medicaid liabilities.

9. Provider Participation. Payments made in accordance with the standards and methods described in this rule are designed to enlist participation of a sufficient number of hospitals in the program, so that eligible persons can receive the medical care and services included in the state plan at least to the extent these services are available to the general public.

10. Payment in Full. Participation in the program shall be limited to hospitals who accept as payment in full for covered services rendered to Medicaid recipients the amount paid in accordance with the rules implementing the Hospital Reimbursement Program.

11. Plan Evaluation. Documentation will be maintained to effectively monitor and evaluate experience during administration of this plan.

12. Inappropriate Placements.

(A) The hospital per diem rate as determined under this plan and in effect on October 1, 1981, shall not apply to any recipient who is receiving inpatient hospital care when s/he is only in need of nursing home care.

1. If a hospital has an established intermediate care facility/skilled nursing facility (ICF/SNF) or SNF-only Medicaid rate for providing nursing home services in a distinct part setting, reimbursement for nursing home services provided in the inpatient hospital setting shall be made at the hospital’s ICF/SNF or SNF-only rate.

2. If a hospital does not have an established Medicaid rate for providing nursing home services in a distinct part setting, reimbursement for nursing home services provided in the inpatient hospital setting shall be made at the state swing bed rate.

3. No Medicaid payments will be made on behalf of any recipient who is receiving inpatient hospital care and is not in need of either inpatient or nursing home care.
(13) Outpatient Hospital Services Reimbursement for Hospitals Located Within Missouri.

(A) Outpatient hospital services, unless otherwise limited by rule, 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 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 FY for all providers and shall be subject to adjustment whenever the inpatient rate is changed.

1. All services provided to GR recipients will be reimbursed from the Medicaid fee schedule in accordance with provisions of 13 CSR 70-2.020.

2. Effective for dates of service September 1, 1985, and annually updated, certain clinical diagnostic laboratory procedures will be reimbursed from a Medicaid fee schedule which shall not exceed a national fee limitation.

3. Services of hospital-based physicians and certified registered nurse anesthetists shall be billed on an HCFA-1500 professional claim form and reimbursed from a Medicaid fee schedule or the billed charge, if less.

(B) The final outpatient settlements for hospitals will be calculated for each fiscal year in accordance with 13 CSR 70-15.040(4).

(C) For reporting purposes in the outpatient Medicaid data, facilities shall not include services reimbursed from a fee schedule, which include services to GR recipients, the clinical diagnostic laboratory services and services of hospital-based physicians and certified registered nurse anesthetists.

(D) 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 under Title XVIII.

(14) Out-of-State Hospital and Instate Federally-Operated Hospital Reimbursement.

(A) Inpatient Reimbursement.

1. Effective for admissions beginning after April 1, 1994, inpatient services for Missouri Medicaid recipients age twenty-one (21) or older in hospitals located outside Missouri and federally-operated hospitals located within Missouri will be reimbursed at the lower of—

   A. The charges billed for those services; or

   B. The individual recipient’s days of care (within benefit limitations) multiplied by the Title XIX per diem rate of three hundred forty-five dollars and thirteen cents ($345.13).

2. Effective for admission beginning after April 1, 1994, inpatient services for children under the age of twenty-one (21) in hospitals located outside Missouri will be reimbursed at the lower of—

   A. The charges billed for those services; or

   B. The individual recipient’s days of care (within benefit limitations) multiplied by the Title XIX per diem rate established by the host state’s Medicaid agency. If the host state does not reimburse inpatient hospital services on a per diem basis, the per diem rate shall be six hundred sixty dollars and eighty-nine cents ($660.89). The inpatient psychiatric limitation (section (15)) shall apply.

3. There will be no adjustments or exemptions to this per diem rate and individual rate reconsideration will be performed.

4. Payments on claims submitted, unless otherwise specified, constitute final payment to hospitals located outside Missouri and to federally-operated hospitals within Missouri on those claims and no year-end cost settlements will be done. Therefore, these hospitals are not required to file Medicaid cost reports with Missouri.

(B) Outpatient Reimbursement.

1. Out-of-state outpatient hospital services and services of federally-operated hospitals located within Missouri will be reimbursed by Missouri Medicaid at sixty percent (60%) of usual and customary charges as billed by the provider for covered services with the exceptions specified in paragraphs (11)(A)1.–4.

   2. Payments on claims submitted, unless otherwise specified, constitute final payment on those claims to hospitals located outside Missouri and to federally-operated hospitals located within Missouri and no year-end cost settlements will be done.

(15) Direct Medicaid Payments.

(A) Direct Medicaid Payments. Direct Medicaid payments will be made to hospitals for the following allowable Medicaid costs not included in the per diem rate as calculated in section (3):

   1. The increased Medicaid costs resulting from the FRA assessment not included in the cost report ending prior to January 1, 2001;

   2. The unreimbursed Medicaid costs applicable to the trend factor which is not included in the per diem rate;

   3. The unreimbursed Medicaid costs for capital and medical education not included in the trended per diem cost as a result of the application of the sixty percent (60%) minimum utilization adjustment in paragraph (3)(A)4.;

   4. The increased cost per day resulting from the utilization adjustment. The increase cost per day results from lower utilization of inpatient hospital services by Medicaid recipients now covered by an MC+ health plan;

   5. The poison control adjustment shall be determined for hospitals which operated a poison control center during the base year and which continues to operate a poison control center in a Medicaid managed care region; and

   6. The increased cost resulting from including out-of-state Medicaid days in total projected Medicaid days.

(B) Direct Medicaid payment will be computed as follows:

1. The Medicaid share of the FRA assessment will be calculated by dividing the hospital’s Medicaid patient days by total hospital’s patient days to arrive at the Medicaid utilization percentage. This percentage is then multiplied by the FRA assessment for the current FY to arrive at the increased allowable Medicaid costs;

2. The unreimbursed Medicaid costs are determined by subtracting the hospital’s per diem rate from its trended per-diem costs. The difference is multiplied by the estimated Medicaid patient days for the current FY.

   A. The trended cost per day is calculated by trend the base year costs per day by the trend indices listed in paragraph (3)(B)1., using the rate calculation in subsection (3)(A). In addition to the trend indices applied to inflate base period costs to the current fiscal year, base year costs will be further adjusted by a Missouri Specific Trend. The Missouri Specific Trend will be used to address the fact that costs for Missouri inpatient care of Medicaid residents have historically exceeded the compounded inflation rates estimated using national hospital indices for a significant number of hospitals. The Missouri Specific Trend will be applied at one and one-half percent (1.5%) per year to the hospital’s base year. For example, hospitals with a 1998 base year will receive an additional six percent (6%) trend and hospitals with a 1999 base year will receive an additional four and one-half percent (4.5%) trend.

   B. For hospitals that meet the requirements in paragraphs (6)(A)1., (6)(A)2. and (6)(A)4. of this rule (safety net hospitals), the additional six percent (6%) trend and no Missouri Specific Trend will be applied.
prior year. For hospitals that meet the requirements in paragraphs (6)(A)1. and (6)(A)3. of this rule (first tier Disproportionate Share Hospitals), the base year operating costs may be the third or fourth prior year cost report. The Division of Medical Services shall exercise its sole discretion as to which report is most representative of costs. For all other hospitals, the base year operating costs are based on the fourth prior year cost report. For any hospital that has both a twelve (12)-month cost report and a partial year cost report, its base period cost report for that year will be the twelve (12)-month cost report.

C. The trended cost per day does not include the costs associated with the FRA assessment, the application of minimum utilization, the utilization adjustment and the poison control costs computed in paragraphs (15)(B)1., 3., 4., and 5.; 3. The minimum utilization costs for capital and medical education is calculated by determining the difference in the hospital’s cost per day when applying the minimum utilization as identified in paragraph (5)(C)4., and without applying the minimum utilization. The difference in the cost per day is multiplied by the estimated Medicaid patient days for the SFY;

4. The utilization adjustment cost is determined by estimating the number of Medicaid inpatient days the hospital will not provide as a result of the MC+ Health Plans limiting inpatient hospital services. These days are multiplied by the hospital’s cost per day to determine the total cost associated with these days. This cost is divided by the remaining total patient days from its base period cost report to arrive at the increased cost per day. This increased cost per day is multiplied by the estimated Medicaid days for the current SFY to arrive at the Medicaid utilization adjustment;

5. The poison control cost shall reimburse the hospital for the prorated Medicaid managed care cost. It will be calculated by multiplying the estimated Medicaid share of the poison control costs by the percentage of MC+ recipients to total Medicaid recipients; and

6. The costs for including out-of-state Medicaid days is calculated by subtracting the hospital’s per diem rate from its trended per diem cost and multiplying this difference by the out-of-state Medicaid days from the base year cost report.

(16) Safety Net Adjustment. A safety net adjustment, in lieu of the Direct Medicaid Payments and Uninsured Add-Ons, shall be provided for each hospital which qualified as disproportionate share under the provision of paragraph (6)(A)4. The safety net adjustment payment shall be made prior to the end of each federal fiscal year.

A. The safety net adjustment for facilities which qualify under subparagraph (6)(A)4.A. of this regulation shall be computed in accordance with the Direct Medicaid Payment calculation described in subsection (15) and the Uninsured Add-Ons calculation in subsection (18)(B) of this regulation. The safety net adjustment will include the last three (3) quarters of the SFY ending June 30 and the first quarter of the next SFY beginning July 1 to correspond with the FFY of October 1 to September 30.

B. The safety net adjustment for facilities which qualify under subparagraph (6)(A)4.B. are trended through the current state fiscal year average of the fourth, fifth, and sixth year utilizing July 1 to correspond with the FFY of October 1 to September 30.

