

5160-2-75

Outpatient hospital reimbursement.

Effective for dates of service on or after the effective date of this rule, eligible providers of hospital services as defined in rule 5160-2-01 of the Administrative Code and assigned to prospective payment peer group as described in 5160-2-05 of the Administrative Code are subject to the enhanced ambulatory patient grouping system (EAPG) prospective payment methodology utilized by the Ohio department of medicaid as described in this rule.

(A) Definitions.

- (1) "Enhanced ambulatory patient grouping (EAPG)" is a group of outpatient procedures, encounters, or ancillary services, which reflect similar patient characteristics and resource utilization and which incorporate the use of International Classification of Diseases diagnosis codes, current procedural terminology (CPT) code set and healthcare common procedure coding system (HCPCS) procedure codes.
- (2) "EAPG grouper" is the software provided by 3M Health Information Systems to group outpatient claims based on services performed and resource intensity.
- (3) "Default EAPG settings" are the default EAPG grouper options in 3M's core grouping software for each EAPG grouper version.
- (4) "Discounting factor" is a factor applicable for multiple significant procedures and/or repeated ancillary services designated by default EAPG settings. The appropriate percentage (fifty or one hundred per cent) will be applied to the highest weighted of the multiple procedures or ancillary services payment group.
 - (a) "Full payment" is the EAPG payment with no applicable discounting factor.
 - (b) "Consolidation factor" is a factor of zero per cent applicable for services designated with a same procedure consolidation flag or clinical procedure consolidation flag by the EAPG grouper under default EAPG settings.
 - (c) "Packaging factor" is a factor of zero per cent applicable for services designated with a packaging flag by the EAPG grouper under default EAPG settings.
- (5) "EAPG base rate" is the dollar value that shall be multiplied by the final EAPG weight for each EAPG on a claim to determine the total allowable medicaid payment for a visit.
- (6) "Hospital peer groups" are for the purposes of setting rates and making payments under the EAPG or prospective payment system. The department

classifies all hospitals not excluded in rule 5160-2-05 of the Administrative Code into one of the mutually exclusive peer groups defined in this paragraph.

- (a) Critical access hospitals as defined in rule 5160-2-05 of the Administrative Code.
 - (b) Rural hospitals as defined in rule 5160-2-05 of the Administrative Code.
 - (c) Children's hospitals as defined in rule 5160-2-05 of the Administrative Code.
 - (d) Teaching hospitals as defined in rule 5160-2-05 of the Administrative Code.
 - (e) Urban hospitals as defined in rule 5160-2-05 of the Administrative Code.
 - (f) All other hospitals not located in Ohio that are not classified in paragraph (A)(6)(a) through (A)(6)(e).
- (7) "Interim period" is the initial time after EAPG implementation when data collection will occur to determine EAPG relative weights for services not currently paid under the EAPG system implemented on the effective date of this rule. The interim period will begin on the effective date of this rule and will last at least six months.
- (8) "Transitional period" is the initial time after EAPG implementation and prior to the department's next EAPG rebasing, wherein EAPG relative weights and peer group base rates are recalculated.
- (9) "Outpatient claim" encompasses the outpatient services rendered to one eligible medicaid recipient on one date of service.
- (10) "Outpatient invoice" is a bill submitted in accordance with chapter 5160-1 of the Administrative Code, to the department for services rendered to one eligible medicaid recipient on one or more date(s) of service. For an invoice encompassing more than one date of service, each date will be processed separately as an individual claim.
- (11) "Procedure code" is the current procedural terminology (CPT) codes or healthcare common procedure coding system (HCPCS) as identified in rule 5160-1-19 of the Administrative Code.
- (12) "Relative weight" is a factor specific to each EAPG that represents that EAPG's relative cost compared to an average case. The relative weights for all EAPGs are calculated as described in paragraph (F) of this rule.

(13) "Revenue center codes" are those in effect on the date of service and are listed in the department's hospital billing guidelines as published on the department's web site, <http://medicaid.ohio.gov/>.

(B) EAPG payment formula.

For dates of service during the interim period, total EAPG payment is the product of the following for each detail line:

(1) Hospital specific base rate adjusted for risk corridor as described in paragraph (E) of this rule; times

(2) EAPG relative weight for which the service was assigned by the EAPG grouper, rounded to the nearest whole cent.

