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Reimbursement Policy

Outpatient Hospital

Policy Number: 4.17
Version Number: 5
Version Effective Date: 11/01/2021

Product Applicability

☐ **All Plan+ Products**

Well Sense Health Plan
☐ Well Sense Health Plan

Boston Medical Center HealthNet Plan
☒ MassHealth MCO
☒ MassHealth ACO
☒ Qualified Health Plans/ConnectorCare/Employer Choice Direct
☐ Senior Care Options

Note: Disclaimer and audit information is located at the end of this document.

Policy Summary

The Plan will reimburse acute hospitals for covered outpatient services based on the contractual terms within their Participating Provider Agreement and the terms of this policy. The terms of your contract may supersede specific sections of this policy only to the extent that the specific service is explicitly referenced within your provider contract.

Prior-Authorization

Please refer to the Plan's Prior Authorization Requirements Matrix at www.bmchp.org.

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Definitions

Outpatient Hospital Services – Medical services provided to a member in a hospital outpatient department. Such services include, but are not limited to, emergency services, primary-care services, observation services, ancillary services, and day-surgery services.

Actual Acquisition Cost - the Hospital's invoice price for the drug, net of all on-or-off invoice reductions, discounts, rebates, charge backs and similar adjustments that the Hospital has or will receive from the drug manufacturer or other party for the drug that was administered to the Member including any efficacy, outcome, or performance-based guarantees (or similar arrangements), whether received pre-or post-payment.

Performance-Based Guarantee - refers to any efficacy, outcome, or performance-based guarantee (or similar arrangement) from the drug manufacturer (or other party) to the hospital that applies to the treatment of the member with the carve-out drug in question, whether or not such an arrangement is required by the Plan

Provider Reimbursement

Adjudicated Payment per Episode of Care (APEC)

The Plan reimburses outpatient hospital services based on the Executive Office of Health and Human Services (EOHHS) Adjudicated Payment per Episode of Care (APEC) payment methodology. This reimbursement is a hospital specific, episode specific, all-inclusive facility payment. The Plan uses the 3M Enhanced Ambulatory Patient Groups (EAPG) according to the EOHHS reimbursement methodology. The Plan utilizes EOHHS assigned weights and hospital rates. The rate assigned to a payable EAPG line is determined by multiplying the base rate by the EAPG weight.

APEC Episode

An episode includes all of the services rendered to a member on one calendar day. An exception to the one calendar day rule is emergency room and observation episodes that cross calendar days. Hospitals are required to include all APEC covered services corresponding to the episode on a single claim. Each claim line must contain only one date of service. Subsequent related claims received after the initial claim will be denied. For unrelated episodes that occur on a single calendar day condition code G0 (G zero) is required on subsequent claims.

APEC Outlier

The APEC outlier component is equal to the difference between the episode-specific case cost and the episode-specific outlier threshold, which is then multiplied by the marginal cost factor.

Ancillary Services

Ancillary services are packaged when a significant procedure or a medical visit is performed on the same date of service. Packaged ancillary services are not separately reimbursed. Ancillary services will be reimbursed when a significant procedure or medical visit is not reported for the same date of service.

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Consolidation
Multiple related significant or clinically related procedures performed on the same date of service will be reimbursed as a single EAPG.

Multiple Services Discounting
Multiple related, significant procedures will be discounted as follows:
- The largest weighted procedure EAPG will be paid at 100%.
- All other related, significant procedure EAPGs will be paid at 50%.

Multiple related, payable ancillary services will be discounted as follows:
- The largest weighted procedure EAPG will be paid at 100%.
- The second largest weighted procedure EAPG will be paid at 50%.
- All other related, payable ancillary EAPGs will be paid at 25%.

Bilateral Procedure Discounting
Bilateral procedures reported with modifier 50 will pay at 150%.

Terminated Procedures
Terminated procedures reported with modifiers 52 or 73 will pay at 50%.

Incidental Services
Incidental services identified by 3M are never separately reimbursed.

Emergency /Observation Services
All services related to an emergency room or observation visit provided on the same date of service and subsequent dates of service are reimbursed as a single episode. Revenue code 450 must be submitted to identify emergency room services. Revenue code 762 must be submitted to identify observation services. For other reimbursement guidelines related to observation services see the Plan's reimbursement policy *Observation Services, 4.36*.

