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**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 Method-  
ology**

*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 publication of the full text of the material that the adopting agency has incorporated by reference in this rule would be unduly cumbersome or expensive. Therefore, the full text of that material will be made available to any interested person at both the Office of the Secretary of State and the office of the adopting agency, pursuant to section 536.031.4, RSMo. Such material will be provided at the cost established by state law.*

**(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, outpatient, and disproportionate share payments. 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 paragraph (16)(A)1., and section (18) include both the federally mandated reimbursement for hospitals which meet the federal requirements in subsection (6)(A) and the discretionary disproportionate share payments which are allowable but not mandated under federal regulation are described in paragraph (16)(A)1., and section (18). These Safety Net and Medicaid Add-Ons are subject to federal limitation described in Omnibus Reconciliation Act of 1993 (OBRA 93) and section (17).

**(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 should not include the cost of caring for patients whose insurance covers the given procedures but limits coverage. In addition, bad debts should 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 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 9/30/94 and a cost report for the three (3) months ending 12/31/94.) 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) Disproportionate share reimbursement. The disproportionate share payments described in paragraph (16)(A)1., and section (18) include both the federally mandated reimbursement for hospitals which meet the federal requirements in subsection (6)(A) and the discretionary disproportionate share payments which are allowed but not mandated under federal regulation are described in paragraph (16)(A)1., and section (18) of this regulation. These Safety Net and Medicaid Add-Ons are subject to federal limitation as described in Omnibus Reconciliation Act of 1993 (OBRA 93) and section (17) of this regulation.

(H) 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.

(I) 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.

(J) 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.

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

(L) 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.

(M) 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.

(N) 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 designed 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).

(O) 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.

(P) 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:

$$\text{Per Diem} = \frac{(\text{OC} * \text{TI})}{\text{MPD}} + \frac{\text{CMC}}{\text{MPDC}}$$

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 (5)(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%.

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%.

(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 Medicaid 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 Medicaid 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 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.

(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 impositions 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 add-on payments, the hospital shall review the desk review data and the schedule of key

data elements and submit amended or corrected data to the division within fifteen (15) days. Data received after the fifteen (15)-day deadline will not be considered by the division for 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 405.406. 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 405.427(a), 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 recordkeeping 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 costs (less swing bed cost) to total hospital cost as submitted on the most recent cost report filed with 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 Medicaid 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 cost which occur subsequent to the base period described in subsection (2)(C). 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); and

C. When the hospital experiences extraordinary circumstances which may include, but are not limited to, an act of God, war or civil disturbance.

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 nonprofit 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 respond 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 third 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 excluded;

$$MIUR = \frac{TMD}{TNID}$$

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;

$$LIUR = \frac{TMPR + CS}{TNR + CS} + \frac{CC - CS}{THC}$$

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

A. Has an un-sponsored care ratio of at least ten percent (10%). The un-sponsored 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 nursery 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 third prior year cost report;

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

A. The hospital has an un-sponsored care ratio of at least sixty-five percent (65%); or

B. 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

C. 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 third 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., 2. and 4. shall be deemed first tier ten percent (10%) add-on DSH. Those hospitals which meet the criteria established in (6)(A)1. and 3. shall be deemed first tier DSH. Those hospitals which meet only the criteria established in paragraphs (6)(A)1. and 2. or (6)(A)1. and 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) 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.

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 the 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 evalu-

ate 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 by (B) or (C) of this subsection using the most recent desk-reviewed cost report. Reimbursement at the applicable percentage shall be effective April 1, 1998, 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 state agency shall review audited Medicaid-Medicare cost reports for each hospital's fiscal year and shall make indicated adjustments of additional payment or recoupment, in order that the hospital's net reimbursement (except for those hospitals identified in subsection (C) of this section) shall be in amounts representing not more than one hundred percent (100%) of the lesser of—

1. Reasonable costs as determined by the state agency's annual review of the participating hospital's outpatient fiscal year-end cost reports and reconciliation of the Medicaid allowable charges and reimbursement for Medicaid services provided during that fiscal year; or

2. Usual and customary charges as billed by the provider of services and as representing a prevailing charge in the locality for comparable services under comparable circumstances.

(C) All facilities which meet the Medicare criteria for exemption from the lower of cost or charge limitation as nominal charge providers for fiscal year cost determination shall have their net reimbursement determined at no more than one hundred percent (100%) of cost.