(3) Multiply the product of (B)(2) by the applicable discounting factor(s) as defined in paragraph (A)(4) of this rule;

(a) Laboratory services billed with valid HCPCS code(s) 36415, 36416, 78267, 78268 and/or 80000-89999 shall be reimbursed the lesser of charges or the assigned EAPG payment.

(b) Radiology services billed with valid CPT code 36251-36254, 62302-62305 and/or 70000-79999 shall be reimbursed the lesser of charges or the assigned EAPG payment.

(4) Rounded to the nearest whole cent.

(C) Sources for inputs in the payment formula.

The dataset used as inputs in the payment formula and determination of relative weights established for dates of service on or after the effective date of this rule consists of:

(1) All outpatient hospital claims with dates of service from January 1, 2012 through December 31 2014;

(2) Cost reports submitted by hospitals to the department on its medicaid cost report for the hospital years that end in state fiscal years 2012 (ODM 02930 rev. 4/2012), 2013 (ODM 02930 rev. 4/2013), 2014 (ODM 02930 rev. 4/2014) and 2015 (ODM 02930 rev 4/2015); and

(3) Inflation factors computed for Ohio by a nationally recognized research firm that computes similar factors for the medicare program. The inflation factors were used to inflate the total cost computed for each case inflating it to June 30, 2017.

(D) Computation of case mix adjusted average cost per case (base rate).

- (1) For each Ohio peer group, sum the total inflated cost for all case; divided by
- (2) The number of cases assigned to each peer group; and multiply the result by seventy-one and nine tenths per cent.
- (3) For each Ohio peer group, sum the relative weight values for all cases assigned to the peer group; divided by
- (4) The number of cases in the peer group.
- (5) Multiply the amount in (D)(2) by the product of (D)(3) and (D)(4).
- (6) For non-Ohio peer groups, the peer group base rate is seventy per cent of the statewide average.

(E) Risk corridors.

Effective for discharges on or after the effective date of this rule, the department will apply the following to Ohio hospital peer groups:

- (1) The peer group base rate calculated in paragraph (D) of this rule if the peer group base rate does not result in more than a zero per cent reduction or five per cent gain in payments compared to the prospective payment system in effect prior to the effective date of this rule; or
- (2) A hospital-specific base rate established to ensure the new peer group base rate does not result in more than a zero per cent reduction or five per cent gain in payments compared to the prior prospective payment system.

(F) Computation of relative weights.

The relative weight is equal to:

- (1) The average inflated cost per case within each EAPG; divided by
- (2) The average inflated cost per case across all EAPGs.

(G) Items which may be paid outside of EAPG.

- (1) Select items may follow the payment methodology listed in paragraphs (G)(1)(a) through (G)(1)(f) of this rule.

(a) Pharmaceuticals.

- (i) When applicable, reimbursement for outpatient hospital

pharmaceuticals shall be the lesser of charges or the payment amounts in the provider-administered pharmaceutical fee schedule as published on the department's web site, <http://medicaid.ohio.gov/>.

(ii) Additional payments for pharmaceuticals will be made in accordance with the discounting factors as determined by the EAPG grouper.

(iii) Pharmaceutical line items without a National Drug Code will be denied payment by the department.

(b) Durable medical equipment (DME).

(i) Additional payments for DME may be made for all line items grouping to EAPG codes 01001, 01002, 01003, 01004, 01005, 01006, 01007, 01008, 01009, 01010, 01011, 01012, 01013, 01014, 01015, 01016, 01017, 01018, 01019, or 01020.

(ii) Reimbursement for outpatient hospital DME shall be the lesser of charges or the payment amounts in the medicaid durable medical equipment fee schedule as published on the department's website, <http://medicaid.ohio.gov/>.

(iii) Additional payments for DME will be made in accordance with the discounting factors as determined by the EAPG grouper.

(c) Independently billed services for drugs or medical supplies and devices.

(i) To request independently billed payment under EAPG, hospitals must report all services provided on the date of service; and

(ii) Report modifier UB with the primary procedure performed. Claims submitted with modifier UB are subject to the following payment methodology:

(a) Charges listed in line items that carry revenue center codes 025X and/or 0636 with a provider administered HCPCS J-code or Q-code will pay in accordance to the provider-administered pharmaceutical fee schedule.

