Bureau of Workers' Compensation

Hospital Outpatient Reimbursement Methodology

BWC Rate Year 2024

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Introduction

Prompt, effective medical care makes a big difference for those who are injured on the job. It is often the key to a quicker recovery, timely return-to-work and increased quality of life for injured workers. Thus, maintaining a network of hospitals to provide appropriate care is an important element to ensure the best possible recovery from workplace injuries. It also ensures access to quality, cost-effective service. Access for injured workers and employers means the availability of quality, cost-effective treatment provided on the basis of medical necessity. It facilitates faster recovery and a prompt, safe return to work.

Part of ensuring access to quality medical care requires the Ohio Bureau of Workers' Compensation (BWC) to set fair reimbursement rates for outpatient services provided to injured workers. Outpatient reimbursement rates for BWC are established via Ohio Administrative Code (OAC) rulemaking process. Specifically, BWC's hospital outpatient reimbursement methodology is detailed in OAC 4123-6-37.2. The rule describes the methods BWC utilizes to reimburse hospitals for outpatient services provided to injured workers covered under the state fund. The rule also details reimbursement options for self-insuring providers.

This document was developed to help BWC customers to understand the background of BWC's hospital outpatient reimbursement methodologies and how BWC utilizes Medicare's data and reimbursement methodologies as a basis for the majority of our hospital outpatient bills. Additionally, this document detail specific changes adopted by BWC for the hospital outpatient reimbursement methodology, as published in our rule. BWC's outpatient reimbursement rule rate year is effective for dates of service beginning May 1 each year and ending April 30 of the following year.

Overview of Hospital Outpatient Reimbursement Methodologies

BWC implemented a prospective payment methodology for hospital outpatient services on January 1, 2011. Specifically, BWC adopted and implemented Medicare's Outpatient Prospective Payment System (OPPS), with some modification thereto. Reimbursement rates and policies are established in advance with the prospective payment methodology, and rates and policies remain constant during the fee schedule effective period.

A key benefit of the prospective methodology is that all facilities experience consistent and equitable reimbursement for services rendered during the effective period. Further, under the prospective payment system, providers are encouraged to practice cost containment. Rates being established in advance provide facilities the data they can use to determine the best mix of their resources to achieve established budget goals without foregoing the provision of quality services.

A. Definition of Hospital Outpatient Services

An injured worker is considered to be an outpatient if they receive emergency department services, observation services, outpatient surgery, lab tests, or X-rays, or any other hospital services, and the doctor has not issued a formal order for admission the injured worker to a hospital as an inpatient. In these cases, the injured worker is outpatient even if they spend the night in the hospital.

B. BWC Hospital Types

OAC 4123-6-01 defines hospitals as an institution that provides facilities for surgical and medical diagnosis and treatment of bed patients under the supervision of staff physicians and furnishes twenty-four hour-a-day care by registered nurses. BWC's enrollment and certification requirements for hospitals are defined in OAC 4123-6-02.2. BWC enrolls eligible hospitals under four different hospital provider types:

- Acute care hospital – provider type 34
- Drug detoxification per diem hospital – provider type 35
- Psychiatric hospital – provider type 36
- Rehabilitation hospital – provider type 37

