

- d. For any remaining outpatient hospital services covered by Medical Assistance, fees will be based on fees for similar services as identified elsewhere in the State plan. For unlisted services and other rare situations where no fee can be calculated, payment will be at a percentage of charges.
2. Payment by fee will be modified in the following situations:
 - a. For bilateral services as appropriately designated by the modifier 50, payment will be at 150% of the otherwise applicable amount.
 - b. For drugs covered under Section 340B of the Public Health Service Act as appropriately designated by the modifier UD, payment will be at 100% of billed charges.
 3. Certain types of services are subject to discount payment when a claim contains more than one line showing procedure codes within each type of service. The line with the highest fee will be paid at 100%, the line with the second-highest fee will be paid at 50% of the otherwise-applicable fee, the line with the third highest fee will be paid at 25% of the otherwise-applicable fee, and the fourth and all subsequent lines will be paid zero. Discounting will only apply within each type of service. For example, if a claim contains three lines for an x-ray, a CT scan, and an ultrasound, each line will be paid 100%. The seven types of service are as follows:
 - a. Significant procedures subject to discounting as designated by Medicare with APC Status "T." (In general, Medical Assistance will use the same list of procedures as Medicare, but specific exceptions may be made.)
 - b. Computed topography scans
 - c. Ultrasound
 - d. X-rays
 - e. Therapeutic radiology
 - f. Nuclear medicine scans
 - g. Magnetic Resonance Imaging
 4. Some claim lines will be packaged, that is, the line will be considered paid but with a payment of zero. Packaging will apply to lines with anesthesia and recovery room codes (regardless of procedure code), lines without procedure codes, and lines with procedure codes designated as packaged under Medicare. (In general, Medical Assistance will use the same list of packaged procedures as Medicare, but specific exceptions may be made.)
 5. Out-of-State hospitals will be reimbursed for outpatient surgery services provided to Rhode Island Medical Assistance Recipients at a rate equal to fifty-three (53%) of the out-of-state hospital's customary charge(s) for such services to Title XIX recipients in that state. The outpatient reimbursement for all other services, exclusive of laboratory, imaging, and physicians, will be sixty-four percent (64%) of the outpatient surgery rate.
 6. Payment for all outpatient services will be final, with no year-end settlement process. .
 7. Hospital outpatient claims and payments are processed through MMIS.
 8. Only hospitals and provider based entities, in accordance with 42 CFR 413.65, are reimbursed according to the outpatient hospital reimbursement methodology.
 - c. Payment will be made for rural health clinic services at the reasonable cost rate per visit established by the Medicare carrier. Payment for each ambulatory service, other than rural health clinic services, will be made in accordance with the rates or charges established for those services when provided in other settings.