C. The trended cost per day does not include the costs associated with the FRA assessment, the application of minimum utilization, the utilization adjustment and the poison control costs computed in paragraphs (15)(B)1., 3., 4., and 5.; 3. The minimum utilization costs for capital and medical education is calculated by determining the difference in the hospital’s cost per day when applying the minimum utilization as identified in paragraph (5)(C)4., and without applying the minimum utilization. The difference in the cost per day is multiplied by the estimated Medicaid patient days for the SFY;

4. The utilization adjustment cost is determined by estimating the number of Medicaid inpatient days the hospital will not provide as a result of the MC+ Health Plans limiting inpatient hospital services. These days are multiplied by the hospital’s cost per day to determine the total cost associated with these days. This cost is divided by the remaining total patient days from its base period cost report to arrive at the increased cost per day. This increased cost per day is multiplied by the estimated Medicaid days for the current SFY to arrive at the Medicaid utilization adjustment;

5. The poison control cost shall reimburse the hospital for the prorated Medicaid managed care cost. It will be calculated by multiplying the estimated Medicaid share of the poison control costs by the percentage of MC+ recipients to total Medicaid recipients; and

6. The costs for including out-of-state Medicaid days is calculated by subtracting the hospital’s per diem rate from its trended per diem cost and multiplying this difference by the out-of-state Medicaid days from the base year cost report.
year cost report and paid in quarterly installments. The base year cost report shall be the fourth prior fiscal year (i.e., the base year for SFY 1999 is the FY 1995 cost report). The hospital per diem shall continue to include a component for GME related to Medicaid clients not included in a managed care system.

1. Total GME cost shall be multiplied by a managed care allocation factor which incorporates the estimated percentage of the hospital’s Medicaid population included in a managed care system and the estimated implementation date for a managed care system. For example: If a hospital has 1) an annual GME cost of one hundred thousand dollars ($100,000), 2) forty percent (40%) of their Medicaid days are related to Medicaid recipients eligible for Medicaid managed care, and 3) the projected implementation date for managed care is October 1, 1995; the prorated GME Add-On is thirty thousand dollars ($30,000).

2. The annual GME Add-On shall be paid in quarterly installments.

(20) Hospital Mergers. Hospitals that merge their operations under one (1) Medicare and Medicaid provider number shall have their Medicaid reimbursement combined under the surviving hospital’s (the hospital whose Medicare and Medicaid provider number remains active) Medicaid provider number.

(A) The disproportionate share status of the merged hospital provider shall be—

1. The same as the surviving hospital’s status was prior to the merger for the remainder of the state fiscal year in which the merger occurred; and

2. Determined based on the combined desk-reviewed data from the appropriate cost reports for the merged hospitals in subsequent fiscal years.

(B) The per diem rate for merged hospitals shall be calculated—

1. For the remainder of the state fiscal year in which the merger occurred by multiplying each hospital’s estimated Medicaid paid days by its per diem rate, summing the estimated per diem payments and estimated Medicaid paid days, and then dividing the total estimated per diem payments by the total estimated paid days to determine the weighted per diem rate. The effective date of the weighted per diem rate will be the date of the merger; and

2. For subsequent state fiscal years based on the combined desk-reviewed data after taking into account the different fiscal year ends of the cost reports.

(C) The Medicaid Direct Payments and Uninsured Add-On shall be—

1. Combined under the surviving hospital’s Medicaid provider number for the remainder of the state fiscal year in which the merger occurred; and

2. Calculated for subsequent state fiscal years based on the combined data from the appropriate cost report for each facility.

(D) Merger of Children’s Acute Care Hospital. When an acute care children’s hospital merges with another acute care hospital, all the provisions in subsection (20)(A) shall apply, except the Medicaid provider number for the children’s hospital will remain active. The only payments made under the children’s provider number will be the per diem and outpatient payments. The Direct Medicaid payments and Uninsured Add-On payments will be made under the Medicaid number associated with the surviving Medicare provider number.

(21) Enhanced Graduate Medical Education (GME) Payment—An enhanced GME payment shall be made to any acute care hospital that provides graduate medical education (teaching hospital).

(A) The enhanced GME payment shall be computed in accordance with subsection (21)(B). The payment shall be made at the end of the state fiscal year. The enhanced GME payment for each state fiscal year shall be computed using the most recent cost data available when the enhanced GME payment is computed. If the cost report is less than or more than a twelve (12)-month period, the cost report data will be adjusted to reflect a twelve (12)-month period. The state share of the enhanced GME payment to a hospital that has cash subsidies shall come from funds certified by the hospital.

(B) The enhanced GME payment will be computed by first determining the percentage difference between the McGraw-Hill CPI index for hospital services and Medicare update factors applied to the per resident amounts from 1986 to the most recent SFY. For example, the percentage difference has been computed to be eighty-five and sixty-two-one-hundredth percent (85.62%) for SFY 2000. The percentage difference is then multiplied by the Medicaid share of the aggregate approved amount reported on worksheet E-3 part IV of the Medicare cost report (HCFA 2552-96) for the fourth prior fiscal year and trended to the current state fiscal year. The resulting product is the enhanced GME payment.

PURPOSE: The Division of Medical Services establishes admission certification and validation procedures on which hospitals furnishing inpatient care to Medicaid recipients will be reviewed to determine that admissions are medically necessary and appropriate for inpatient care.
(H) Fee for service. Fee for service refers to recipients and/or services not included in the MC+ Missouri Managed Care program or other prepaid health plans;

(J) MC+. MC+ is the Missouri Medicaid “Managed Care Plus” program under which some Medicaid recipients are enrolled with a health plan who contract with the department to provide a package of Medicaid benefits for a monthly fee per enrollee;

(K) Medical record. Medical record means all or any portion of the medical record as requested by the medical review agent;

(L) Medical review agent. Medical review agent means the state’s representative who is authorized to make decisions about admission certifications and validation reviews;

(M) Medically necessary. Medically necessary means a review conducted after admission is required by the physician or hospital to obtain a preadmission or postadmission certification, which includes recipient, physician and hospital identifying information, admission date, admission diagnosis, procedures, surgery date, indications for inpatient setting and plan of care;

(U) Transfer. Transfer means the movement of a recipient after admission from one hospital directly to another or within the same facility;

(V) Urgent admission. Urgent admission means a case which requires prompt admission to the hospital to prevent deterioration of a medical condition from an urgent to an emergency situation;

(W) Validation review. Validation review means a review conducted after admission certification has been approved. The review is focused on validating the admitting information and confirming the determination of medical necessity of the admission.

(2) All admissions of Medicaid recipients to Medicaid participating hospitals in Missouri and bordering states are subject to admission certification procedures and validation review with the following exceptions as specified in Missouri Medicaid provider manuals or bulletins:

(A) Admissions of recipients enrolled in a Medicare or Medicaid;

(B) Admissions for deliveries;

(C) A review of quality will be performed for those cases selected as part of the focused and random validation and Certification of Need Samples. Potential quality issues that represent a minor or less than serious risk to a patient will not be pursued. However, potentially serious quality issues will proceed through three (3) levels of specialty physician review if the issue is upheld by the physician reviewers at the first and second level physician review.

(5) Time requirements for the certification procedures are as follows:

(A) Physician or hospital notification to the medical review agent of the occurrence of an emergency or urgent admission must be made no later than two (2) working days prior to the date of the actual admission;
(E) After receipt of all the required medical record information, the medical review agent will determine medical necessity of admissions specified in subsection (4)(C) within fifteen (15) working days if the criteria in section (6) are met or within twenty-five (25) working days if the case is referred to a physician reviewer.

(6) The criteria to be used in the admission certification and validation review are as follows:

(A) The severity of illness/intensity of service (SI/IS) criteria set includes adult and pediatric criteria for general medical care admissions;

(B) Supplemental criteria sets are included for adult and child psychiatric care, rehabilitation care and alcohol/drug abuse treatment;

(C) Ambulatory procedure screening criteria is used in screening admissions for procedures on the Medicaid outpatient surgery list; and

(D) Urgent/emergency criteria are used as guidelines for determination of type of admission and are defined in section (1).

(7) The admission certification procedure is as follows:

(A) Certification requests can be made in the following manner:

1. For preadmission and postadmission certification, the physician or hospital contacts the medical review agent to provide the required information to obtain certification; or

2. For retrospective certification, the hospital submits, at its own expense, the recipient's medical record to the medical review agent to obtain certification which is to include the emergency room record; history and physical; any operative, pathology or consultation reports; the first three (3) days of physician orders, progress notes, nurses' notes, graphic vital signs, medication sheets and diagnostic testing results;

(B) Initial screening of information is conducted by nurse reviewers using the criteria in section (6) as appropriate to the case under review;

(C) If the medical information submitted regarding the patient's condition and planned services meets the applicable criteria in section (6), the approval decision and a unique certification number are communicated to the physician and hospital;

(D) If the applicable criteria in section (6) are not met, the nurse reviewer refers the case to a physician reviewer for a medical necessity determination. The physician reviewer is not bound by any criteria and makes the determination based on medical facts in the case using his/her medical judgment;

(E) If the physician reviewer approves the admission, the approval determination and unique certification number are communicated to the physician and hospital;

(F) The physician will be contacted prior to a denial determination and allowed the opportunity to provide additional information. This additional information will be considered by the physician reviewer prior to a determination to approve or deny admissions. Determination decisions will be communicated as follows:

1. If the admission is approved, the approval determination and unique certification number are communicated to the physician and hospital; and

2. Denial determinations are communicated to the physician, hospital and recipient;

(G) The physician, hospital or recipient who is dissatisfied with an initial denial determination is entitled to a reconsideration by the medical review agent as outlined in section (8); and

(H) If inpatient admission is approved and surgery is planned, day of surgery admission will be required unless the physician reviewer approves a preoperative day for evaluating concurrent medical conditions or other risk factors.

(8) Reconsideration Requests. The medical review agent's denial decisions relate to medical necessity and appropriateness of the inpatient setting in which services were furnished or are proposed to be furnished. The procedure to request reconsideration of an initial denial determination is as follows:

(A) Time Requirements.

1. To request a reconsideration for a patient prior to admission or for a patient still in the hospital, the provider should telephone a request to the medical review agent. In either of these situations, the request for reconsideration must be received within three (3) working days of receipt of the written denial notice. In order to expedite the process, the provider must indicate that this is a request for a reconsideration. The medical review agent will complete the reconsideration review and issue a determination within three (3) working days of receipt of the request and all pertinent information; and

2. If the patient has been discharged from the hospital, the provider must submit a request for reconsideration in writing or by facsimile (FAX). This reconsideration cannot be requested by telephone. The request must be made within sixty (60) calendar days of receipt of the written denial notice. The medical review agent will complete the reconsideration review within thirty (30) days after receipt of the request for reconsideration, medical records and all pertinent information. A written notice will be issued to the recipient, physician and hospital within three (3) days after the reconsideration is completed;

(B) The reconsideration shall consist of a review of all medical records and additional documentation submitted by any one of the parties to the initial denial notice;

(C) The reconsideration will be conducted by a physician reviewer who has had no previous involvement in the case;

(D) Reconsideration determination by the medical review agent is the final level of the review for the provider. The division will accept the medical review agent’s decision; and

(E) If the recipient disagrees with a reconsideration denial by the medical review agent, s/he has the right to a fair hearing under sections 208.080, RSMo and 208.156, RSMo.