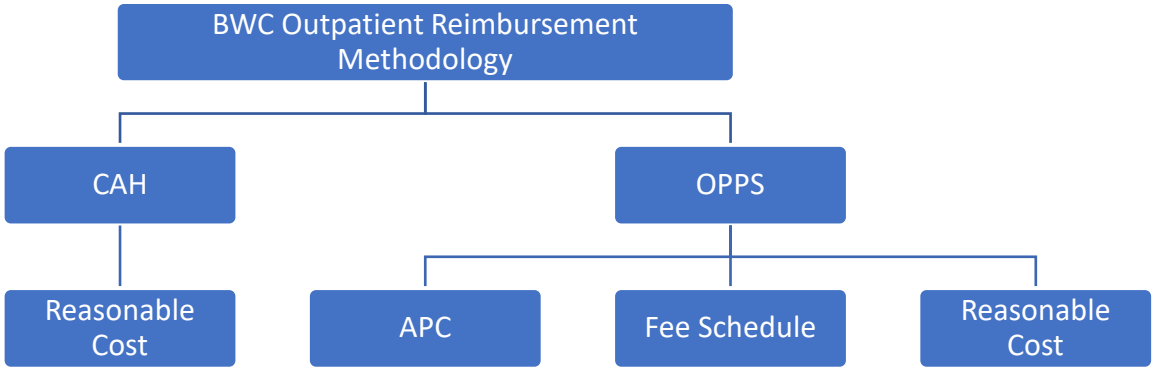
A single hospital may be enrolled with BWC under more than one provider type if they have separate and distinct units that qualify for separate enrollment. For example, an acute care hospital (provider type 34) may also have a separate and distinct psychiatric unit that would be separately enrolled a psychiatric hospital (provider type 36).

BWC recognizes Medicare hospital provider types for the purposes of reimbursement through the OPPS. OAC 4123-6-37.2 identifies such providers, including critical access hospitals, rural sole community hospitals, essential access community hospitals, exempt cancer hospitals, and children's hospitals based on the hospitals' designation in the Medicare outpatient provider specific file.[1]

C. BWC Outpatient Methodologies

There are two primary distinctions for BWC's hospital outpatient reimbursement methodology. These distinctions are based upon a facility's Medicare classification of whether it is a critical access hospital (CAH). Hospitals without this designation follows the OPPS with some modifications. The methodologies of BWC payment for different scenarios is summarized in the figure below.

BWC Outpatient Reimbursement Methodologies



Methodology 1: Critical Access Hospital Reimbursement

Critical Access Hospitals

Critical Access Hospitals are reimbursed under an OPPS-exempt or percent-of-charges methodology known as reasonable cost. BWC identifies critical access hospitals as designated and certified by Medicare. Generally, critical access hospitals can be identified with the XX13XX Medicare Oscar number format.

Reasonable Cost

BWC reimburses critical access hospitals at 101% of reasonable cost for all payable line items. Additionally, the BWC payment adjustment factor applies to all payable lines. The reasonable

[1] 50.1 Outpatient Provider Specific File. https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ProspMedicareFeeSvcPmtGen/psf_text

cost payment methodology is described as multiplying the line-item charge by the hospital's outpatient cost-to-charge ratio (CCR) from the Medicare outpatient provider specific file in effect as indicated in OAC 4123-6-37.2. If the hospital is not found in Medicare's outpatient provider specific file, the line charges are multiplied by the statewide average cost-to-charge ratio of the applicable rate year.

CAH Reimbursement = Line provider charge x CAH CCR x 1.01 x BWC PAF

Methodology 2: OPPS-Based Reimbursement

OPPS Reimbursement

Most outpatient services provided to Ohio's injured workers are paid under a modified version of Medicare's OPPS. Medicare uses ambulatory payment classifications (APCs) as the OPPS unit of payment. Individual services are assigned to APCs based on similar clinical characteristics and costs. The APC payment rate applies to each service assigned to the APC. An important feature of OPPS is the concept of "packaging," or grouping integral, ancillary, supportive, dependent, and adjunctive services into the payment for the associated primary procedure or service. This system does not make separate payments to the packaged services and encourages hospitals to contain-costs. Medicare describes some types of packaged items and services including:[2]

- All supplies
- Ancillary services
- Anesthesia
- Operating and recovery room use
- Clinical diagnostic laboratory tests
- Capital-related costs
- Procedures described by add-on codes
- Implantable medical devices used in connection with diagnostic X-ray tests, diagnostic laboratory tests, and other diagnostic tests, such as pacemakers
- Inexpensive drugs under a per-day drug threshold packaging amount
- Intraocular lenses (IOLs)
- Drugs, biologicals, and radiopharmaceuticals functioning as supplies, including diagnostic radiopharmaceuticals, contrast agents, stress agents, implantable biologicals, and skin substitutes
- Guidance services
- Image processing services
- Intraoperative services
- Imaging supervision and interpretation services
- Observation services