(D) Within ninety (90) days following the receipt of the complete unaudited Medicaid-Medicare cost report filed by the provider in accordance with subsection (5)(A) of this rule, interim outpatient settlements for facilities having a fiscal year-end subsequent to January 1, 1984, will be done after desk review of the report for only the following hospitals:

1. High volume Medicaid hospitals that serve a disproportionate number of low income recipients and meet the criteria defined in paragraphs (6)(A)2. and 3. of this rule. Interim settlements will be at not more than one hundred percent (100%) of the lower of unaudited costs of usual and customary charges for covered services; and

2. Hospitals as defined in subsection (C) of this section. Interim settlements will be at not more than one hundred percent (100%) of cost. A letter from Medicare attesting to the exemption must accompany the cost report.

(E) 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 listed in paragraph (11)(A)2. and services of hospital-based physicians and certified registered nurse anesthetists.

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

(G) 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 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 no 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 becoming an allowable cost on January 1, 1999;

2. The unreimbursed Medicaid costs applicable to the SFY 1999 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; and

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.

(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 SFY 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 SFY.

A. The trended cost per day is calculated by trending the base year operating costs per day by the trend indices listed in paragraph (3)(B)1., using the rate calculation in subsection (3)(A).

B. 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; and

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.

(C) The SFY 1999 Direct Medicaid Payments starting January 1, 1999 will be determined by subtracting the Add-On payments made for unreimbursed Medicaid costs between July 1, 1998 and December 31, 1998 from the SFY 1999 unreimbursed Medicaid costs calculated in subsection (15)(B). The difference in the unreimbursed Medicaid costs will be prorated over the remainder of the SFY 1999 and paid directly to the hospitals.

(16) Safety Net Adjustment. A safety net adjustment shall be provided for each hospital which qualified as disproportionate share under the provision of paragraph (6)(A)4., prior to the end of each federal fiscal year.

(A) The safety net adjustment shall be computed in accordance with the OBRA 93 Limitation identified in section (17) of this regulation.

(B) Adjustments provided under this section shall be considered reasonable costs for purpose of the determinations described in paragraph (5)(D)2.

(17) OBRA 93 Limitation. In accordance with OBRA 93, disproportionate share payments shall not exceed one hundred percent (100%) of the unreimbursed cost for Medicaid and the cost of the uninsured. The OBRA 93 Limitation shall be computed using the fourth prior year desk-reviewed cost report trended through the current state fiscal year. If the sum of disproportionate share



payments exceeds the estimated OBRA 93 Limitation, the difference shall be deducted in order as necessary from the Safety Net payment, other disproportionate share lump sum payments, direct Medicaid payments and if necessary as a reduced per diem.

(18) In accordance with state and federal laws regarding reimbursement of unreimbursed costs and the costs of services provided to uninsured patients, reimbursement for each State Fiscal Year (SFY) (July 1–June 30) shall be determined as follows:

(A) Medicaid Add-Ons for Shortfall. The Medicaid Add-On for the period of July 1, 1998 to December 31, 1998 will be based on fifty percent (50%) of the unreimbursed Medicaid costs as calculated for SFY 98 (Medicaid Shortfall); and

(B) Uninsured Add-Ons. The hospital shall receive eighty-one percent (81%) of the Uninsured costs prorated over the SFY. Hospitals which contribute through a plan approved by the director of health to support the state's poison control center and the Primary Care Resource Initiative for Missouri (PRIMO) shall receive eighty-two percent (82%) of its uninsured costs prorated over the SFY. The uninsured Add-On will include:

1. The Add-On payment for the cost of the Uninsured. This is determined by multiplying the charges for charity care and allowable bad debts by the hospital's total cost-to-charge ratio for allowable hospital services from the base year cost report's desk review. The cost of the Uninsured is then trended to the current year using the trend indices reported in subsection (3)(B). Allowable bad debts do not include the costs of caring for patients whose insurance covers the particular service, procedure or treatment;

2. An adjustment to recognize the Uninsured patients share of the FRA assessment not included in the desk-reviewed cost. The FRA assessment for Uninsured patients is determined by multiplying the current FRA assessment by the ratio of uninsured days to total inpatient days from the base year cost report;

3. The difference in the projected General Relief per-diem payments and trended costs for General Relief patient days;

4. The increased costs per day resulting from the utilization adjustment in subsection (15)(B) is multiplied by the estimated uninsured days; and

5. In order to maintain compliance with the Balance Budget Act of 1997 (BBA) DSH cap and the budget neutrality provisions contained in Missouri's Medicaid Section 1115

Health Care Reform Demonstration Proposal, the Uninsured Add-On for SFY 2000 has been established at eighty-two percent (82%) of the cost of the uninsured as computed in accordance with this subsection. One factor in determination of the payment percentage is an estimate that fifty-four (\$54) million dollars shall be paid from July 1, 1999 thru April 30, 2000 related to previously uninsured parents covered under the Medicaid Section 1115 Health Care Reform Demonstration Proposal. The SFY 2000 payment percentage shall be increased by an additional one percent (1%) for every three point five (\$3.5) million dollars increment not paid for parents covered under the Medicaid Section 1115 Health Care Reform Demonstration Proposal as of April 30, 2000. For example, if total spending on the Medicaid Section 1115 Health Care Reform Demonstration Proposal parent population is forty-seven (\$47) million dollars, as of April 30, 2000, the Uninsured Add-On percentage for SFY 2000 shall be increased by two percent (2%).

