Reimbursement Policy

Outpatient Hospital

Policy Number: 4.17
Version Number: 1
Version Effective Date: 12/30/2016

Product Applicability

- All Plan Products

Well Sense Health Plan
- New Hampshire Medicaid
- NH Health Protection Program

Boston Medical Center HealthNet Plan
- MassHealth
- 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.

Outpatient Hospital Services Reimbursement

Adjudicated Payment per Episode of Care (APEC)
Effective for dates of service on or after 12/30/2016 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 EAPG grouper according to the EOHHS reimbursement methodology. The Plan uses 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.

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

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%.

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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 Observation Reimbursement Policy, 4.36.

**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 Inpatient reimbursement policy, 4.112.

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

- 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

**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.

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Service Limitations

- 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 Serious Reportable Event (SRE)/Provider Preventable Condition (PPC), 4.610
- Experimental, Investigational, or Cosmetic services—including all supporting services even when those supporting services may be reimbursed under other circumstances
- Hospitals will not be reimbursed for outpatient services provided to any member who is concurrently an inpatient of any hospital.

Policy History

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Policy Revisions History

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<td>11/15/2016</td>
<td>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</td>
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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, 4.112
- Observation Services, 4.36
- Physician and Non Physician Practitioner Services, 4.608
- Serious Reportable Event (SRE)/Provider Preventable Condition (PPC), 4.610
- Transportation, 4.113
- Vision Services, 4.38

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References

- 114.1 CMR 36.00 – Acute Care Hospital
- 130 CMR 410 – Outpatient Hospital
- 244 CMR 4.00 – Hospital-Based Non-Physician Practitioners
- 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
- Notice of Final Agency Action: MassHealth Payment for In-State Acute Hospital Services and Out-Of-State Acute Hospital Services, effective October 1, 2016

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.

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