[2] CMS Hospital Outpatient Prospective Payment System MLN: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/html/medicare-payment-systems.html#Hospital

In most simplistic terms, BWC's payment formula for hospital outpatient services is:

BWC payment = Medicare base rate x BWC PAF*

**if applicable*

1. Standard APC Processing

Medicare assigns individual services to APCs based on similar clinical characteristics and costs. An individual APC has a cost-based relative weight value, to which a conversion factor transforms the weighted value into a dollar amount. An OPPS-based payment is typically composed of a primary reimbursable service coupled with ancillary items and services packaged together as an APC payment. There are many rules regarding the packaging and payment of hospital outpatient services. For more information, Medicare details these rules and policies within the Medicare Claims Processing Manual, Chapter 4. Certain services (e.g., physical therapy, diagnostic clinical laboratory) are excluded from Medicare's prospective payment system for hospital outpatient departments. These services are exceptions paid under fee schedules and other prospectively determined rates.

To determine the appropriate APC groupings for the calculation of the BWC rate, BWC utilizes bill editor software to adopt the Medicare methodology. The Medicare Integrated Outpatient Code Editor (IOCE) performs the bill clinical editing and grouping functions to align with the OPPS payment methodology. BWC currently uses FinThrive's product to align with Medicare's IOCE.

a) Clinical Editing

The IOCE generates National Correct Coding Initiative (NCCI) edits and are incorporated into the software package. The NCCI edits are applied to services submitted on a single bill, and on lines with the same dates of service. The editor addresses unacceptable code combinations based on coding rules, standards of medical practice, two services being mutually exclusive, or a variety of other reasons and returns a series of edit flags to identify the errors.

All hospital outpatient bills are processed through the IOCE. However, not all edits are applicable for every hospital outpatient provider type. For example, the IOCE edits critical access hospitals under a specified set of edits which may be different to edits applicable to hospitals subject to OPPS. BWC's table 1 of the OAC 4123-6-37.2 appendix details the IOCE edits BWC bypasses to adjudicate outpatient bills.

b) APC Assignment

The other function of the IOCE is to assign an APC for each service that is covered under the OPPS and return critical information to be used as inputs to a pricer program. In general, the IOCE executes a complex process to take all the information on the bill and determine the following outputs used to calculate reimbursement. For more information, refer to the IOCE specifications documents found in each software release.

- Medicare-designated status indicators
- Payment indicators
- Discounting computation
- Bill disposition based on generated IOCE edits
- Packaging applicability
- Payment adjustment applicability

2. Determining the Hospital-Specific Base Rate

To account for geographic price differences, Medicare adjusts the APC payment by breaking the rate down into two portions, the labor and non-labor portion of the base payment. The labor portion of the payment rate (60%) is adjusted based on the wage index assigned to the hospital's physical location. The wage index for the hospital can be found in the FY 2024 Final Rule and Correction Notice Data Files, which is based on the CBSA of the geographic location.

Medicare base rate = (APC x .60 x wage index) + (APC x .40)

3. Calculating Reimbursement

BWC utilizes a pricing software developed by CAM (Custom Applications Management) to gather the grouper outputs and apply pricing logic according to the Medicare OPPS. The software accounts for hospital-specific data, rate year data, and BWC-specific rates. BWC utilizes the addendum pricing data effective for Medicare on January 1 of each year.

Reimbursement is calculated by the application of:

a. The wage-adjusted Medicare base payment.
b. The BWC payment adjustment factor, as applicable.
c. Add-on payments.

BWC Reimbursement = (Medicare base rate * PAF) + add-on payments

4. Add-on payments

In certain scenarios under OPPS, some bills may receive additional add-on payments, along with the standard reimbursement. It is important to note that the BWC payment

adjustment factor (PAF) is applied to the Medicare base rate prior to the application of add-on payments.