(9) Validation Sample of Approved Admissions.

(A) A quarterly validation sample of approved admissions will be selected to ensure that the information provided during the certification process is substantiated by documentation and clinical findings in the medical record.

(B) The sample size is a random sample of five percent (5%) of the medical review agent’s certified admissions.

(C) For admissions subject to review, the medical review agent will request medical records. Providers have thirty (30) calendar days from the date of request to submit documentation. At rates determined by the medical review agent, provider costs associated with submission of requested documentation will be reimbursed. Records not received within the thirty (30) days will result in the admission being denied.

(D) Admission certification is not a guarantee of Medicaid payment. If the information provided during the certification process cannot be validated in the medical record by a nurse reviewer using the criteria in section (6), or was false, misleading or incomplete, the case will be referred to a physician reviewer for a medical necessity determination. The physician reviewer is not bound by any criteria and makes the determination based on medical facts in the case using his/her medical judgment.

(E) The physician or hospital will be allowed an opportunity to respond to a proposed denial prior to issuance of a final denial notice.
(F) If the physician reviewer determines the admission was not medically necessary, a denial notice will be issued to all parties. Reconsideration procedures in section (8) apply to this review.

(G) A validation review determination of denial will result in recovery of Medicaid payments in accordance with 13 CSR 70-3.030. Overpayment determinations may be appealed to the Administrative Hearing Commission within thirty (30) days of the date of the notice letter if the sum in dispute exceeds five hundred dollars ($500).

(H) Review of the quality of care will also be performed on the validation review sample for admissions on or after August 1, 1996. Potentially serious quality of care issues identified by the nurse reviewer will be referred to a physician of the medical review agent.

(10) As specific in relation to administration of the provisions of this rule and not otherwise inconsistent with recipient liability as determined under provisions of 13 CSR 70-4.030, recipient liability issues for admission certification and validation review are as follows:

(A) The recipient is liable for inpatient hospital services in the following circumstances:

1. When the preadmission request for certification is denied and the recipient is notified of the denial but the recipient chooses to be admitted, s/he is liable for all days;
2. When a postadmission request for certification of an admission is denied, the recipient is liable for those days of inpatient hospital service provided after the date of the notification to him/her of the denial;
3. When the recipient’s eligibility was not established on or by the date of admission and the request for certification is denied, the recipient is liable for all days; and
4. When the recipient has signed a written agreement with the provider indicating that Medicaid is not the intended payer for the specific item or service, s/he is liable for all days. The agreement must be signed prior to receiving the services. In this situation, the recipient accepts the status and liabilities of a private pay patient in accordance with 13 CSR 70-4.030; and

(B) The recipient is not liable for inpatient hospital services in the following circumstances:

1. When the provider fails to comply with preadmission certification requirements, the recipient is not liable for any days;
2. When a postadmission request for certification of an admission is denied, the recipient is not liable for those days of inpatient hospital service provided prior to and including the date of the notification to him/her of the denial; and
3. When the medical review agent performs a validation review as provided in section (9) of this rule and determines an admission was not medically necessary for inpatient services, the recipient is not liable for any days.

(11) Continued stay reviews will be performed for all other fee-for-service Missouri Medicaid recipients subject to admission certification to determine that services are medically necessary and appropriate for inpatient care. The continued stay review procedure is as follows:

(A) When extended hospitalization is indicated beyond the initial length of stay assigned by the medical review agent, the hospital and attending physician are required to provide additional medical information to warrant the continued hospital stay as well as request the number of additional days needed;

(B) The nurse reviewer applies the severity of illness/intensity of services (SI/IS) criteria as described in section (6) of this rule. If the case meets intensity of services criteria, an appropriate extension is assigned up to the length-of-stay (LOS) seventy-fifth percentile;

(C) A physician reviewer will review cases when continued stay is requested beyond the seventy-fifth percentile. The physician reviewer shall approve or deny the continued stay days;

(D) The requesting physician and hospital are notified of the review decision as stated in section (7) of this rule; and

(E) Sections (8)–(10) of this rule apply to continued stay reviews.

(12) Continued stay reviews will be performed for diagnosis relating to alcohol and drug abuse, ICD 9-CM diagnosis codes in the ranges of 291, 292, 303, 304 and 305 for admission of July 15, 1991, and after that to determine that services are medically necessary and appropriate for inpatient care. The continued stay review procedure for alcohol and drug abuse detoxification services is as follows:

(A) At the time of admission certification, as described in section (7) of this rule, the hospital or attending physician shall specify the anticipated medically necessary length-of-stay;

(B) If the applicable criteria in section (6) of this rule is met, the nurse reviewer shall assign a number of days not to exceed three (3) days;

(C) If an extension of services is required, the hospital or attending physician shall contact the medical review agent to request additional days for inpatient hospital care. If the applicable criteria in section (6) of this rule is met, the nurse reviewer shall assign a total length-of-stay days not to exceed five (5) days;

(D) If either the applicable criteria in section (6) of this rule is not met or the total length-of-stay exceeds five (5) days, the case shall be referred to a physician reviewer. The physician reviewer is not bound by the criteria in section (6) of this rule and makes the determination based on medical facts in the case using his/her medical judgment. The physician reviewer shall approve or deny the admission or continued stay days;

(E) The physician and hospital are notified of the review decision as stated in section (7) of this rule; and

(F) Sections (8)–(10) of this rule apply to continued stay reviews.

(13) Large case management will be performed for fee-for-service recipients with potentially catastrophic conditions whenever specific trigger diagnoses or other qualifying events are met. MC+ health plans eligible under the state’s reinsurance plan for additional reimbursement of eighty percent (80%) of the plan’s payment for inpatient days which exceed fifty thousand dollars ($50,000) in an MC+ enrollee’s plan year are subject to the medical review agent’s monitoring of the plan’s large case management intervention.

(A) Large case management procedures for fee-for-service recipients are as follows:

1. Preadmission review nurses identify patients who may qualify and benefit from case management, and refer to a case manager of the medical review agent. Cases include but are not limited to the following:

   A. Patients with high costs or anticipated high costs; or
   B. Patients with repeated admissions or unusually long lengths-of-stay; or
   C. Patients who encounter significant variances from the intervention or from expected outcomes associated with a clinical path; or
   D. Patients who meet one (1) or more of the indicators on the Trigger Diagnosis/Qualifying Events list;

2. The medical review agent will complete an initial screening which will include a review of the medical information, and interviews with the health care providers and patient if needed or feasible;

3. An in-depth assessment will be conducted, which will include evaluation of the patient’s health status, health care treatment and service needs, support system, home environment and physical and psychosocial functioning. The assessment will be used to recommend one (1) of the following:
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indicated; or

4. If an alternative treatment plan is indicated, the medical review agent will collaborate with the patient’s attending physician to develop an alternative treatment plan. The attending physician is responsible for implementation of the alternative treatment plan; and

5. The medical review agent will monitor and assess the effectiveness of the case management and will report to the state.

(B) Large case management procedures for MC+ cases reaching the fifty thousand dollar ($50,000) reinsurance cap are as follows:

1. The MC+ health plan case manager or established liaison will be responsible for notifying the medical review agent as soon as a potential case management patient is identified. The medical review agent must be notified of MC+ enrollees who reach a threshold of forty thousand dollars ($40,000), and provide information needed for the initial screen;

2. The medical review agent will complete an initial screening which will include a review of the medical information, patient status, current plan of care, hospital discharge summaries, and other records as appropriate, to be supplied by the health plan;

3. An in-depth assessment will be conducted, which will include evaluation of the patient’s health status, health care treatment and service needs, support system, home environment and physical and psychosocial functioning. The assessment will be used to recommend one (1) of the following:

   A. Reassessment later; or
   B. No potential for case management; or
   C. Active monitoring in anticipation of a future plan for alternative treatment; or
   D. An alternative treatment plan is indicated;

4. If an alternative treatment plan is indicated, the medical review agent will collaborate with a physician representative from the health plan’s Utilization Review/Quality Assessment (UR/QA) Committee to discuss and develop an alternative treatment plan. The medical review agent will recommend an alternative treatment plan to the health plan;

5. The medical review agent will monitor and assess the effectiveness of the case management and will report to the state; and

6. The medical review agent will monitor each day of inpatient hospital care provided subsequent to the fifty thousand dollar ($50,000)-threshold for appropriateness and acute level of care.

(14) Psychiatric admissions for Medicaid recipients twenty-one (21) and over enrolled in a MC+ health plan who have exceeded the thirty (30) inpatient days/twenty (20) outpatient days limitation of behavioral health care in a plan year will be subject to a retrospective postpayment utilization/quality of care review by the medical review agent. The objectives of this review focus are to collect data on potentially medically unnecessary inpatient days of care to assist the division in projecting potential expenditures that could be made available for outpatient care, assuring that inpatient care is of acceptable quality, identify social or placement problems when post-hospital psychiatric services are needed, and monitor and report health plan compliance to notification requirements for enrollees meeting the thirty/twenty (30/20) cap.

AUTHORITY: section 208.201, RSMo 1994.*

PUBLISHER’S NOTE: The secretary of state has determined that the publication of the entire text of the material which is incorporated by reference as a portion of this rule would be unduly cumbersome or expensive. Therefore, the material which is so incorporated is on file with the agency who filed this rule, and with the Office of the Secretary of State. Any interested person may view this material at either agency’s headquarters or the same will be made available at the Office of the Secretary of State at a cost not to exceed actual cost of copy reproduction. The entire text of the rule is printed here. This note refers only to the incorporated by reference material.

13 CSR 70-15.030 Limitations on Payment for Inpatient Hospital Care

PURPOSE: This rule establishes a limitation on admissions occurring on Friday or Saturday for inpatient hospital care and on the number of days of preoperative inpatient hospital care which may be paid for by Title XIX Medicaid on behalf of eligible recipients. Budgetary limitations necessitate the restriction.

