Ohio Administrative Code

Rule 4123-6-37.2 Payment of hospital outpatient services.

Effective: May 6, 2021

(A) HPP:

Unless an MCO has negotiated a different payment rate with a hospital pursuant to rule 4123-6-10 of the Administrative Code, reimbursement for hospital outpatient services with a date of service of May 1, 2021 or after shall be the applicable rate set forth in this rule as follows:

(1) Except as otherwise provided in this rule, reimbursement for hospital outpatient services shall be equal to the applicable medicare reimbursement rate for the hospital outpatient service under the medicare outpatient prospective payment system as implemented by the materials specified in paragraph (A)(9) of this rule, multiplied by a bureau-specific payment adjustment factor, which shall be 2.985 for children's hospitals and 1.389 for all hospitals other than children's hospitals, plus the add-on payments set forth in paragraph (A)(4) of this rule, if applicable.

The medicare integrated outpatient code editor and medicare medically unlikely edits in effect as implemented by the materials specified in paragraph (A)(9) of this rule and table 7 of the appendix to this rule shall be utilized to process bills for hospital outpatient services under this rule; however, the outpatient code edits identified in table 1 of the appendix to this rule shall not be applied.

The annual medicare outpatient prospective payment system outlier, hold harmless, and exempt cancer hospital reconciliation processes shall not be applied to payments for hospital outpatient services under this rule.

For purposes of this rule, hospitals shall be identified as critical access hospitals, rural sole community hospitals, essential access community hospitals and exempt cancer hospitals based on the hospitals' designation in the medicare outpatient provider specific file in effect implemented by the materials specified in paragraph (A)(9) of this rule.

For purposes of this rule, the following hospitals shall be recognized as "children's hospitals":

nationwide children's hospital (Columbus), Cincinnati children's hospital medical center, shriners hospital for children (Cincinnati), university hospitals rainbow babies and children's hospital (Cleveland), Toledo children's hospital, children's hospital medical center of Akron, and children's medical center of Dayton.

In the event the centers for medicare and medicaid services makes subsequent adjustments to the medicare reimbursement rates under the medicare outpatient prospective payment system as implemented by the materials specified in paragraph (A)(9) of this rule, other than technical corrections, including but not limited to adjustments related to federal budget sequestration pursuant to the Budget Control Act of 2011, 125 Stat. 239, 2 U.S.C. 900 to 907(d) as amended as of the effective date of this rule, the "applicable medicare reimbursement rate for the hospital outpatient service under the medicare outpatient prospective payment system" as specified in this paragraph shall be determined by the bureau without regard to such subsequent adjustments.

(2) Services reimbursed via fee schedule. These services shall not be wage index adjusted.

(a) Services reimbursed via fee schedule to which the bureau-specific payment adjustment factor shall be applied.

Except as otherwise provided in paragraphs (A)(2)(b)(ii) and (A)(2)(b)(iii) of this rule, hospital outpatient services reimbursed via fee schedule under the medicare outpatient prospective payment system shall be reimbursed under the applicable medicare fee schedule in effect as implemented by the materials specified in paragraph (A)(9) of this rule, plus the add-on payments set forth in paragraph (A)(4) of this rule, if applicable.

(b) Services reimbursed via fee schedule to which the bureau-specific payment adjustment factor shall not be applied.

The following services shall be reimbursed the lesser of the charges billed by the hospital for the allowed services rendered, the applicable fee schedule rates set forth in tables 2, 3, 4 and 5 of the appendix to this rule, or the rate the MCO contracted or negotiated with the hospital:

(i) Hospital outpatient vocational rehabilitation services for which the bureau has established a fee as

set forth in table 2 of the appendix to this rule.

(ii) Hospital outpatient services reimbursed via fee schedule under the medicare outpatient prospective payment system that the bureau has determined shall be reimbursed at a rate other than the applicable medicare fee schedule in effect as implemented by the materials specified in paragraph (A)(9) of this rule, for which the bureau has established a fee as set forth in table 3 of the appendix to this rule.

(iii) Hospital outpatient services not reimbursed under the medicare outpatient prospective payment system that the bureau has determined are necessary for treatment of injured workers, for which the bureau has established a fee as set forth in tables 4 and 5 of the appendix to this rule.

(3) Services reimbursed at reasonable cost. To calculate reasonable cost, the line item charge shall be multiplied by the hospital's outpatient cost to charge ratio from the medicare outpatient provider specific file in effect as implemented by the materials specified in paragraph (A)(9) of this rule. These services shall not be wage index adjusted.

(a) Services reimbursed at reasonable cost to which the bureau-specific payment adjustment factor shall be applied.

Critical access hospitals shall be reimbursed at one hundred one per cent of reasonable cost for all payable line items.

(b) Services reimbursed at reasonable cost to which the bureau-specific payment adjustment factor shall not be applied.

(i) Services designated as inpatient only under the medicare outpatient prospective payment system.

(ii) Hospital outpatient services reimbursed at reasonable cost as identified in tables 3 and 4 of the appendix to this rule.