BWC Reimbursement = (Medicare base rate * PAF) + Rural Payment + Outlier Payment + Hold-Harmless Payment

a) The rural add-on gives additional payment for services that are provided in identified rural hospitals. Healthcare facilities that are designated as Rural Sole Community Hospitals and Essential Access Community Hospitals are eligible for this add-on based on this OPPS provision. Rural sole community hospitals are identified as type 16, 17, 21, and 22 under the 'Provider Type' in the outpatient provider specific file. BWC aligns with Medicare such that the 7.1% add-on payment of the line item is applied.
b) An outlier add-on is an additional payment for services that are considered extremely costly compared to other services. All outpatient hospitals, except for those identified as a Critical Access Hospitals, are eligible to receive outlier add-on payments. The BWC adopts the Medicare Outlier formulas and annual fixed dollar threshold. The Medicare outlier payment formula = (cost-(APC payment x 1.75))/2.
c) A hold harmless add-on is an additional payment for services rendered in a children's or exempt cancer hospitals under OPPS. The outpatient provider specific file identifies these provider types (13 – cancer facility and 05 – pediatric). When the hold harmless calculation is greater than the APC payment, the add-on amount is added to the APC payment to ensure the hospital is reimbursed up to the hold harmless amount. HH calculation = billed charges * pay-to-cost ratio * cost to charge ratio.

5. Rural Emergency Hospital Payment Adjustment

Rural Emergency Hospital (REH) is a new provider classification for 2023, identified by provider type 24 in the Medicare Outpatient Provider Specific File (file position 55-56). REH's are reimbursed according to OPPS plus an additional 5%. For additional information, the Medicare Claims Processing Manual, Chapter 4, 10.6.4.

REH Reimbursement = OPPS rate x 1.05

6. Hospital Outpatient Quality Reporting Program

Outpatient hospitals that have failed to meet the specified hospital outpatient quality reporting requirements for the relevant calendar year will receive payment under the OPPS that reflects a 2 percentage point reduction of the annual OPPS update factor.

The reduction of payments does not apply to services paid under the OPPS if the payment amounts are not calculated using the conversion factor to which the annual

update factor applies (e.g., drugs and biologicals paid based on the average sales price (ASP) methodology, new technology services paid at a fixed amount, and services paid at charges adjusted to cost). The reduction also does not apply to hospital outpatient services paid through other fee schedules or other mechanisms, including those items found on BWC's rules' tables 2-5.

The reduction applies to services that have status indicator assignments P, J, Q1, Q2, Q3, R, S, T, U, V or X, excluding services paid under New Technology APCs (APC 1491 through 1599). The calculation for this reduction is as follows: Full Unadjusted National Payment Amount * 0.98 = Reduced Unadjusted National Payment Amount. All other applicable standard adjustments shall be applied to the Reduced Unadjusted National Payment Amount (e.g., wage indexing, multiple procedure discounting, etc). The Reduced Unadjusted National Payment Amount will be used to calculate outlier payments.

1) For dates of service prior to 4/30/2023: If the OPSF quality indicator is BLANK (null) and
    a. the status indicator is P, V, J, X, R, U or S then the 2% penalty is applied;
    b. except when the APC is between 1491 and 1599, (new technology) and the status indicator is S or T, then reduction is excluded.
    c. This information is located in the Addendum B file.
2) For dates of service on or after 5/01/2023: If the OPSF quality indicator is BLANK (null) and the status indicator is J1, J2, P, Q1, Q2, Q3, R, S, T, U, or V or the APC is 2616-2699, 4001-5881, 8004-8011, 9397-9399, or 9500-9540, then the 2% penalty is applied. The APC range 1491-1599 is excluded from the reduction as they are the New Technology status S and T (located in the Addendum B file)

Examples of these exceptions are services paid under the physician fee schedule (e.g., physical therapy and diagnostic and screening mammography), services paid at reasonable cost (e.g., influenza and pneumococcal vaccines), and services paid under other fee schedules (e.g., clinical laboratory services and durable medical equipment).

