4123-6-37.2 Payment of hospital outpatient services.

(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, ~~2017~~ 2018 or after shall be the applicable rate set forth in paragraphs (A)(1) to (A)(~~6~~7) of 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)(~~7~~8) of this rule, multiplied by a bureau-specific payment adjustment factor, which shall be ~~2.669~~ 2.664 for children's hospitals and ~~1.529~~ 1.447 for all hospitals other than children's hospitals.

The medicare integrated outpatient code editor and medicare medically unlikely edits in effect as implemented by the materials specified in paragraph (A)(~~7~~8) of 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)(~~7~~8) 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.

~~The medicare site-neutral payment provisions of Section 603 of the Bipartisan Budget Act of 2015, 129 Stat. 584, 42 U.S.C. 42 U.S.C. 1395l(t)(1)(B)(v) and (t)(21) as amended as of the effective date of this rule, shall not be applied to payments to non-excepted provider-based departments for hospital outpatient services under this rule. Provider-based and non-excepted provider-based departments shall follow medicare outpatient prospective payment system billing guidelines as implemented by the materials specified in paragraph (A)(7) of this rule, including the use of modifier PN. However, bills submitted to the bureau by a non-excepted provider-based department shall not be subject to the medicare site-neutral reimbursement reduction.~~

Reimbursement for hospital outpatient services identified in table 6 of the appendix to this rule shall be determined using the medicare outpatient prospective payment system methodology as set forth in this

paragraph, applying the status indicator, ambulatory payment classification, relative weight, and medicare base payment amount specified for the service in table 6.

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)(~~7~~8) 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)(~~7~~8) of this rule.

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

(i) Hospital outpatient vocational rehabilitation services for which the bureau has established a fee, which shall be reimbursed in accordance with 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)(~~7~~8) of this rule, which shall be reimbursed in accordance with table 3 of the appendix ~~A~~ 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, which shall be reimbursed in accordance with 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)(~~7~~8) 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)(~~7~~8) of this rule. These add-on payments shall be calculated prior to 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 ~~a default hospital outpatient cost-to-charge ratio of forty-seven per cent where applicable~~ the applicable FY18 urban or rural statewide average outpatient cost-to-charge ratio set forth in table 9 of the federal rule referenced in paragraph (A)(8)(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, ~~2016~~ 2017 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 7 of the appendix to this rule.

(8) 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~~, excluding 42 U.S.C. 1395l(t)(1)(B)(v) and (t)(21)~~, as implemented by the following materials, which are incorporated by reference:

(a) 42 C.F.R. Part 419 as published in the October 1, ~~2016~~ 2017 Code of Federal Regulations;

(b) Department of health and human services, centers for medicare and medicaid services' "42 CFR Parts 414, 416, and 419~~, 482, 486, 488, and 495~~ Medicare Program: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs~~; Organ Procurement Organization Reporting and Communication; Transplant Outcome Measures and Documentation Requirements; Electronic Health Record (EHR) Incentive Programs; Payment to Nonexcepted Off-Campus Provider-Based Department of a Provider; Hospital Value-Based Purchasing (VBP) Program; Establishment of Payment Rates Under the Medicare Physician Fee Schedule for Nonexcepted Items and Services Furnished by an Off-Campus Provider-Based Department of a Hospital~~; Final Rule", ~~81~~ 82 Fed. Reg. ~~79562 - 79892~~ 59216 - 59497 (~~2016~~ 2017).

(c) The department of health and human services, centers for medicare and medicaid services' hospital-specific cost-to-charge ratio information as of the July 2017 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 ~~maintained~~ maintains hospital-specific cost-to-charge ratio information on~~as of January 1, 2017, based on the hospitals' submitted cost report (CMS-2552-10)~~, the hospital's allowable billed charges multiplied by the hospital's ~~reported~~ cost-to-charge ratio ~~(from the outpatient provider specific file in use by medicare on January 1, 2017)~~ information referenced in paragraph (A)(8)(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 ~~did~~ does not maintain hospital-specific cost-to-charge ratio information on~~as of January 1, 2017~~, the hospital's allowable billed charges multiplied by the applicable ~~FY17~~ FY18 urban or rural statewide average outpatient cost-to-charge ratio set forth in table ~~4~~ 9 of the federal rule referenced in paragraph (A)(~~7~~8)(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.

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