Diagnosis Description, Code and Days

<table>
<thead>
<tr>
<th>Diagnosis Description</th>
<th>Code</th>
<th>Days</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spinal cord injury—quadriplegia</td>
<td>SC1</td>
<td>thirty (30) days</td>
</tr>
<tr>
<td>Spinal cord injury—cervical fracture</td>
<td>SC2</td>
<td>twenty-five (25) days</td>
</tr>
<tr>
<td>Spinal cord injury—paraplegia</td>
<td>SC3</td>
<td>thirty (30) days</td>
</tr>
<tr>
<td>Spinal cord injury—hemiplegia</td>
<td>SC4</td>
<td>twenty-five (25) days</td>
</tr>
<tr>
<td>Cerebral vascular accident—Code CVA—twenty-nine (29) days</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Head trauma—Code HT1—thirty-five (35) days</td>
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<tr>
<td>Muscular dystrophy—Code MUD—twenty (20) days</td>
<td></td>
<td></td>
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<tr>
<td>Orthopedic trauma—arm—Code OT1—twenty-nine (29) days</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Orthopedic trauma—leg—Code OT2—twenty-nine (29) days</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Late effect of injury to the nervous system—
Code ENS—thirty (30) days
Degenerative joint disease—Code DJD—
twenty (20) days.

3. An average length-of-stay schedule, as developed by the Medicaid agency, for
liveborn infants according to type of birth.

Diagnosis Description, Code and Days

V3000, V3900
Single diagnosis, not operated—three (3)
days
Single diagnosis, operated—four (4) days
Multiple diagnosis, not operated—four (4)
days
Multiple diagnosis, operated—ten (10)
days
V3001, V3101, V3201, V3301, V3401,
V3501, V3601, V3701, V3901
Single diagnosis, not operated—three (3)
days
Single diagnosis, operated—three (3) days
Multiple diagnosis, not operated—five (5)
days
Multiple diagnosis, operated—fifteen (15)
days
V3100, V3200, V3300, V3400, V3500,
V3600, V3700
Single diagnosis, not operated—four (4)
days
Single diagnosis, operated—four (4) days
Multiple diagnosis, not operated—seven
(7) days
Multiple diagnosis, operated—twelve (12)
days
V301, V311, V321, V331, V341, V351,
V361, V371, V391
Single diagnosis, not operated—two (2)
days
Single diagnosis, operated—two (2) days
Multiple diagnosis, not operated—four (4)
days
Multiple diagnosis, operated—fifteen (15)
days

Any liveborn low birthweight (under two
thousand grams (2,000 g)) born in a hospital
or before admission to a hospital, single or
multiple diagnosis, operated or not operated,
may be billed under the code GRO. All inpa-
tient days to and including the day on which
the infant reaches two thousand grams (2,000
g) weight will be paid. Use of this code will
require attachment to the claim of medical
chart progress notes which show the date on
which this weight is attained.

4. For infants who are less than one (1)
year of age at admission, all medically neces-
sary days will be paid at any hospital. For
children who are less than six (6) years of age
at admission and who receive services from a
disproportionate share hospital, all medically
necessary days will be paid.

5. Continued stay reviews will be per-
formed for alcohol and drug abuse detoxifi-
cation services to determine the days that are
medically necessary and appropriate for inpa-
tient hospital care.

(B) The number of days certified as med-
ically necessary by the Hospital Utilization
Review Committee.

(C) The number of days billed as covered
service by the provider.

(2) In administering this limitation, the
 counting of days which may be allowable
under the provider’s internal Hospital
Utilization Review Committee’s certified
 medically necessary days always shall be
from the beginning date of admission for a
continuous period of hospitalization. The
 counting of days which may be Medicaid
 allowable also will be from the beginning
date of admission unless conditions described
in subsection (2)(A), (B) or (C) apply.

(A) If the recipient’s beginning date of eli-
gibility is later than the date of admission, the
counting of days which may be allowable will
be from the beginning eligibility date.

(B) If the recipient has exhausted Title
XVIII inpatient benefits, the counting of days
which may be allowable will be from the date
following the date on which the Title XVIII
benefits are exhausted.

(C) If the date of admission is not certified
under 13 CSR 70-15.020 as medically neces-
sary, the counting of days which may be
allowable for reimbursement will be from the
date approved for admission by the medical
review agent.

(3) Except for reimbursement rates applicable
to GR recipients, inpatient services as
described in section (6) of this rule, reim-
bursement shall be made at the applicable per
diem rate in effect as of the initial date of
admission and for only allowable days during
which the recipient is eligible.

(4) This limitation applies to inpatient hospi-
tal stays or portions of hospital stays during
which there are no Medicare Part A Benefits
available.

(5) Effective with this limitation, there shall
be no provision for claiming of additional
covered days through submission of a form of
medical necessity and medical documenta-
tion.

(6) Effective for all inpatient hospital ad-
missions of GR assistance recipients on or after
September 1, 1981, Medicaid payment for
covered services provided during the allow-
able days of each admission shall be made at
the lesser of—

(A) The rate which was in effect
between the hospital and the Medicaid pro-
gram on September 1, 1981; or

(B) The rate which was in effect
between the hospital and the Medicaid pro-
gram as of the beginning date of the hospital
admission.

(7) Effective for inpatient hospital stays for
GR assistance recipients beginning on or
after January 1, 1982, Medicaid coverage of
the number of days during any one (1) con-
tinuous period of hospitalization will be lim-
ited to a maximum of twenty-one (21) days
during which the recipient is Medicaid-eligi-
able and if twenty-one (21) days should be the
lesser of allowable days as derived from pro-
visions of sections (1) and (2).

(8) Exception Process.

(A) An exception process to the coverage
of inpatient days as determined under provi-
sions of section (1) shall be established for
post-payment consideration of inpatient
claims exceeding fifteen (15) days beyond the
allowable days, if requested by the provider,
and the date of receipt was prior to
September 1, 1986.

(B) For requests received on or after
September 1, 1986, for admissions prior to
July 1, 1988, post-payment consideration of
inpatient claims will only be made for claims
exceeding thirty (30) days beyond the
allowable days. Only the days exceeding thirty (30)
days beyond the allowed days are eligible for
approval; days one through thirty (1–30) in
excess of the allowed days are not eligible for
consideration of approval nor additional reim-
bursement. There will be no post-payment
consideration of inpatient claims for admis-
sions on and after July 1, 1988.

(C) The state agency will conduct reviews,
approve and specify any additional days
which may be allowed beyond the number of
days already paid, or may review recommenda-
tions submitted by either a duly appointed
Medicaid utilization review subcommittee or
a medical consultant licensed to practice
medicine in Missouri. At its discretion, the
state may concur with a recommendation and
approve all days for payment, disagree and
not pay any days or modify and pay some
portion of the days recommended.

(D) Reimbursement for any additional
days approved for acute care will be made at
the hospital’s per diem rate in effect on the date
of admission. If a hospital has an established
intermediate care facility/skilled nursing
facility (ICF/SNF) or SNF-only Medicaid
rate for providing nursing home services in a distinct part setting, reimbursement for any additional days approved for only ICF or SNF level of care provided in the inpatient hospital setting will be made at the hospital’s ICF/SNF or SNF-only rate. If a hospital does not have an established ICF/SNF or SNF-only Medicaid rate for providing nursing home services in a distinct part setting, reimbursement for any additional days approved for only ICF or SNF level of care will be made at the statewide swing bed rate. No additional days will be approved and no Medicaid payments will be made on behalf of any recipient who it is determined received inpatient hospital care when s/he did not need either inpatient hospital services or nursing home ICF or SNF services.

(C) Requests for post-payment consideration of inpatient claims must be received no later than one (1) year from the date of discharge.


13 CSR 70-15.040 Inpatient Hospital and Outpatient Hospital Settlements

PURPOSE: This regulation defines the specific procedures used to calculate the final or amended settlements for hospital providers. These settlements are authorized in 13 CSR 70-15.010.

PUBLISHER’S NOTE: The secretary of state has determined that the publication of the entire text of the material which is incorporated by reference as a portion of this rule would be unduly cumbersome or expensive. Therefore, the material which is so incorporated is on file with the agency who filed this rule, and with the Office of the Secretary of State. Any interested person may view this material at either agency’s headquarters or office. Therefore, the material which is so incorporated by reference as a portion of this rule has been defined to be in effect for the purpose of this regulation.

(E) Definitions. (A) Reimbursable cost. Reimbursable costs are the costs which are identified as reimbursable in 13 CSR 70-15.010 and the Hospital Provider Manual. (B) Labor/delivery room day. A labor/delivery room day is a day where the mother enters the hospital prior to the census hour but is not admitted to the hospital until the next day after she delivers. (C) Medicaid payments. Medicaid payments included in the settlement include actual Medicaid claims payments, partial insurance payments on claims, patient liability amounts for coinsurance and deductibles and outlier claim payments. If the insurance payments exceed the Medicaid liability, the claim will not be considered a Medicaid claim. (D) Inpatient service costs. The reimbursable costs for inpatient services or costs which will be included in the final settlement are those services or costs which are provided to the Medicaid beneficiary after being admitted to the hospital. Services or costs provided prior to admission as an inpatient should be billed as outpatient services, except for cost associated with labor and delivery room days. (E) Outpatient services/cost. Reimbursable outpatient services or costs are services or costs that are provided prior to the patient being admitted to the hospital. Only outpatient services or cost which are reimbursed...
on a percentage of charge as defined in 13 CSR 70-15.160 will be included in the final settlement, unless they are excluded elsewhere in this regulation.

(F) Routine cost center. A routine cost center is an adult and peds unit, subprovider unit, nursery unit or special care unit.

(G) Special care unit. A special care unit is a hospital unit that furnishes services to critically ill inpatients. Examples are Intensive Care Units (ICU), Coronary Care Unit (CCU), or Neonatal Care Unit. The ICU unit may be for only one (1) type of patient or for all critically ill patients.

(H) Paid days. Paid days are the actual number of days paid for inpatient services on claims with the first date of service within the fiscal period of the cost report.

(I) Routine charges. Routine charges are the charges billed by the hospital for the care provided to the patient in a routine care center. These services are normally provided to all patients in the hospital.

(J) Ancillary charges. Ancillary charges are the charges billed by the hospital for services that are not routinely provided in the routine care center and are not provided to all patients.

(K) Private room day. A private room day is a day when due to the patient’s medical condition it is determined that the patient should be alone in a room.