(19) Medicaid GME Add-On—A Medicaid Add-On determined for Graduate Medical Education (GME) costs shall be allocated based on the estimated effect of implementation of a Medicaid managed care system such as MC+ in accordance with this section.

(A) The Medicaid GME Add-On for Medicaid clients covered under a Managed Care Plan shall be determined using the base 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 an acute care hospital that provides graduate medical education

(teaching hospital) if the hospital is a children's hospital or is a safety net hospital. A safety net hospital for purposes of this section is a hospital that has an unsponsored care ratio of at least sixty-five percent (65%) or 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.

(A) The enhanced GME payment shall be fifty percent (50%) of the teaching hospital's remaining unreimbursed aggregate approved amount for direct GME. 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 from the Medicare cost report 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.

(B) The remaining unreimbursed aggregate approved amount for direct GME shall be calculated by subtracting the current state fiscal year Medicare and Medicaid GME payments based on the Medicare methodology on worksheet E-3 Part IV from the Medicare cost report (HCFA 2552-96), the provisions of which are incorporated by reference and made part of this rule, from the total unreimbursed aggregate approved amount for direct GME. The Medicaid GME payments will include both non-managed care and managed care payments from the hospital's base year cost report trended forward.

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### 13 CSR 70-15.011 Reimbursement for Essential Disproportionate Share Hospitals

*Emergency rule filed April 21, 1995, effective May 1, 1995, expired June 30, 1995.*

### 13 CSR 70-15.020 Procedures for Admission Certification, Continued Stay Review and Validation Review of Hospital Admissions

*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.*

*Editor's Note: The secretary of state has determined that the publication of this rule in its entirety would be unduly cumbersome or expensive. The entire text of the material referenced has been filed with the secretary of state. This material may be found at the Office of the Secretary of State or at the headquarters of the agency and is available to any interested person at a cost established by state law.*

(1) The following definitions will be used in administering this rule:

(A) Admission. Admission means the act of registration and entry into a general medical and surgical, psychiatric or rehabilitation hospital on the order of a qualified medical practitioner having privileges of admission for the purpose of providing inpatient hospital services under the supervision of a physician member of the hospital's medical staff;

(B) Admission certification. Admission certification means the determination by the medical review agent, as transmitted to the hospital/physician and the fiscal agent, that the admission of a recipient for inpatient hospital services is approved as medically necessary, reasonable and appropriate as to placement at an acute level of care;

(C) Admitting diagnosis. Admitting diagnosis means the physician's tentative or provisional diagnosis of the recipient's condition as a basis for examination and treatment

when the physician requests admission certification;

(D) Admitting physician. Admitting physician means the physician who orders the recipient's admission to the hospital;

(E) Certification number. Certification number means the number issued by the medical review agent that establishes that, based upon information furnished by the provider, a recipient's admission for inpatient hospital services is approved as medically necessary;

(F) Department. Department means the Missouri Department of Social Services;

(G) Emergency admission. Emergency admission means an admission in which the medical condition manifests itself by acute symptoms of sufficient severity (including severe pain) that absence of immediate medical attention could reasonably be expected to result in placing the patient's health in serious jeopardy, serious impairment to bodily function or serious dysfunction of any bodily organ or part;

(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;

(I) Inpatient hospital service. Inpatient hospital service means a service provided by or under the supervision of a physician after a recipient's admission to a hospital and furnished in the hospital for the care and treatment of the recipient;

(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 an inpatient hospital service that is consistent with the recipient's diagnosis or condition and is in accordance with the criteria as specified by the department;

(N) Nurse reviewer. Nurse reviewer means a person who is employed by or under contract with the medical review agent and who is licensed to practice professional nursing in Missouri;

(O) Pertinent information. Pertinent information means any information that the physician, hospital or recipient feels may justify or qualify the hospitalization;

(P) Physician reviewer. Physician reviewer means a physician who is a peer of the admitting/attending physician or who specializes in the type of care under review. Exceptions will be made only if the efficiency or effectiveness of the review would be compromised, but in every situation the review will be performed by a physician;