Drug Waste/Discarded Drugs and Biologicals
The Plan does not reimburse providers for drug waste. Providers are required to report the JW modifier on claims with unused drugs or biologicals from single use vials or single use packages that are appropriately discarded. Providers should report drug waste on a separate and distinct claim line with the procedure code along with modifier "JW". Drug waste will be denied as not reimbursable.

Outpatient Services Related To an Inpatient Stay
All outpatient services rendered on the same date of an inpatient admission are included in the reimbursement for the inpatient admission. These outpatient services must be reported on the inpatient claim. Please refer to the Plan's reimbursement policy *Inpatient Hospital, 4.110*.

Services Paid Outside of the APEC Methodology
The following services are separately reimbursed from the APEC payment:

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- Professional fees
- Ambulance Services
- Laboratory Services
  - Hospitals will be paid for surgical pathology services rendered by hospital based physicians.
  - A professional component is only payable for services which require a written interpretation and report. Any other professional service rendered associated with a lab will be denied by the Plan.
- Audiology dispensing services provided by a hospital based audiologist
- Ophthalmic dispensing services provided by a hospital based optometrist, ophthalmologist or other licensed ophthalmic dispensing practitioner
- APEC Carve-Out drugs
- Emergency department dispensed Nasal Naloxone packages
- Emergency Service Program Services (ESP) for behavioral health crises in the emergency department
- Certain MassHealth Outpatient Physician Administered Drugs to be Paid by Fee Schedule

APEC Carve Out Drugs

The Plan will separately reimburse providers for Carve-Out drugs that are identified on the MassHealth Acute Hospital Carve-Out Drugs List published on the MassHealth website. The Plan reimburses for APEC Carve-Out Drugs separately from the outpatient hospital payment in accordance with following guidelines:

- Payment to Hospitals for APEC Carve-Out Drugs administered to members during an acute outpatient hospital visit will be the Hospital's "actual acquisition cost" of the Drug.
- Costs, charges, and any other claims-based data corresponding to the APEC Carve-Out Drug must be excluded from the facility/institutional outpatient visit claim; and
- Hospitals must submit claims for payment for APEC Carve-Out Drugs on a UB-04/facility claim separate from the claim for the visit; and
- Hospitals must include the National Drug Code (NDC) and corresponding HCPCS for the drug, as well as the number of units administered to the member to ensure accurate payment; and
- Hospital must include the following as separate attachments to the claim for the APEC Carve-Out Drug:
  1. A statement of the Hospital's actual acquisition cost of the drug; and
  2. A copy of the invoice for the APEC Carve-Out Drug from the drug manufacturer, supplier, distributer, or other similar party; and
  3. Any other evidentiary documentation, if applicable.
- In the event that the hospital is a party to or a direct beneficiary of a performance-based guarantee from the drug manufacturer (or other party), and the terms of the performance-based guarantee allow the hospital to pay in full or in part for the carve-out drug only if certain conditions are met (e.g., the hospital is only required to pay for the drug if the member goes into remission), the hospital must not submit a claim to the Plan for the carve-out drug until the hospital actually makes the payment it will be required to make to the drug manufacturer or

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other party and must not submit any claim for the carve-out drug to the Plan in the event that it is not ultimately required to pay for the drug.

Nasal Naloxone Packages Distributed by Acute Outpatient Hospital Emergency Departments

The Plan will separately reimburse acute outpatient hospitals outside of the APEC methodology at the fee schedule rate for nasal naloxone packages distributed to a member through the Emergency Department (ED). Outpatient hospitals should include the claim line for the distribution of nasal naloxone on the same claim as the ED visit. Outpatient hospitals must include all of the following information when submitting claims for reimbursement of nasal naloxone packages dispensed to members through their Emergency Departments (ED):

- HCPCS code: J3490
- Revenue code: 636
- Modifier: HG

Hospitals may not bill for distribution of the package as a Hospital-based Physician service.

ESP Services for Behavioral Health Crises in the Emergency Department

The Plan will reimburse hospitals providing Emergency Service Program (ESP) services in the Emergency Department to members experiencing behavioral health crises. Hospitals should bill code S9485 for this service. Reimbursement for this service is in addition to other services rendered to the member as part of the Emergency department visit.