(L) Incorporation by Reference. This rule adopts and incorporates by reference the provisions of the—

1. Current Medicare/Medicaid cost report forms that have a Notice of Provider Reimbursement (NPR) from the Medicare fiscal intermediary; and


(3) Inpatient settlements will be calculated based on paid day hospital services after the Medicare/Medicaid cost report is received from the fiscal intermediary. Based on this settlement the division shall make any recoupments necessary to ensure that Title XIX Medicaid payments for inpatient services do not exceed the allowable inpatient Medicaid charges. This settlement shall not result in additional payment to the hospital if its cost exceeds its payments. This settlement will be determined in the following manner:

(A) Data will be gathered from the Medicaid inpatient claim history for paid days by routine cost center; private room days; routine charges; charges for each ancillary cost center; and inpatient payments for claims with first date of service in the cost report period;

(B) The division will extract the following data from the cost report received from the fiscal intermediary:

1. The total patient days from worksheet S-3 for each routine cost center and observation bed days. The total patient days for adults and peds may be adjusted for labor and delivery room days reported on questionnaire, if not included on worksheet S-3;

2. The total cost from worksheet D-1 for adults and peds, after removing swing-beds and private room cost differential, and if the hospital has a subprovider, the total cost from worksheet D-1 for the subprovider after removing the private room cost differential. These costs are before the Respiratory Therapy/Physical Therapy (RT/PT) limit and Reasonable Compensation Equivalent (RCE) disallowance;

3. The total cost from worksheet D-1 for special care units and nursery unit. These costs are before RT/PT limit adjustment and RCE disallowance;

4. The cost-to-charge ratio for each covered ancillary service from worksheet C Part I column 7;

5. The Direct Graduate Medical Education (GME) amount reported on worksheet E-3 Part IV line 3;

6. If the hospital is proprietary, the equity ratio from worksheet F-5 Part I line 4 column 1; and

7. The private room cost differential per diem from worksheet D-1 for adults and peds and subproviders, if provided;

(C) The inpatient Medicaid reimbursable cost will be determined as follows:

1. The Medicaid routine cost for adults and peds and subprovider units will be calculated by taking the total routine cost from paragraph (3)(B)2. From this cost will be removed the cost of observation bed days from subparagraph (3)(C)1.A. This total cost will be divided by the total patient days for adults and peds not including observation days (adjusted for labor and delivery room days if not included on worksheet S-3) plus patient days for any subprovider unit. This cost per day will be multiplied by the Medicaid paid days for adults and peds and subprovider units to determine Medicaid routine adult and peds cost. The cost of private room days will be added to this cost.

A. Observation cost will be determined by dividing the routine cost for adults and peds from paragraph (3)(C)2., by adult and peds days, adjusted by labor and delivery room days if not included, plus observation bed days. This cost per day is multiplied by the observation bed days reported on worksheet S-3 column 6 line 19 to determine the observation cost.

B. If the hospital reports medically necessary Medicaid private room days on worksheet D-1 line 14 and the data from the division’s paid claim history reports private room days, the private room cost will be calculated by multiplying the private room cost differential per diem from worksheet D-1 line 35 by the lower of Medicaid private room days from the division’s claims data or the private room days reported on worksheet D-1;

2. The routine inpatient cost for each special care unit will be determined by dividing the routine cost for the special care unit by the total patient days for that special care unit to determine the unit’s cost per day. This cost per day will be multiplied by Medicaid paid days for that special care unit from the division’s paid claim history to determine Medicaid cost. If the hospital has more than one (1) ICU unit with Medicaid days reported on the cost report, the Medicaid patient days for ICU from the division’s records will be prorated based on the Medicaid days reported on the cost report.);

3. The routine cost for the nursery unit will be determined by dividing total nursery cost by total nursery days to determine the nursery cost per day. This cost per day will be multiplied by the Medicaid paid days to determine Medicaid nursery cost (Nursery days will not be prorated between nursery and neonatal. The hospital must use the proper room accommodation revenue code to bill neonatal days.);

4. The ancillary cost for each ancillary cost center will be determined by multiplying the Medicaid ancillary cost center’s charges by its cost-to-charge ratio from paragraph (3)(B)4. (Based on the information in the cost report and in the division’s data some ancillary accounts on the division’s data may be combined.);

5. The Medicaid inpatient portion of the GME will be determined using the methodology on worksheet E-3 part IV from the Medicare/Medicaid cost report by substituting Medicaid data in place of the Medicare data;

6. If the hospital is a proprietary hospital it may be entitled to a return on equity. This cost would be determined by multiplying the equity ratio from paragraph (3)(B)6., by the Medicaid cost in paragraphs (3)(C)1.–4.; and

(D) Comparison of Inpatient Medicaid Cost to Inpatient Medicaid Payments.

1. The total inpatient Medicaid cost will be determined as the sum of the cost in paragraphs (3)(C)1.–6.;

2. The Medicaid inpatient payments include the following amounts:
A. Partial payments made by third party payers (that is, insurance companies, HMO, etc);
B. Coinsurance and deductibles, which are the responsibility of the patient whether or not they were actually collected;
C. Inpatient claims payments made by the Medicaid program; and
D. Outlier claim payments with service dates within the cost report period.

3. The total payments from subparagraph (3)(D)1.—4., will be subtracted from the lesser of the total cost in paragraph (3)(D)1. or the Medicaid charges from subsection (3)(A) (except hospitals identified by Medicare as a nominal charge provider for that fiscal year shall have their settlements based on cost). If the lesser of cost or charge exceeds the payment, no additional payment is due the hospital. (The inpatient settlement is zero (0) under the prospective payment plan.) If these payments exceed the charges the difference will result in an overpayment which will be due from the hospital (Disproportionate share payments are waived from the overpayment determination).

(4) Outpatient Hospital Settlements, Provider Based Rural Health Clinic (PBRHC) settlements or Provider Based Federally Qualified Health Centers (PBFQHC) settlements will be calculated after the division receives the Medicare/Medicaid cost report with a NPR from the hospital fiscal intermediary.

(A) The Division of Medical Services shall adjust the hospital’s outpatient Medicaid payments, PBRHC or PBFQHC Medicaid payments to conform with the percent of cost paid on an interim basis under 13 CSR 70-15.160 for the appropriate time period (except for those hospitals that qualify under subsection (4)(B), whose payments will be based on the percent of cost in paragraph (4)(A)1., 2., or 3.) for—

1. Services prior to January 5, 1994, the lower of eighty percent (80%) of the outpatient share of the costs from subsection (4)(D), or eighty percent (80%) of the outpatient charges from paragraph (4)(C)1.;
2. Services after January 4, 1994 and prior to April 1, 1998, the lower of ninety percent (90%) of the outpatient share of the cost from subsection (4)(D), or ninety percent (90%) of the outpatient charge from paragraph (4)(C)1.;
3. Services after March 31, 1998, included in cost reports ending prior to January 1, 1999, the lower of one hundred percent (100%) of the outpatient share of the cost from subsection (4)(D), or one hundred percent (100%) of the outpatient charge from paragraph (4)(C)1.; and
4. PBRHC and PBFQHC shall be reimbursed one hundred percent (100%) of its share of the cost in paragraph (4)(E)2.

(B) A facility that meets the Medicare criteria of nominal charge provider for the fiscal period shall have its net cost reimbursement based on its cost in paragraph (4)(A)1., 2., or 3. (C) The Medicaid charges used to determine the cost, and the payments used to determine the settlement will be—

1. For outpatient services the charges and payments extracted from the Medicaid outpatient claims history for reimbursable services paid on a percentage basis under 13 CSR 70-15.160.
2. For PBRHC and PBFQHC the charges and payments will be for services billed under 13 CSR 70-94.020.

(D) The Medicaid hospital’s outpatient, cost will be determined by multiplying the overall outpatient cost-to-charge ratio, determined in accordance with paragraph (4)(D)1., by the Medicaid charges from paragraph (4)(C)1. This product will be added the Medicaid outpatient share of GME. The GME will be determined using the methodology on worksheet E-3 part IV from the Medicare/Medicaid cost report (HCFA 2552-92) by substituting Medicaid data in place of Medicare data.

1. The overall outpatient cost-to-charge ratio will be determined by multiplying the reported total outpatient charges for each ancillary cost center, excluding PBRHC or PBFQHC, on the supplemental worksheet C column 10 (HCFA 2552-83) or substitute schedule by the appropriate cost-to-charge ratio from worksheet C (HCFA 2552-92) column 7 part I of the fiscal intermediary’s audited Medicare/Medicaid cost report to determine the outpatient cost for each cost center reimbursed on a percentage of charge basis by Medicaid under 13 CSR 70-15.160. Total the outpatient costs from each cost center and total the outpatient charges from each cost center. Divide the total outpatient costs by the total outpatient charges to arrive at the overall outpatient cost-to-charge ratio.

(E) The Medicaid outpatient final settlement for cost reports ending prior to January 1, 1999, unless the hospital closed or had a change in ownership or merger prior to January 1, 2002, will determine either an overpayment or an underpayment for the hospital’s outpatient services.

1. The outpatient Medicaid cost determined in subsection (4)(D) is multiplied by the percent of cost allowed in paragraph (4)(A)1., 2., or 3., to determine the reimbursable cost for outpatient services. (If a cost report covers both periods the outpatient Medicaid charges will be split to determine the reimbursable cost for each time period.) From this cost subtract the outpatient payments made on a percentage of charge basis under 13 CSR 70-15.010 for the time period. (Medicaid payments include the actual payment by Medicaid, third party payments, coinsurance and deductibles.) The difference is either an overpayment (negative amount) due from provider or underpayment (positive amount) due to provider;
2. 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)(E)1.;
3. New hospitals which do not have a fourth, fifth, and sixth prior year cost report necessary for establishment of a prospective rate will have final settlement calculated for their initial three (3) cost report periods;
4. Hospitals who qualify as nominal charge providers in accordance with 42 CFR 413.13(f) will have final settlements calculated for all cost report periods; and
5. Hospitals which had a change in ownership or merged with another hospital between January 1, 1997 and June 30, 2002 will have a final settlement calculated in accordance with this regulation for the first three (3) cost report periods after the change in ownership or merger after which it will be reimbursed under the prospective outpatient hospital reimbursement methodology unless it elects to be reimbursed under the prospective payment methodology starting July 1, 2002.