(b) Charges listed in line items that carry revenue center code 025X without a provider-administered pharmaceutical CPT/HCPCS code or revenue center code 027X with or without a DME HCPCS code will pay in accordance to paragraph (G)(1)(c)(ii)(d) of this rule.

(c) Charges listed in line items that carry revenue center code 025X and/or 0636 with a provider-administered pharmaceutical HCPCS J-code, except HCPCS J-code J0714, that are not listed on the provider-administered pharmaceutical fee schedule or listed as "by report" will pay in accordance to paragraph (G)(1)(c)(ii)(d) of this rule.

(d) Payment for charges listed in paragraphs (G)(1)(c)(ii)(b) or (G)(1)(c)(ii)(c) is the product of the following for each detail line:

(i) Allowed charges multiplied by the hospital's specific medicaid outpatient cost-to-charge ratio as described in paragraph (B)(2) of rule 5160-2-22 of the Administrative Code, rounded to the nearest whole cent.

(ii) Multiply the product of (G)(1)(c)(ii)(d)(i) by sixty per cent; rounded to the nearest whole cent.

(e) Charges listed in line items that carry revenue center code 025X and/or 0636 with a non-pharmaceutical HCPCS Q-code not listed on the provider-administered pharmaceutical fee schedule will be denied payment by the department.

(f) All other detail lines on the same date of service will be paid zero.

(d) Dental services.

For dates of service during the interim period: reimbursement for claims assigned to dental service EAPG 00350, 00351, 00352, 00353, 00354, 00355, 00356, 00357, 00358, 00359, 00360, 00361, 00362, 00363, 00364, 00365, 00366, 00367, 00368, 00369, 00370, 00371, or 00372 will be paid as follows:

(i) Children's hospitals, as defined in rule 5160-2-05 of the Administrative Code, will be paid one-thousand sixty-two dollars.

(ii) All other hospitals will be paid one-thousand one-hundred ninety-two dollars.

(iii) Payments shall be multiplied by any applicable discounting factor, rounded to the nearest whole cent.

(e) Vaccines for children (VFC).

- (i) The administration of immunizations covered under the VFC program may be reimbursed for recipients eighteen years or younger.
- (ii) Reimbursement for the administration of immunizations covered under the VFC program will be ten dollars for individuals eighteen years of age or younger, contingent upon the EAPG grouper. However, no payment will be made for vaccines that can be obtained at no cost through the federal VFC program.
- (iii) Additional payments for designated free vaccines will be made in accordance with the discounting factors as determined by the EAPG grouper.

(f) Observation services.

- (i) For dates of service during the interim period: payment for observation HCPCS code G0378 will be made using an average rate.
- (ii) Payments for observation services grouped to EAPG code 00450, 00500, 00501, or 00502, will be limited to one unit per day, and a maximum of two consecutive days, except as provided in paragraph (G)(f)(iii) of this rule.
- (iii) Payments for observation services reported with HCPCS code G0378 will be made for up to twenty-four units per day or forty-eight consecutive units (which could extend over a three-day period).
- (iv) Additional payment for observation services will be made in accordance with the discounting factors as determined by the EAPG grouper.

(2) Additional items paid outside of EAPG.

Behavioral health (BH) services. As used in this paragraph, "Behavioral health services" refers to mental health and substance use disorder services.

(a) To receive payments described in this paragraph, all hospitals that provide outpatient BH services must:

- (i) Meet the medicare conditions of participation;

(ii) Have accreditation by a national accrediting body; and

(iii) Have accreditation for the BH services they provide.

(b) Each hospital claim for BH services must contain the following:

(i) HE modifier at the detail level for each BH CPT/HCPCS code;

(ii) Revenue center code 0671, 0900, 0904, 0906, 0907, 0911, 0912, 0913, 0914, 0915, 0916, 0918, 0919 or 1002 for each BH detail line; and

(iii) A BH diagnosis code.

(c) Payments for BH services will be paid the lesser of charges or in accordance with the outpatient hospital behavioral health fee schedule as published on the department's website, <http://medicaid.ohio.gov/>.

(d) Notwithstanding rule 5160-2-02(B)(2) of the Administrative Code, BH services reimbursed under this paragraph are excluded from inpatient services.

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