(Q) Readmission. Readmission means an admission that occurs within fifteen (15) days of a discharge of the same recipient from the same or a different hospital. The fifteen (15)-day period does not include the day of discharge or the day of readmission;

(R) Recipient. Recipient means a person who has applied and been determined eligible for Medicaid benefits;

(S) Reconsideration. Reconsideration means a review of a denial or withdrawal of admission certification;

(T) Required information. Required information means the information to be provided 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 (1) 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; and

(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 Medicaid prepaid health plan;

(B) Admissions of recipients eligible for both Part A Medicare and Medicaid;

(C) Admissions for deliveries;

(D) Admissions for newborns; and

(E) Admissions for certain pregnancy-related diagnoses. The diagnoses codes for deliveries, newborns and pregnancy-related conditions are as published in the ICD9-CM



(Internal Classification of Diseases, 9th Revision, Clinical Modification). Admissions with diagnoses codes for missed abortion, pregnancy with abortive outcome and postpartum condition or complication will continue to require admission certification and validation review.

(3) The admission certification procedure and validation review will be performed by a medical review agent. The confidentiality of all information shall be adhered to in accordance with section 208.155, RSMo and Title 42, *Code of Federal Regulations* part 431, subpart F. The medical review agent's decisions related to certification or noncertification of Medicaid admissions are advisory in nature. The department is the final payment authority. The medical review agent's review decisions will be used as the basis for Medicaid reimbursement.

(4) The types of certification and review include:

(A) Preadmission certification of nonemergency (elective) admissions of Medicaid recipients with established eligibility on date of admission;

(B) Postadmission certification of emergency and urgent admissions of Medicaid recipients with established eligibility on date of admission;

(C) Retrospective certification if the following occurs:

1. The request for preadmission or postadmission certification is not obtained in a timely manner as stated in subsection (5)(A) or (B); or

2. Recipient eligibility is not established on or by date of admission;

(D) Retrospective validation review of sample cases to assure information provided during admission certification is substantiated by documentation in the medical record; and

(E) 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 a planned elective admission must occur no later than two (2)

full working days prior to the date of the planned admission;

(B) Physician or hospital notification to the medical review agent of the occurrence of an emergency or urgent admission is required by the end of the first full working day after the date of the actual admission;

(C) The medical review agent will determine the medical necessity of admissions specified in subsections (4)(A) and (B) within two (2) working days after receipt of all required information from the physician or hospital;

(D) The hospital shall submit, at its own expense, the recipient's medical record to the medical review agent for retrospective certification cases specified in subsection (4)(C). Retrospective certification requests must be submitted in a reasonable period of time so as to allow the hospital to meet the claims timely filing requirements of 13 CSR 70-3.100; and

(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 med-

ical 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 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:

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 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.

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*\*Original authority: 208.201, RSMo 1987.*

**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.

*Editor's Note:* The secretary of state has determined that the publication of this rule in its entirety would be unduly cumbersome or expensive. The entire text of the material referenced has been filed with the secretary of state. This material may be found at the Office of the Secretary of State or at the headquarters of the agency and is available to any interested person at a cost established by state law.

(1) For inpatient hospital admissions that have been certified under 13 CSR 70-15.020 and for admissions that do not require certification, the number of days which Medicaid will cover for each admission and continuous period of hospitalization shall be limited to the lowest of subsection (1)(A), (B) or (C). General Relief (GR) recipients are further limited in section (7) of this rule.

(A) The number of days indicated as appropriate in accordance with the length-of-stay schedule as set forth in paragraph (1)(A)1. with the exception of those specific diagnoses for which a length-of-stay schedule has been developed by the Medicaid agency as set forth in paragraphs (1)(A)2. and 3., or as stated in paragraph (1)(A)4., or as established in 13 CSR 70-15.020 and as stated in paragraph (1)(A)5.

1. For the diagnosis at the 75th percentile average length-of-stay in the 1988 edition of the *Length of Stay by Diagnosis for the United States, North Central Region* for claims and adjustments processed for payment on or after January 1, 1990.