(F) The Medicaid PBRHC or PBFQHC final settlement will determine either an overpayment or an underpayment for the hospital’s PBRHC or PBFQHC services. For PBRHC or PBFQHC services multiply the PBRHC or PBFQHC Medicaid charges from paragraph (4)(C)2., by the cost center’s cost-to-charge ratio to determine PBRHC or PBFQHC cost. From this cost, the PBRHC or PBFQHC payments associated with charges from paragraph (4)(C)2., are subtracted. The difference is either an overpayment (negative amount) due from provider or an underpayment (positive amount) due to provider.

(5) Reopened cost reports received after the division has completed a final settlement will be calculated in the same manner as the original settlement. The division will not reopen any cost report when the amended NPR is received more than five (5) years after the hospital’s fiscal year end unless the reopening is due to the provider submitting false or
 Services shall be subject to the same provisions and conditions of coverage as are provided within a licensed acute care general hospital not subject to the provisions and conditions of coverage as expressed in this rule, even though provided within an inpatient program or a part of the general hospital facility which is separately accredited as a psychiatric hospital by the Joint Commission on Accreditation of Hospitals. These inpatient psychiatric services shall be subject to the same provisions of coverage and the same benefits and limitations for inpatient hospital services as apply to all Medicaid-eligible recipients.

(A) Under the direction of a physician;
(B) In a psychiatric hospital facility or an inpatient program in a psychiatric facility, either of which is accredited by the Joint Commission on Accreditation of Hospitals and meets the qualification definition in section (2); and
(C) For claimants under the age of twenty-one (21) or, if receiving the services immediately before attaining the age of twenty-one (21), not to extend beyond the earlier of the date—
1. Services are no longer required; or
2. Individual reaches the age of twenty-two (22).

For purposes of administration of inpatient psychiatric hospital services coverage for individuals under age twenty-one (21), the Division of Family Services defines a qualified psychiatric hospital facility or inpatient program in a psychiatric facility as follows:

(A) The facility or program within the facility is currently accredited as a psychiatric hospital by the Joint Commission on Accreditation of Hospitals;
(B) The psychiatric facility is currently licensed by the hospital licensing authority of Missouri; and
(C) A psychiatric facility which is operated as a public institution and exempt from the hospital licensing law, must be operated by the Missouri Department of Mental Health.


(1) Pursuant to provisions of section 208.161, RSMo, Medicaid program coverage will be afforded eligible individuals under age twenty-one (21) for inpatient psychiatric hospital services provided under the following conditions:

(A) A board-eligible or board-certified psychiatrist who is a licensed physician;
(B) A clinical psychologist who has a doctoral degree and is licensed, if required by the state, and a physician licensed to practice medicine or osteopathy; or
(C) A physician licensed to practice medicine or osteopathy with specialized training

(A) Ambulatory care resources available in the community do not meet the treatment needs of the youth;
(B) Inpatient treatment under the direction of a physician is needed; and
(C) The services can reasonably be expected to improve the patient's condition, or prevent further regression, so that the services will no longer be needed.

(6) The certifications of need for care shall be made by different teams depending on the status of the individual patients as follows:

(A) For an individual who is receiving Medicaid at the time of admission, the certification of need shall be made by an independent team of health professionals at the time of admission. A team member cannot be employed by the admitting hospital or be receiving payment as a consultant on a regular and frequent basis. The team must include a licensed physician who has competence in diagnosis and treatment of mental illness preferably in child psychiatry, and has knowledge of the patient's situation and one (1) other mental health professional who is licensed, if a part of a licensed discipline;

(B) For an individual who applies for Medicaid while in the facility, the certification of need shall be made by the treatment facility interdisciplinary team responsible for the individual's plan of care as specified in section (7). The certification of need is to be made before submitting a Medicaid claim for payment and must cover any period for which Medicaid claims are made; or

(C) For an individual who undergoes an emergency admission, the certification of need shall be made by the treatment facility interdisciplinary team responsible for the individual's plan of care as specified in section (7) within fourteen (14) days after admission.

(7) The treatment facility’s interdisciplinary team shall be a team of physicians and other personnel who are employed by, or provide services to patients in, the facility.

(A) The team shall include, as a minimum, either:
1. A board-eligible or board-certified psychiatrist who is a licensed physician;
2. A clinical psychologist who has a doctoral degree and is licensed, if required by the state, and a physician licensed to practice medicine or osteopathy; or
3. A physician licensed to practice medicine or osteopathy with specialized training

13 CSR 70-15.070 Inpatient Hospital Psychiatric Services for Individuals Under Age Twenty-One

PURPOSE: This rule provides the legal basis under which inpatient hospital psychiatric services provided eligible individuals under the age of twenty-one might be afforded coverage for purposes of vendor payment under the Title XIX Medicaid program.

PUBLISHER'S NOTE: The secretary of state has determined that the publication of the entire text of the material which is incorporated by reference as a portion of this rule would be unduly cumbersome or expensive. Therefore, the material which is so incorporated is on file with the agency which filed this rule, and with the Office of the Secretary of State. Any interested person may view this material at either agency's headquarters or the same shall be made available at the Office of the Secretary of State at a cost not to exceed actual cost of copy reproduction. The entire text of the rule is printed here. This note refers only to the incorporated by reference material.

(A) Under the direction of a physician;
(B) In a psychiatric hospital facility or an inpatient program in a psychiatric facility, either of which is accredited by the Joint Commission on Accreditation of Hospitals and meets the qualification definition in section (2); and
(C) For claimants under the age of twenty-one (21) or, if receiving the services immediately before attaining the age of twenty-one (21), not to extend beyond the earlier of the date—
1. Services are no longer required; or
2. Individual reaches the age of twenty-two (22).

(2) For purposes of administration of inpatient psychiatric hospital services coverage for individuals under age twenty-one (21), the Division of Family Services defines a qualified psychiatric hospital facility or inpatient program in a psychiatric facility as follows:

(A) The facility or program within the facility is currently accredited as a psychiatric hospital by the Joint Commission on Accreditation of Hospitals;

1. Services are no longer required; or
2. Individual reaches the age of twenty-two (22).
and experience in the diagnosis and treatment of mental diseases, and a psychologist who has a master’s degree in clinical psychology and is licensed, if required by the state or, if licensure is not required by the state, who has been certified by the state or by the state psychological association.

(B) The team shall also include one (1) of the following:
1. A psychiatric social worker who is licensed, if required by the state;
2. A licensed registered nurse with specialized training or one (1) year’s experience in treating mentally ill individuals;
3. An occupational therapist who is licensed, if required by the state, and who has specialized training or one (1) year of experience in treating mentally ill individuals; or
4. A psychologist who has a master’s degree in clinical psychology and is licensed, if required by the state or, if licensure is not required by the state, who has been certified by the state or by the state psychological association.

(C) The team must be capable of performing the following responsibilities:
1. Assessing the individual’s immediate and long-range therapeutic needs, developmental priorities, and personal strengths and liabilities;
2. Assessing the potential resources of the individual’s family;
3. Setting treatment objectives; and
4. Prescribing therapeutic modalities to achieve the plan of care objectives.

(8) Inpatient psychiatric services shall include active treatment which means implementation of a professionally developed and supervised individual plan of care, as described in section (9), that meet the following requirements:
(A) Developed and implemented no later than fourteen (14) days after admission; and
(B) Designed to achieve the recipient’s discharge from inpatient status at the earliest possible time.

(9) An individual plan of care is a written plan developed for each recipient to improve his/her condition to the extent that inpatient care is no longer necessary. The plan of care shall—
(A) Be based on a diagnostic evaluation that includes examination of the medical, psychological, social, behavioral and developmental aspects of the recipient’s situation and reflects the need for inpatient psychiatric care;
(B) Be developed by a team of professionals specified under section (7) in consultation with the recipient; and his/her parents, legal guardians or others in whose care s/he will be released after discharge;
(C) State treatment objectives;
(D) Prescribe an integrated program of therapies, activities and experiences designed to meet objectives;
(E) Include, at an appropriate time, post-discharge plans and coordination of inpatient services with partial discharge plans and related community services to ensure continuity of care with the recipient’s family, school and community upon discharge; and
(F) Be reviewed every thirty (30) days by the treatment facility interdisciplinary team specified in section (7) to provide the following requirements:
1. Determine that services being provided are or were required on an inpatient basis; and
2. Recommend changes in the plan as indicated by the recipient’s overall adjustment as an inpatient.

(10) Before admission or before authorization for payment, the team described in section (6) of this rule must make medical, psychiatric and social evaluations of each applicant’s or recipient’s need for care in the hospital. Each medical evaluation must include the following elements:
(A) Diagnoses;
(B) Summary of present medical findings;
(C) Medical history;
(D) Mental and physical functional capacity;
(E) Prognoses; and
(F) A recommendation by a licensed physician concerning admission to the mental hospital or continued care in the mental hospital for individuals who apply for Medicaid while in the mental hospital.

(11) Audits to monitor hospital compliance shall be performed by a medical review agent authorized by the Division of Medical Services. Hospital admissions of July 1, 1991, and after, that will be subject to audits which may include up to one hundred percent (100%) of Medicaid admissions. Documentation of certification of need, medical/psychiatric/social evaluations, plan of care and active treatment shall be a part of the individual’s medical record. All required documentation must be a part of the medical record at the time of audit to be considered during the audit. Failure of the medical record to contain the required documents at the time of audit shall result in recoupment. The medical review agent’s audit process is as follows:
(A) The hospital has thirty (30) calendar days from the date of the request to furnish medical records for desk audits. At rates determined by the medical review agent, provider costs associated with submission of records will be reimbursed. Records not received within thirty (30) days will result in the services being denied and the Medicaid payment recouped;
(B) Review of the certification of need, medical/psychiatric/social evaluations and plan of care documentation is performed to determine compliance with this rule;
(C) A sample of claims will be reviewed for quality of care using the Health Care Financing Administration (HCFA) psychiatric generic quality screens;
(D) An initial review of the medical record information for active treatment is performed by either a nurse who is licensed or social worker reviewer who is licensed using the Child and Adolescent Assessment Psychiatric Treatment screening criteria;
(E) If the medical record documentation regarding the patient’s condition and planned services meet the criteria in subsection (11)(D) of this rule, the services are approved by either the nurse or social worker reviewer;
(F) If the criteria in subsection (11)(D) of this rule is not met, the nurse or social worker reviewer refers the case to a physician reviewer who is a licensed physician for a determination of documentation and medical necessity. The physician reviewer is not bound by criteria used by the nurse or social worker reviewer. The physician reviewer uses his/her medical judgment to make a determination based on the documented medical facts in the record;
(G) If the physician reviewer denies the admission or days of stay, the attending physician and hospital shall be notified. The hospital may request of the medical review agent a reconsideration review. The hospital is notified of the medical review agent’s reconsideration determination;
(H) Reconsideration determination is the final level of review by the medical review agent. The division will accept the medical review agent’s decision;
(I) Hospitals are notified by the Division of Medical Services if an adjustment of Medicaid payments is required as a result of audit findings;
(J) The following Medicaid policies apply for calculation of Medicaid payments:
1. Medicaid shall reimburse nursing facility care provided in the inpatient hospital setting in accordance with 13 CSR 70-15.010;
2. No Medicaid payment shall be made on behalf of any recipient who is receiving inpatient hospital care and is not in need of either inpatient or nursing facility care. No
payment will be made for outpatient services rendered on an inpatient basis; or
3. Medicaid shall not pay for admissions or continued days for social situations, placement problems, court commitments or abuse/neglect without medical risk; and

(K) Overpayment determinations may be appealed in accordance with section 208.156, RSMo.


