Ohio Administrative Code

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

Effective: May 1, 2024

(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, 2024 or after will be the applicable rate set forth in this rule as follows:

(1) Except as otherwise provided in this rule, reimbursement for hospital outpatient services will 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)(10) of this rule, multiplied by a bureau-specific payment adjustment factor, which will be 2.758 for children's hospitals and 1.485 for all hospitals other than children's hospitals, plus the add-on payments set forth in paragraph (A)(4) of this rule, if applicable.

BWC will use 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 8 of the appendix to this rule to process bills for hospital outpatient services under this rule; however, BWC will not apply the outpatient code edits identified in table 1 of the appendix to this rule.

BWC will not apply the annual medicare outpatient prospective payment system outlier, hold harmless, and exempt cancer hospital reconciliation processes to payments for hospital outpatient services under this rule.

For purposes of this rule, hospitals are 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)(10) of this rule.

For purposes of this rule, the following hospitals are 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.

Reimbursement for any hospital outpatient services identified in table 6 of the appendix to this rule will be determined using the medicare outpatient prospective payment system methodology as set forth in this paragraph, applying the status indicator and ambulatory payment classification specified for the service in table 6 of the appendix to this rule.

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)(10) 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 will be determined by the bureau without regard to such subsequent adjustments.

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

(a) Services reimbursed via fee schedule to which the bureau-specific payment adjustment factor will 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 will be reimbursed under the applicable medicare fee schedule in effect as implemented by the materials specified in paragraph (A)(10) 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 will not be applied.

The following services will 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 will be reimbursed at a rate other than the applicable medicare fee schedule in effect as implemented by the materials specified in paragraph (A)(10) 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 will 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)(10) of this rule. These services will not be wage index adjusted.

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

Notwithstanding any other reimbursement methodology set forth in this rule, critical access hospitals will 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 will 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)(10) of this rule. These add-on payments will be applied after the application of the bureau-specific payment adjustment factor.

(a) Outlier add-on payment. An outlier add-on payment will 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 will 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 will be excluded. The rural add-on payment will be calculated prior to the outlier add-on payment calculation.

(c) Hold harmless add-on payment. A hold harmless add-on payment will be provided on a line item basis to exempt cancer centers and children's hospitals. The hold harmless add-on payment will 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 will be calculated in accordance with the methodologies set forth in this rule, using the applicable FY24 urban or rural statewide average outpatient cost-to-charge ratio adopted by the medicare program pursuant to the federal rule referenced in paragraph (A)(10)(b) of this rule (the Ohio average cost-to-charge ratio will 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, 2023 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 are to report the applicable outpatient revenue codes for accommodation and ancillary services set forth in table 7 of the appendix to this rule.

(8) For purposes of this rule, coverage status for designated hospital outpatient services is set forth in table 9 of the appendix to this rule.

(9) For purposes of this rule, services subject to always and sometimes therapy editing are set forth in table 10 of the appendix to this rule.

(10) 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 " will 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, 2023 Code of Federal Regulations;

(b) Department of health and human services, centers for medicare and medicaid services' "42 CFR Parts 405, 410, 416, 419, 424, 485, 488, 489 Medicare Program: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems; Quality Reporting Programs; Payment for Intensive Outpatient Services in Hospital Outpatient Departments, Community Mental Health Centers, Rural Health Clinics, Federally Qualified Health Centers, and Opioid Treatment Programs; Hospital Price Transparency; Changes to Community Mental Health Centers Conditions of Participation, Proposed Changes to the Inpatient Prospective Payment System Medicare Code Editor; Rural Emergency Hospital Conditions of Participation Technical Correction" final rule 88 Fed. Reg. 81540 - 82185 (2023).

(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 2023 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)(10)(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 FY24 urban or rural statewide average outpatient cost-to-charge ratio adopted by the medicare program pursuant to the federal rule referenced in paragraph (A)(10)(b) of this rule (the Ohio average cost-to-charge ratio will 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, 2023 Code of Federal Regulations. The information requested may include an attestation by the facility.