2. A length-of-stay schedule, as developed by the Medicaid agency, for limited categories of rehabilitation diagnoses provided in facilities which meet the following criteria:

A. Medicare certification of ten (10) beds or more as a rehabilitation hospital or a rehabilitation distinct part which is exempt from the Medicare prospective rate-setting system; or

B. Certification of ten (10) beds or more by the Commission for Accreditation of Rehabilitation Facilities.

**Diagnosis Description, Code and Days**

Spinal cord injury—quadraplegia—Code SC1—thirty (30) days  
 Spinal cord injury—cervical fracture—Code SC2—twenty-five (25) days  
 Spinal cord injury—paraplegia—Code SC3—thirty (30) days  
 Spinal cord injury—hemiplegia—Code SC4—twenty-five (25) days  
 Cerebral vascular accident—Code CVA—twenty-nine (29) days  
 Head trauma—Code HT1—thirty-five (35) days  
 Muscular dystrophy—Code MUD—twenty (20) days  
 Orthopedic trauma—arm—Code OT1—twenty-nine (29) days  
 Orthopedic trauma—leg—Code OT2—twenty-nine (29) days  
 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 (2000 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 inpatient days to and including the day on which the infant reaches two thousand grams (2000 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 necessary 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 performed for alcohol and drug abuse detoxification services to determine the days that are medically necessary and appropriate for inpatient hospital care.

(B) The number of days certified as medically 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 eligibility 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 necessary, 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, reimbursement 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 hospital 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 documentation.

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

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

(B) The rate which was in effect between the hospital and the Medicaid program 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) continuous period of hospitalization will be limited to a maximum of twenty-one (21) days during which the recipient is Medicaid-eligible and if twenty-one (21) days should be the lesser of allowable days as derived from provisions of sections (1) and (2).

(8) Exception Process.

(A) An exception process to the coverage of inpatient days as determined under provisions 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 allowed 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 admissions 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 recommendations 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.

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

*AUTHORITY: sections 208.153, RSMo Supp. 1991 and 208.201, RSMo Supp. 1987. \* This rule was previously filed as 13 CSR 40-81.051. Emergency rule filed April 7, 1981, effective April 20, 1981, expired July 10, 1981. Original rule filed April 7, 1981, effective July 11, 1981. Emergency amendment filed July 15, 1981, effective Aug. 1, 1981, expired Oct. 10, 1981. Emergency amendment filed Aug. 21, 1981, effective Sept. 1, 1981, expired Dec. 10, 1981. Amended: Filed July 15, 1981, effective Oct. 11, 1981. Emergency amendment filed Nov. 20, 1981, effective Dec. 1, 1981, expired March 10, 1982. Amended: Filed Aug. 21, 1981, effective Dec. 11, 1981. Amended: Filed Nov. 20, 1981, effective March 11, 1982. Amended: Filed April 14, 1982, effective July 11, 1982.*

*Emergency amendment filed Nov. 24, 1982, effective Dec. 4, 1982, expired March 10, 1983. Amended: Filed Nov. 24, 1982, effective March 11, 1983. Emergency amendment filed April 8, 1983, effective April 18, 1983, expired July 10, 1983. Amended: Filed April 8, 1983, effective July 11, 1983. Emergency amendment filed Dec. 21, 1983, effective Jan. 1, 1984, expired April 11, 1984. Emergency amendment filed March 14, 1984, effective March 28, 1984, expired June 10, 1984. Amended: Filed March 14, 1984, effective June 11, 1984. Amended: Filed Oct. 15, 1984, effective Feb. 11, 1985. Amended: Filed Jan. 15, 1985, effective April 11, 1985. Amended: Filed April 2, 1986, effective Sept. 1, 1986. Amended: Filed June 17, 1986, effective Sept. 1, 1986. Emergency amendment filed Sept. 17, 1986, effective Sept. 27, 1986, expired Jan. 25, 1987. Amended: Filed Aug. 1, 1986, effective Oct. 11, 1986. Amended: Filed Nov. 14, 1986, effective Jan. 30, 1987. Amended: Filed May 4, 1987, effective July 23, 1987. Amended: Filed Jan. 5, 1988, effective March 25, 1988. Amended: Filed April 4, 1988, effective July 1, 1988. Emergency amendment filed Dec. 1, 1989, effective Jan. 1, 1990, expired April 29, 1990. Amended: Filed Dec. 1, 1989, effective Feb. 25, 1990. Amended: Filed Dec. 4, 1989, effective Feb. 25, 1990. Emergency amendment filed June 18, 1991, effective July 15, 1991, expired Oct. 28, 1991. Amended: Filed March 18, 1991, effective Aug. 30, 1991. Emergency amendment filed June 20, 1991, effective July 1, 1991, expired Oct. 28, 1991. Emergency amendment filed Oct. 15, 1991, effective Oct. 29, 1991, expired Feb. 6, 1992. Emergency amendment filed Oct. 15, 1991, effective Oct. 29, 1991, expired Feb. 6, 1992. Amended: Filed June 18, 1991, effective Oct. 31, 1991. Amended: Filed June 18, 1991, effective Oct. 31, 1991.*

*\*Original authority: 208.153, RSMo 1967, amended 1973, 1989, 1991 and 208.201, RSMo 1987.*

**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 publication of the full text of the material that the adopting agency has incorporated by reference in this rule would be unduly cumbersome or expensive. Therefore, the full text of that material*



will be made available to any interested person at both the Office of the Secretary of State and the office of the adopting agency, pursuant to section 536.031.4, RSMo. Such material will be provided at the cost established by state law.