*Original authority: 208.201, RSMo 1987.

13 CSR 70-15.080 Payment Method for General Relief Recipient Hospital Outpatient Services

PURPOSE: This rule establishes the method of payment to be used in computing Medicaid program reimbursement for covered hospital outpatient services provided to General Relief assistance recipients.

(1) Effective August 1, 1981, and applying to all services received on or after that date, all outpatient hospital services provided to recipients of General Relief assistance shall be reimbursed by Medicaid in accordance with an established fee schedule. This fee schedule shall be established by the Division of Family Services and shall be based on the reasonable cost to the hospital providing the service. Payment shall not be made for those services which the Division of Family Services may determine are not medically necessary.


13 CSR 70-15.090 Procedures for Evaluation of Appropriate Inpatient Hospital Admissions and Continued Days of Stay

PURPOSE: This rule establishes the basis on which hospitals furnishing inpatient care to Medicaid recipients are audited to determine that admissions/lengths of stay were medically necessary, of appropriate duration and setting, and in compliance with Medicaid rules and policies.

PUBLISHER’S NOTE: The secretary of state has determined that the publication of the entire text of the material which is incorporated by reference as a portion of this rule would be unduly cumbersome or expensive. Therefore, the material which is so incorporated is on file with the agency who filed this rule, and with the Office of the Secretary of State. Any interested person may view this material at either agency’s headquarters or the same will be made available at the Office of the Secretary of State at a cost not to exceed actual cost of copy reproduction. The entire text of the rule is printed here. This note refers only to the incorporated by reference material.

(1) The following definitions are used in administering this rule:
   (A) Acute care means medical care delivered on an inpatient basis requiring continuous direction by a physician;
   (B) Adequate documentation means documentation from which services rendered and the amount of reimbursement received by a provider can be readily discerned and verified with reasonable certainty;
   (C) Adequate hospital inpatient medical records are records which are of the type and in a form required of good medical practice and containing:
      1. Patient identification data;
      2. Medical history of the patient;
      3. Report of a relevant physical examination;
      4. Diagnostic and therapeutic orders;
      5. Evidence of appropriate informed consent. When consent is not available, the reason shall be entered in the record;
      6. Clinical observations, including results of therapy;
      7. Reports of procedures, tests and the results; and
      8. Conclusions at termination of hospitalization or evaluation/treatment;
   (D) Medical history means chief complaint; details of present illness, including assessment of the patient’s emotional, behavioral and social status; relevant past, social and family histories; and inventory by body systems where necessary for diagnosis and treatment;
   (E) Medically necessary inpatient services means medical treatment for health reasons requiring continuous direction by a physician in an acute care setting;
   (F) Nursing facility means a level-of-care which can be provided in a nursing facility either by or under the supervision of licensed nursing personnel for persons requiring personal care, observation, basic health care, supervision of diets, storage, distribution or administration of medications; or treatments prescribed by a licensed physician or nurse practitioner on an acute-care level;
   (G) Pertinent information means information sufficient to identify the patient, to support the diagnosis and to justify the treatment; and
   (H) Physician reviewer means physicians currently practicing in Missouri under contract to the division to perform peer review.

(2) Medicaid-participating hospitals in Missouri and bordering states are subject to desk or on-site audit procedures as outlined in this rule. The division or its representatives will conduct audits to determine medically necessary services, appropriateness of setting and program compliance for admissions and continued days of stay. Audits may include any of the following:
   (A) Admission and continued days-of-stay audits for admissions of deliveries and newborns, and diagnosis exempt from admission certification; and
   (B) Continued days-of-stay audits, beginning with the day after admission, which require admission certification as required by 13 CSR 70-15.020.

(3) At the discretion of the division, the audit may include, but is not limited to, any of the following:
   (A) An examination by division personnel of—
      1. Closed medical records of all Medicaid recipients;
      2. Open and active/open medical records of all Medicaid recipients;
      3. The current and all past utilization review plans;
      4. All minutes of utilization review committee meetings which concern Medicaid-recipient stays;
      5. Utilization review documents which concern Medicaid-recipient stays;
      6. Medical/psychological care evaluation/quality assurance studies completed and in progress; and
      7. Plans of care required by a federal or state authority(ies); and
   (B) Discussions with hospital staff and employees regarding hospital policies and procedures related to medical documentation and claims of Medicaid recipients.
(4) The severity of illness/intensity of service (SI/IS) criteria are used as screening criteria for medical review audits. The SI/IS criteria filed with this rule and incorporated in this rule includes adult and pediatric criteria for general medical care. Supplemental criteria sets are included for adult and child/adolescent psychiatric care, rehabilitation care and alcohol/drug abuse treatment. The SI/IS criteria and supplemental sets are criteria used by the division for admission certification elaborated in 13 CSR 70-15.020(6).

(5) The medical review audit procedure may include the following:

(A) A notice letter of the audit sent to the hospital administrator with the following time requirements:
   1. The hospital receives fifteen (15) calendar days’ notice prior to the date upon which an on-site audit is to begin; or
   2. The hospital has thirty (30) calendar days from the date of notice to furnish medical records for desk audits. A single extension not to exceed fifteen (15) calendar days may be granted upon the request of the hospital. Records not received timely will automatically result in the services being denied;

(B) An initial screening of the medical record information is performed by nurse reviewers using the criteria in section (4) as appropriate to the case;

(C) If the medical record documentation regarding the patient’s condition and planned services meet the applicable criteria in section (4), the services are approved as medically necessary;

(D) If the applicable criteria in section (4) are not met, the nurse reviewer refers the case to a physician reviewer for a medical necessity and appropriateness of setting determination. The physician reviewer is not bound by criteria used. The physician reviewer uses his/her medical judgment to make a determination based on the documented medical facts in the record;

(E) If the physician reviewer denies the admission or continued days of stay, a preliminary denial notice is mailed to the attending physician and hospital;

(F) The attending physician and hospital have fifteen (15) working days from the date of notice to send in additional documentation;

(G) The physician reviewer examines the medical record and the additional documentation prior to a determination to approve or deny the admission or continued days of stay. The determination made by the physician reviewer completes the final level of review; and

(H) A written report of the physician reviewer’s determinations, as approved by the division, is issued.

(6) A policy compliance audit can be performed to determine conformity with written and published policies and procedures of the Medicaid inpatient hospital program as contained in provider manuals and bulletins.

(7) A utilization review audit can be performed to determine compliance with the hospital’s utilization review plan applicable to the Medicaid program and defined in federal regulation Title 42 CFR 456 subparts C and D, and 42 CFR 482.30.

(8) All pertinent and complete medical record documentation and utilization review records must be made available at the time of the review and copies provided, if requested, by the hospital to the division. The review and decision are based upon the documents provided at the time of review contained in the medical record for the specific date of admission.

(9) Payment for requested copies will be reimbursed at ten cents (10¢) per page by submitting to the division an invoice indicating the number of pages per record. No additional reimbursement will be made for postage. Copies must be legible.

(10) Hospitals are notified by the division if an adjustment of Medicaid payments is required as a result of audit findings. The following Medicaid policies apply for calculation of Medicaid payment:

(A) Medicaid shall reimburse nursing facility care provided in the inpatient hospital setting in accordance with 13 CSR 70-15.010(11);

(B) No Medicaid payment will be made on behalf of any recipient who is receiving inpatient hospital care and is not in need of either inpatient or nursing facility care. No payment will be made for outpatient services rendered on an inpatient basis; or

(C) Medicaid does not pay for admissions or continued days of stay for social situations, placement problems, court commitments or abuse/neglect without medical risk.

(11) Overpayment determinations may be appealed to the Administrative Hearing Commission within thirty (30) days of the date of notice letter if the sum in dispute exceeds five hundred dollars ($500).

PUBLISHER’S NOTE: The secretary of state has determined that the publication of the entire text of the material which is incorporated by reference as a portion of this rule would be unduly cumbersome or expensive. Therefore, the material which is so incorporated is on file with the agency who filed this rule, and with the Office of the Secretary of State. Any interested person may view this material at either agency’s headquarters or the same will be made available at the Office of the Secretary of State at a cost not to exceed actual cost of copy reproduction. The entire text of the rule is printed here. This note refers only to the incorporated by reference material.

1. Federal Reimbursement Allowance (FRA). FRA shall be assessed as described in this section.

(A) Definitions.

1. Bad debts—Amounts considered to be uncollectible from accounts and notes receivable that were created or acquired in providing services. Allowable bad debts include the costs of caring for patients who have insurance but their insurance does not cover the
particular service procedures or treatment rendered.

2. Base cost report—Desk-reviewed Medicare/Medicaid cost report for the latest hospital fiscal year ending during the calendar year. (For example, a provider has a cost report for the nine (9) months ending 9/30/95 and a cost report for the three (3) months ending 12/31/95.) 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.

3. Charity care—Those charges written off by a hospital based on the hospital’s policy to provide health care services free of charge or at a reduced charge because of the indigence or medical indigence of the patient.

4. Contractual allowances—Difference between established rates for covered services and the amount paid by third-party payers under contractual agreements.