(4) Add-on payments calculated using the applicable medicare outpatient prospective payment system methodology and formula in effect as implemented by the materials specified in paragraph

(A)(9) of this rule. These add-on payments shall be applied after the application of the bureau-specific payment adjustment factor.

(a) Outlier add-on payment. An outlier add-on payment shall be provided on a line item basis for partial hospitalization services and for ambulatory payment classification reimbursed services for all hospitals other than critical access hospitals.

(b) Rural hospital add-on payment. A rural hospital add-on payment shall be provided on a line item basis for rural sole community hospitals, including essential access community hospitals; however, drugs, biological, devices reimbursed via pass-through and reasonable cost items shall be excluded. The rural add-on payment shall be calculated prior to the outlier add-on payment calculation.

(c) Hold harmless add-on payment. A hold harmless add-on payment shall be provided on a line item basis to exempt cancer centers and children's hospitals. The hold harmless add-on payment shall be calculated after the outlier add-on payment calculation.

(5) Providers not participating in the medicare program.

Reimbursement for outpatient services provided by hospitals and distinct-part units of hospitals that do not participate in the medicare program shall be calculated in accordance with the methodologies set forth in this rule, using the applicable FY21 urban or rural statewide average outpatient cost-to-charge ratio adopted by the medicare program pursuant to the federal rule referenced in paragraph (A)(9)(b) of this rule (the Ohio average cost-to-charge ratio shall be used for hospitals outside the United States).

(6) Reimbursement for outpatient services provided by "new hospitals" as defined in 42 C.F.R. 412.300(b) as published in the October 1, 2020 Code of Federal Regulations shall be calculated in the same manner as provided under paragraph (A)(5) of this rule.

(7) For purposes of this rule, hospitals must report the applicable outpatient revenue codes for accommodation and ancillary services set forth in table 6 of the appendix to this rule.

(8) For purposes of this rule, coverage status for designated hospital outpatient services is set forth in

table 8 of the appendix to this rule.

(9) For purposes of this rule, the "applicable medicare reimbursement rate for the hospital outpatient service under the medicare outpatient prospective payment system " and the "medicare outpatient prospective payment system " shall be determined in accordance with the medicare program established under Title XVIII of the Social Security Act, 79 Stat. 286 (1965), 42 U.S.C. 1395 to 1395lll as amended, as of the effective date of this rule, as implemented by the following materials, which are incorporated by reference:

(a) 42 C.F.R. Part 419 as published in the October 1, 2020 Code of Federal Regulations;

(b) Department of health and human services, centers for medicare and medicaid services' "42 CFR Parts 410, 411, 412, 414, 416, 419, 482, 485, 512 Medicare Program: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs; New Categories for Hospital Outpatient Department Prior Authorization Process; Clinical Laboratory Fee Schedule: Laboratory Date of Service Policy; Overall Hospital Quality Star Rating Methodology; Physician-Owned Hospitals; Notice of Closure of Two Teaching Hospitals and Opportunity To Apply for Available Slots, Radiation Oncology Model; and Reporting Requirements for Hospitals and Critical Access Hospitals (CAHs) To Report COVID-19 Therapeutic Inventory and Usage and To Report Acute Respiratory Illness During the Public Health Emergency (PHE) for Coronavirus Disease 2019 (COVID-19)" final rule 85 Fed. Reg. 85866 - 86305(2020).

(c) The department of health and human services, centers for medicare and medicaid services' hospital-specific cost-to-charge ratio information as of the October 2020 update to the department of health and human services, centers for medicare and medicaid services' outpatient-provider specific file (OPSF).

(B) QHP or self-insuring employer (non-QHP):

A QHP or self-insuring employer may reimburse hospital outpatient services at:

(1) The applicable rate under the methodology set forth in paragraph (A) of this rule; or

(a) For hospitals the department of health and human services, centers for medicare and medicaid services maintains hospital-specific cost-to-charge ratio information on, the hospital's allowable billed charges multiplied by the hospital's cost-to-charge ratio information referenced in paragraph (A)(9)(c) of this rule multiplied by a payment adjustment factor of 1.16, not to exceed sixty per cent of the hospital's allowed billed charges.

(b) For hospitals the department of health and human services, centers for medicare and medicaid services does not maintain hospital-specific cost-to-charge ratio information on the hospital's allowable billed charges multiplied by the applicable FY21urban or rural statewide average outpatient cost-to-charge ratio adopted by the medicare program pursuant to the federal rule referenced in paragraph (A)(9)(b) of this rule (the Ohio average cost-to-charge ratio shall be used for hospitals outside the United States) multiplied by a payment adjustment factor of 1.16, not to exceed sixty per cent of the hospital's allowed billed charges; or

(2) The rate negotiated between the hospital and the QHP or self-insuring employer in accordance with rule 4123-6-46 of the Administrative Code.

(C) Provider-based status

The bureau may request information from any facility billing the bureau for services as a provider-based facility as may be necessary to establish whether the facility meets the criteria for provider-based status under 42 C.F.R. 413.65 as published in the October 1, 2020 Code of Federal Regulations. The information requested may include an attestation by the facility.