(1) General. This regulation defines the specific procedures used to calculate inpatient and outpatient settlements for Missouri in-state hospitals participating in the Missouri Medicaid program. Although inpatient and outpatient settlements are calculated at the same time, an overpayment for outpatient services shall not be offset against an underpayment for inpatient services.

(A) The hospital's settlement will be determined after the division receives a Medicare/Medicaid cost report from the Medicare fiscal intermediary with a Notice of Provider Reimbursement (NPR). The cost report used for the settlement shall be the one with the latest NPR at the time the settlement is calculated. The data used, except for Medicaid data, shall be as reported in the cost report unless adjusted by this regulation. The current version of the cost report is HCFA 2552-92, and references in this regulation are from this cost report. However, the division will use the version of the report received from the fiscal intermediary, which may change the references.

(B) The Medicaid data used in the final settlements will be from the division's paid claims history. This data includes only claims on which Medicaid made payment.

(2) 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 70-15.010 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

2. *Missouri Medicaid Institutional (Hospital) Manual*.

(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)2.A.-D., 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 (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., or 2.) 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, 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.; and

3. PBRHC and PBFQHC shall be reimbursed one hundred percent (100%) of the lower of its share of the cost in subsection (4)(D) or its charges in paragraph (4)(C)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., or 2.

(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 70-15.010.

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 paragraphs (4)(C)1. To 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 70-15.010. 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 will determine either an overpayment or an underpayment for the hospital's outpatient services and PBRHC or PBFQHC.

1. The outpatient Medicaid cost determined in subsection (4)(D) is multiplied by the percent of cost allowed in paragraph (4)(A)1., or 2., 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; and

2. 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 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. If the amended cost report changes the previous settlement by less than one hundred dollars (\$100) the cost report will not be reopened. If the prior settlement(s) resulted in an overpayment on the inpatient side, then an underpayment, up to the amount of the net inpatient recoupment, may be made.

*AUTHORITY:* sections 208.152, 208.153, 208.201 and 208.471, RSMo 1994. \* Original rule filed June 2, 1994, effective Dec. 30, 1994. Amended: Filed June 3, 1997, effective Dec. 30, 1997. Amended: Filed May 14, 1999, effective Nov. 30, 1999. Amended: Filed June 15, 1999, effective Dec. 30, 1999.

\*Original authority: 208.152, RSMo 1967, amended 1969, 1971, 1972, 1973, 1975, 1977, 1978, 1981, 1986, 1988, 1990, 1992, 1993; 208.153, RSMo 1967, amended 1973, 1989, 1990, 1991; 208.201, RSMo 1987; and 208.471, RSMo 1992.

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

*PURPOSE:* This rule provides the legal basis where 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.

*Editor's Note:* The secretary of state has determined that the publication of this rule in its entirety would be unduly cumbersome or expensive. The entire text of the material referenced has been filed with the secretary of state. This material may be found at the Office of the Secretary of State or at the headquarters of the agency and is available to any interested person at a cost established by state law.

(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) 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;

(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.

(3) Inpatient psychiatric hospital services which are provided within a licensed acute care general hospital are 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.

(4) Reimbursement for inpatient psychiatric hospital services, as provided for in this rule, shall be made in accordance with the provisions for inpatient hospital care reimbursement at 13 CSR 70-15.010 as rescinded effective October 1, 1981, for services prior

to October 1, 1981, and at 13 CSR 70-15.010 as a readopted rule effective October 1, 1981, for services on or after October 1, 1981.

(5) A written and signed certification of need for services must be completed for every admission reimbursed by Medicaid that attests to—

(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 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 also shall 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 develop-

mental 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 as 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.

*AUTHORITY: section 208.201, RSMo Supp. 1987.\* This rule was previously filed as 13 CSR 40-81.053. Emergency rule filed Sept. 24, 1981, effective Oct. 4, 1981, expired Jan. 13, 1982. Original rule filed Sept. 24, 1981, effective Jan. 14, 1982. Emergency amendment filed Sept. 13, 1991, effective Oct. 2, 1991, expired Jan. 29, 1992. Amended: Filed June 18, 1991, effective Dec. 9, 1991.*

*\*Original authority 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.