5. Department—Department of Social Services.

6. Director—Director of the Department of Social Services.

7. Division—Division of Medical Services, Department of Social Services.

8. Engaging in the business of providing inpatient health care—Accepting payment for inpatient services rendered.

9. Fiscal period—Twelve (12)-month reporting period determined by each hospital.

10. Gross hospital service charges—Total charges made by the hospital for inpatient and outpatient hospital services that are covered under 13 CSR 70-15.010.

11. Hospital—A place devoted primarily to the maintenance and operation of facilities for the diagnosis, treatment or care for not fewer than twenty-four (24) hours in any week of three (3) or more nonrelated individuals suffering from illness, disease, injury, deformity or other abnormal physical conditions; or a place devoted primarily to provide for not fewer than twenty-four (24) hours in any week, medical or nursing care for three (3) or more nonrelated individuals. The term hospital does not include convalescent, nursing, shelter or boarding homes as defined in Chapter 198, RSMo.

12. Net operating revenue—Gross charges less bad debts, less charity care, and less contractual allowances times the trend indices listed in 13 CSR 70-15.010(3)(B).

13. Other operating revenues—The other operating revenue is total other revenue less government appropriations, less donations and less income from investments times the trend indices listed in 13 CSR 70-15.010(5)(B).

14. Base cost—The total of the contractual allowance and the hospital’s other operating revenue.

15. Net operating revenue—Subtract the contractual allowances and other operating revenues from the base cost.

16. Total charges—Add the contractual allowances and other operating revenues to the base cost.

17. Medicare/Medicaid net revenue per bed—The Medicare/Medicaid net revenue divided by the total beds in the hospital.

18. Medicaid net revenue per bed—The Medicaid net revenue divided by the total beds in the hospital.

19. Medicaid net revenue—Medicare/Medicaid net revenue is the total charges made by the hospital for inpatient hospital services that are covered under 13 CSR 70-15.010.

20. Medicare/Medicaid net revenue—The total charges made by the hospital for inpatient hospital services that are covered under 13 CSR 70-15.010.

21. Federal Reimbursement Allowance (FRA)—The amount remitted shall be deposited in the state treasury to the credit of the Federal Reimbursement Allowance Fund.

22. Federal Reimbursement Allowance—The Federal Reimbursement Allowance is the amount remitted to the state treasury to the credit of the Federal Reimbursement Allowance Fund.

23. FRA—The Federal Reimbursement Allowance is the amount remitted to the state treasury to the credit of the Federal Reimbursement Allowance Fund.

24. State Fiscal Year 1996—The Federal Reimbursement Allowance is the amount remitted to the state treasury to the credit of the Federal Reimbursement Allowance Fund.

25. Federal Fiscal Year 1994—The Federal Reimbursement Allowance is the amount remitted to the state treasury to the credit of the Federal Reimbursement Allowance Fund.

26. Medicaid—Medicare/Medicaid services are rendered.
(A) The FRA assessment for State Fiscal Year 1997 shall be determined at the rate of five and sixty-three hundredths percent (5.63 %) of the hospital’s total operating revenue less tax revenue/other government appropriations plus non-operating gains and losses as published by the Missouri Department of Health, State Center for Health Statistics in the Missouri Hospital Revenues 1995–2000 manual, which is incorporated by reference in this rule. The base financial data for 1997 will be annualized, if necessary, and will be adjusted by the trend factor listed in 13 CSR 70-15.010(3)(B) to determine revenues for the current state fiscal year.

(5) Federal Reimbursement Allowance (FRA) for State Fiscal Year 1998.

(A) The FRA assessment for State Fiscal Year 1998 shall be determined at the rate of five and forty-six hundredths percent (5.46%) of the hospital’s total operating revenue as determined from information reported in the hospital’s 1995 base year cost report.

(6) Federal Reimbursement Allowance (FRA) for State Fiscal Year 1999. The FRA assessment for State Fiscal Year 1999 shall be determined at the rate of five and thirty hundredths percent (5.30 %) of the hospital’s net operating revenues and other operating revenues defined in paragraphs (1)(A)12. and 13., as determined from information reported in the hospital’s 1998 base year cost report. The State Fiscal Year 1999 assessment rate of five and thirty hundredths percent (5.30 %) shall continue as an estimate of the FRA assessment percentage until such time as the State Fiscal Year 2000 assessment rate is established.

(7) Federal Reimbursement Allowance (FRA) for State Fiscal Year 2000. The FRA assessment for State Fiscal Year 2000 shall be determined at the rate of five and two hundredths percent (5.02 %) of the hospital’s net operating revenues and other operating revenues defined in paragraphs (1)(A)12. and 13., as determined from information reported in the hospital’s 1999 base year cost report. The State Fiscal (SFY) 2001 FRA Assessment shall be used as an estimate of the SFY 2002 FRA Assessment until such time as the regulation establishing the SFY 2002 FRA Assessment is effective.

(8) Federal Reimbursement Allowance (FRA) for State Fiscal Year 2001. The FRA assessment for State Fiscal Year 2001 shall be determined at the rate of five and fifty hundredths percent (5.50%) of the hospital’s net operating revenues and other operating revenues defined in paragraphs (1)(A)12. and 13., as determined from information reported in the hospital’s 1999 base year cost report. The State Fiscal (SFY) 2001 FRA Assessment shall be used as an estimate of the SFY 2002 FRA Assessment until such time as the regulation establishing the SFY 2002 FRA Assessment is effective.

(9) Federal Reimbursement Allowance (FRA) for State Fiscal Year 2002. The FRA assessment for State Fiscal Year (SFY) 2002 shall be determined at the rate of five and zero hundredths percent (5.00 %) of the hospital’s total operating revenue less tax revenue/other government appropriations plus non-operating gains and losses as published by the Missouri Department of Health and Senior Services, Section of Health Statistics.

The base financial data for 2000 will be annualized, if necessary, and will be adjusted by the trend factor listed in 13 CSR 70-15.010(3)(B) to determine revenues for the current state fiscal year. The financial data that is submitted by the hospitals to the Missouri Department of Health and Senior Services is required as part of 19 CSR 10-33.030 Reporting Financial Data by Hospitals. If the pertinent information is not available through the Department of Health and Senior Services’ hospital database, the Division of Medical Services will use the Medicaid data similarly defined from the Medicaid cost report that is required to be submitted pursuant to 13 CSR 70-15.010(5)(A).

13 CSR 70-15.150 Enhancement Pools

PURPOSE: This rule creates enhancement pools to increase reimbursement to government-owned hospitals and all hospitals, in an amount not to exceed the Medicare Upper Limit payment for the Medicaid program.

(1) Medicaid Enhancement Pools. Each participating government-owned or operated hospital may be paid a one-time per year payment from an enhancement pool that shall be calculated at a percentage to be specified by the department of the aggregate difference between the Medicare Upper Limit and the per diem Medicaid reimbursement for all facilities.

(B) The enhancement payment shall be distributed to participating governmental hospitals based on their pro rata share of Medicaid patient days.

(C) A participating government-owned or operated hospital is one that has entered into an intergovernmental funds transfer agreement with the department.

(2) All Medicaid enrolled hospitals may participate in distributions from a second pool that shall be calculated at a percentage to be specified by the department of the aggregate difference between the Medicare Upper Limit and the per diem Medicaid reimbursement for all Medicaid enrolled hospitals for services covered by the Missouri Medicaid program, as defined above. The second pool shall be distributed annually as a one-time payment, made in addition to per diem payments, to all Medicaid enrolled hospitals based on their pro rata share of Medicaid days.


13 CSR 70-15.160 Prospective Outpatient Hospital Services Reimbursement Methodology

PURPOSE: This rule establishes a prospective outpatient reimbursement methodology for hospitals in place of the current retrospective reimbursement methodology. This rule establishes the methodology for setting a hospital’s prospective outpatient payment percentage for hospital services effective July 1, 2002.

PUBLISHER’S NOTE: The secretary of state has determined that the publication of the entire text of the material which is incorporated by reference as a portion of this rule would be unduly cumbersome or expensive. Therefore, the material which is incorporated is on file with the agency who filed this rule, and with the Office of the Secretary of State. Any interested person may view this material at either agency’s headquarters or the same will be made available at the Office of the Secretary of State at a cost not to exceed actual cost of copy reproduction. The entire text of the rule is printed here. This note refers only to the incorporated by reference material.

(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 over-all outpatient cost-to-charge ratio from the fourth, fifth, and sixth prior 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.) 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.

(C) Outpatient hospital services reimbursement limited by rule.

1. All services provided to General Relief (GR) recipients will be reimbursed from the Medicaid fee schedule in accordance with provisions of 13 CSR 70-2.020.

2. Effective for dates of service September 1, 1985, and annually updated, certain clinical diagnostic laboratory procedures will be reimbursed from a Medicaid fee schedule which shall not exceed a national fee limitation.

3. Services of hospital-based physicians and certified registered nurse anesthetists shall be billed on an HCFA-1500 professional claim form which is incorporated by reference as part of this rule, and reimbursed from a Medicaid fee schedule or the billed charge, if less.

4. 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 under Title XVIII.

(2) Exempt Hospitals. Exempt Hospital Outpatient 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

will occur as follows:

prospective outpatient payment percentage settlements calculated in accordance with paragraph (2)(C)2.

starting July 1, 2002 and may have final settlements calculated in accordance with paragraph (2)(C)2.

will receive an outpatient payment percentage based on the overall 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)1., 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:

<table>
<thead>
<tr>
<th>1st cost report filed calendar year</th>
<th>Settlement calculated</th>
<th>SFY</th>
<th>SFY Prospective rate granted</th>
<th>Cost reports used for Prospective rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>1999</td>
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<td>1999</td>
<td>No</td>
<td>1999</td>
</tr>
<tr>
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<td>1999</td>
</tr>
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<td>2004</td>
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<td>1998, 1999 &amp; 2000</td>
</tr>
<tr>
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<td>No</td>
<td>2005</td>
<td>Yes</td>
<td>1999, 2000 &amp; 2001</td>
</tr>
</tbody>
</table>

(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.

(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.

(5) Out-of-State Outpatient Reimbursement.

(A) Out-of-state outpatient hospital services and services of federally-operated hospitals located within Missouri will be reimbursed by Missouri Medicaid at sixty percent (60%) of usual and customary charges as billed by the provider for covered services with the exceptions for services in subsection (1)(C).


13 CSR 70-15.170 Enhanced Disproportionate Share Payment to Trauma Hospitals for the Cost of Care to the Uninsured Provided by Physicians Not Employed by the Hospital