Certain MassHealth Outpatient Physician Administered Drugs to be Paid by Fee Schedule

The Plan will separately reimburse acute outpatient hospitals outside of the APEC methodology at the fee schedule rate for outpatient administration of certain physician administered drugs identified on the "Certain MassHealth Outpatient Physician Administered Drugs to be paid by fee schedule" section of the MassHealth Drug List (Fee Schedule Drugs). The list of Fee Schedule Drugs may be updated from time-to-time. Payment to hospitals for the outpatient administration of any Fee Schedule Drug shall be the amount as listed by the quarterly Medicare Part B Drug Average Sales Price for the Fee Schedule Drug, as set forth on CMS's website.

Hospital Based Physicians

A hospital-based physician or dentist may not bill for any professional component of a service that is billed by the hospital.

Service Limitations

The Plan does not reimburse the following services:

- Serious Reportable Events ("SREs")/Provider Preventable Conditions (PPCs)– for additional information, refer to the Quality Management section of the Provider Manual as well as the Plan's reimbursement policy *Provider Preventable Conditions and Serious Reportable Events, 4.610*
- Experimental, Investigational, or Cosmetic services – including all supporting services even when those supporting services may be reimbursed under other circumstances
- Outpatient services provided to any member who is concurrently an inpatient of any hospital.

Policy History

Original Approval Date	Original Effective Date	Policy Owner	Approved by
11/18/2016	12/30/2016	Payment Policy	Payment Policy Committee

Policy Revisions History			
Review Date	**Summary of Revisions**	**Revision Effective Date**	**Approved by**
11/15/2016	Retired Outpatient Hospital policy for dates of service prior to 12/30/2016; new policy effective for dates of service on or after 12/30/2016	12/30/2016	Payment Policy Committee
04/01/2020	Added reimbursement requirements for Nasal Naloxone.	04/01/2020	Payment Policy Committee
12/15/2020	Annual Review. Added language for APEC Carve-Out drugs	01/01/2021	Payment Policy Committee
06/15/2021	Added section for drug waste/unused drugs and biologicals.	07/01/2021	Payment Policy Committee
11/16/2021	Added language for Certain Physician administered drugs reimbursement by Fee schedule	11/01/2021	Payment Policy Committee

Other Applicable Policies

Reimbursement Policies:

- Dental Services, 4.15
- General Billing and Coding Guidelines, 4.31
- General Clinical Editing and Payment Accuracy Review Guidelines, 4.108

- Hearing Aid Dispensing and Repairs, 4.111
- Inpatient Hospital, 4.110
- Modifiers, 4.23
- Observation Services, 4.36
- Physician and Non Physician Practitioner Services, 4.608
- Provider Preventable Conditions and Serious Reportable Events, 4.610
- Transportation, 4.113
- Vision Services, 4.38

References

- 130 CMR 410 – Outpatient Hospital
- 244 CMR 4.00 – Advanced Practice Registered Nursing
- MassHealth Regulation Acute Outpatient Hospital Manual, Subchapter 6
- MassHealth Managed Care Bulletin 42
- CMS Medicare Part B Drug Average Sales Price (ASP) quarterly pricing files
- MassHealth Drug List
- Certain MassHealth Outpatient Physician Administered Drugs to be Paid by Fee Schedule
- MassHealth Acute Hospital Carve-Out Drugs list
- BMC HealthNet Plan Qualified Health Plans, including ConnectorCare Evidence of Coverage
- Contract between The Office of Health and Human Services (EOHHS), and Boston Medical Center HealthNet Plan MassHealth
- Form of Contract between the Commonwealth Health Insurance Connector Authority and Boston Medical Center HealthNet Plan

Disclaimer Information

This Policy provides information about the Plan's reimbursement/claims adjudication processing guidelines. The use of this Policy is neither a guarantee of payment nor a final prediction of how specific claim(s) will be adjudicated. Reimbursement is based on many factors, including member eligibility and benefits on the date of service; medical necessity; utilization management guidelines (when applicable); coordination of benefits; adherence with applicable Plan policies and procedures; clinical coding criteria; claim editing logic; and the applicable Plan – Provider agreement. Member cost-sharing (deductibles, coinsurance and copayments) may apply – depending on the member's benefit plan. Unless otherwise specified in writing, reimbursement will be made at the lesser of billed charges or the contractual rate of payment. Plan policies may be amended from time to time, at Plan's discretion. Plan policies are developed in accordance with applicable state and federal laws and regulations, and accrediting organization guidelines (including NCQA). The Plan reserves the right to conduct Provider audits to ensure compliance with this Policy. If an audit determines that the Provider did not comply with this Policy, the Plan will expect the Provider to refund all payments related to non-compliance. For more information about the Plan's audit policies, refer to the Provider Manual.