*AUTHORITY: section 207.020, RSMo 1986.\* This rule was previously filed as 13 CSR 40-81.180. Emergency rule filed July 15, 1981, effective Aug. 1, 1981, expired Oct. 10, 1981. Original rule filed July 15, 1981, effective Oct. 11, 1981.*

*\*Original authority 1945, amended 1961, 1965, 1977, 1981, 1982, 1986.*

### 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.*

*Editor's Note: The secretary of state has determined that the publication of this rule in its entirety would be unduly cumbersome or expensive. The entire text of the material referenced has been filed with the secretary of state. This material may be found at the Office of the Secretary of State or at the headquarters of the agency and is available to any interested person at a cost established by state law.*

(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 care 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 not 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 the following areas:

(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).

*AUTHORITY: sections 208.153, RSMo Supp. 1991 and 208.201, RSMo Supp. 1987.\* This rule was previously filed as 13 CSR 40-*

*81.162. Original rule filed May 3, 1985, effective Sept. 1, 1985. Amended: Filed Nov. 15, 1988, effective Feb. 11, 1989. Amended: Filed April 4, 1989, effective June 29, 1989. Rescinded: Filed Nov. 2, 1989, effective Jan. 26, 1990. Emergency rule filed June 4, 1990, effective June 28, 1990, expired Oct. 25, 1990. Readopted: Filed June 4, 1990, effective Nov. 30, 1990.*

*\*Original authority: 208.153, RSMo 1967, amended 1973, 1989, 1990, 1991 and 208.201, RSMo 1987.*

**13 CSR 70-15.100 Unreimbursed Care Payment Methodology**

*Emergency rule filed May 4, 1992, effective May 15, 1992, expired Sept. 11, 1992.*

**13 CSR 70-15.110 Federal Reimbursement Allowance (FRA)**

*PURPOSE: This rule establishes the formula for determining the Federal Reimbursement Allowance each hospital, except public hospitals which are operated primarily for the care and treatment of mental disorders and any hospital operated by the Department of Health, is required to pay for the privilege of engaging in the business of providing inpatient health care in Missouri.*

(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(3)(B).

(B) Each hospital, except public hospitals which are operated primarily for the care and treatment of mental disorders and any hospital operated by the Department of Health, engaging in the business of providing inpatient health care in Missouri shall pay an FRA. The FRA shall be calculated by the Department of Social Services.

1. The FRA shall be sixty-three dollars and sixty-three cents (\$63.63) per inpatient hospital day from the 1991 base cost report for Federal Fiscal Year 1994. The FRA shall be as described in sections (2), (3) and (4) for succeeding periods.

2. If a hospital does not have a base cost report, total net revenues less Medicaid net revenues shall be estimated as follows:

A. Hospitals required to pay the FRA shall be divided in quartiles based on total beds;

B. Average net revenues less Medicaid net revenues shall be individually summed and divided by the total beds in the quartile to yield an average net revenue less Medicaid net revenue per bed; and

C. Finally, the number of beds for the hospital without the base cost report shall be multiplied by the average net revenue less Medicaid net revenue per bed.

3. The FRA assessment for hospitals that merge operation under one (1) Medicare and Medicaid provider number shall be determined as follows:

A. The previously determined FRA assessment for each hospital shall be combined under the active Medicaid provider number for the remainder of the state fiscal year after the division receives official notification of the merger; and

B. The FRA assessment for subsequent fiscal years shall be based on the combined data for both facilities.

(C) Each hospital shall submit to the Department of Social Services a statement that accurately reflects if the hospital—

1. Is publicly or privately owned;

2. Is operated primarily for the care and treatment of mental disorders;

3. Is operated by the Department of Health; and

4. Accepts payment for services rendered.

(D) The Department of Social Services shall prepare a confirmation schedule of the information from each hospital's third prior year cost report and provide each hospital with this schedule.

1. The schedule shall include:

A. Provider name;

B. Provider number;

C. Fiscal period;

D. Total number of licensed beds;

E. Total inpatient days;

F. Total cost of contractual allowance for Medicare;

G. Total cost of contractual allowance for Medicaid;

H. Gross charges;

I. Charity care; and

J. Bad debts.

2. Each hospital required to pay the FRA shall review this information and provide the Department of Social Services with correct information, if the information supplied by the Department of Social Services is incorrect, or affirm the information is correct within fifteen (15) days of receiving the confirmation schedule. If the hospital fails to submit the corrected data within the fifteen

(15)-day time period, the hospital shall be barred from submitting corrected data later to have its FRA assessment or the add-on payments from 13 CSR 70-15.010 adjusted.

3. Each hospital may request that its FRA be offset against any Missouri Medicaid payment due. Assessments shall be allocated and deducted over the applicable period.

4. The FRA owed or, if an offset has been requested, the balance due, if any, after that offset shall be remitted by the hospital to the Department of Social Services on a twice monthly basis, on the first and fifteenth of each month beginning October 15, 1992. The remittance shall be made payable to the director of the Department of Revenue. The amount remitted shall be deposited in the state treasury to the credit of the Federal Reimbursement Allowance Fund.

(E) In accordance with sections 62.055 and 208.156, RSMo, hospitals may seek a hearing before the Administrative Hearing Commission from a final decision of the director of the department or division.

(2) Federal Reimbursement Allowance (FRA) subsequent to Federal Fiscal Year 1994.

(A) The FRA shall continue at the Federal Fiscal Year 1994 prorated assessment level for the nine (9) Medicaid payrolls from October 1, 1994 through February 19, 1995.

(B) The FRA shall be seventy-two dollars and seventy-five cents (\$72.75) per inpatient hospital day from the 1992 base cost report multiplied by nine twenty-fourths (9/24) for the period February 20, 1995 through June 30, 1995.

(3) FRA for State Fiscal Year (SFY) 1996.

(A) The FRA for SFY 96 shall be seventy-five dollars and eighty-seven cents (\$75.87) per inpatient hospital day from the 1993 base cost report.

(4) FRA for State Fiscal Year 1997.

(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 net operating revenues as determined from information reported on the hospital's 1994 base cost report.

(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 net 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 1995 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 1996 base year cost report.

(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 ninety hundredths percent (5.90%) 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 1997 base year cost report.

*AUTHORITY:* sections 208.201 and 208.453, RSMo 1994 and 208.455, RSMo Supp. 1999.\* *Emergency rule filed Sept. 21, 1992, effective Oct. 1, 1992, expired Jan. 28, 1993. Emergency rule filed Jan. 15, 1993, effective Jan. 25, 1993, expired May 24, 1993. Original rule filed Sept. 21, 1992, effective June 7, 1993. Emergency amendment filed Sept. 2, 1993, effective Sept. 18, 1993, expired Jan. 15, 1994. Amended: Filed Oct. 15, 1993, effective June 6, 1994. Emergency amendment filed Sept. 23, 1994, effective Oct. 3, 1994, expired Feb. 1, 1995. Emergency amendment filed Jan. 20, 1995, effective Jan. 31, 1995, expired May 30, 1995. Emergency amendment filed Feb. 9, 1995, effective Feb. 20, 1995, expired June 19, 1995. Amended: Filed Feb. 9, 1995, effective Aug. 30, 1995. Emergency amendment filed June 20, 1995, effective July 1, 1995, expired Oct. 28, 1995. Emergency amendment filed July 31, 1995, effective Aug. 10, 1995, expired Dec. 7, 1995. Amended: Filed May 19, 1995, effective Dec. 30, 1995. Emergency amendment filed Nov. 27, 1995, effective Dec. 8, 1995, expired June 4, 1996.*

*Amended: Filed Nov. 27, 1995, effective June 30, 1996. Emergency amendment filed June 21, 1996, effective July 1, 1996, expired Dec. 27, 1996. Amended: Filed April 15, 1996, effective Nov. 30, 1996. Emergency amendment filed June 21, 1996, effective July 1, 1996, expired Dec. 31, 1996. Emergency amendment filed Sept. 13, 1996, effective Oct. 1, 1996, expired March 29, 1997. Amended: Filed Sept. 13, 1996, effective April 30, 1997. Emergency amendment filed June 3, 1997, effective July 1, 1997, expired Dec. 27, 1997. Amended: Filed June 3, 1997, effective Dec. 30, 1997. Emergency amendment filed March 2, 1998, effective April 1, 1998, expired Sept. 28, 1998. Amended: Filed March 2, 1998, effective Sept. 30, 1998. Emergency amendment filed Aug. 31, 1998, effective Sept. 10, 1998, expired March 8, 1999. Amended: Filed Jan. 14, 1999, effective July 30, 1999. Emergency amendment filed March 29, 1999, effective April 8, 1999, expired Oct. 4, 1999. Amended: Filed Aug. 16, 1999, effective March 30, 2000. Amended: Filed March 3, 2000, effective Oct. 30, 2000.*

*\*Original authority: 208.201, RSMo 1987; 208.453, RSMo 1992, amended 1993, 1994; and 208.455, RSMo 1992, amended 1993, 1994, 1995.*