Identifying the hospital specific quality indicator in the Medicare Outpatient Provider Specific File (OPSF)

a) The hospital-specific quality indicator for the BWC hospital outpatient prospective payment system (OPPS) methodology is obtained from the October 2023 outpatient

provider specific file (OPSF) update as referenced in the final rule. They can be found on the Medicare Web site: Home > Medicare > Prospective Payment Systems – General Information > Provider Specific Data for Public Use in Text Format.

b) Select the appropriate provider specific file. For BWC rate year beginning 5/1/24, select "Outpatient PSF." Users can convert this text file to an Excel file or other format for ease of use. Information about the formatting and data in the OPSF can be found in the Medicare Claims Processing Manual, Chapter 4, Section 50.1 at the following link. https://www.cms.gov/manuals/downloads/clm104c04.pdf

c) The October 2023 OPSF update is used for the BWC rate year beginning May 1, 2024, and ending April 30, 2025. Subsequent Medicare OPSF updates from 2024 quarters are not used for pricing BWC outpatient bills.

d) Find the hospital using their numeric or alpha-numeric Medicare provider number, also known as the OSCAR number and/ or the National Provider ID (NPI).

e) Find the 10/01/2023 or prior effective date listed for that hospital. If the file was converted to an Excel file, this will be in column C. Dates are formatted in this field as YYYYMMDD.

f) The quality indicator is located in position 74. A "1" in this position indicates the hospital quality reporting standards have been met or hospital is not required to submit quality data. A blank in position 74 indicates that the hospital does not meet quality reporting standards and will be subject to the 2% payment reduction.

7. Other Reimbursement Methodologies

A. Reimbursement by Fee Schedule

Under the OPPS, payment status indicator A indicates that payment is based from a fee schedule according to the services billed. Payment is based on one of three fee schedules: Medicare physician fee schedule (MPFS), Medicare clinical laboratory fee schedule, or the BWC customized fee schedule. The BWC payment adjustment factor applies to services reimbursed from the Medicare fee schedules but not the BWC customized fee schedule. BWC's fee schedule is found in the appendix to OAC 4123-6-37.2. Specifically, tables 2, 3, 4, and 5 of the appendices detail specific services with a BWC customized fee. All services reimbursed by a fee schedule are **not wage adjusted**.

- Table 2: BWC-specific hospital outpatient vocational rehabilitation codes.
- Table 3: Medicare OPPS fee schedule items with BWC rates.
- Table 4: Medicare OPPS non-covered items with BWC rates. These are services not covered by Medicare that BWC has assigned a rate to.
- Table 5: BWC hospital outpatient local codes established by BWC.

B. Reimbursement by Reasonable Cost

Services designated to be reimbursed by reasonable cost are reimbursed through the following calculation. The line-item charge is multiplied by the hospital's outpatient cost to charge ratio from the Medicare outpatient provider specific file in effect as of the quarterly file detailed in OAC 4123-6-37.2. These services are not wage index adjusted.

BWC Reimbursement = Provider charge x hospital CCR

8. BWC Customizations to the Medicare OPPS Methodology

A. Modification to Effective Dates

Medicare's hospital outpatient rate year is effective for dates of service from January 1 through December 31 of each year. It is important to note that BWC's outpatient rate year differs in that it is effective for dates of service from May 1 through April 30. Since BWC does not adopt Medicare's updates to payment policies until May 1, bills with dates of service between January 1 and April 30 may require special handling:

a) Bills adjudicated during this time period are processed using the software and policies in effect for the BWC rate year, which is difference from the Medicare rate year. Therefore, there may be differences in clinical editing, grouping, and or pricing using the BWC rate year software.
b) Bills for these dates of service which contain new procedure codes or other data elements effective for Medicare may not be recognized by BWC's rate year software. BWC's managed care organizations are required to work with the hospital to crosswalk coding to allow the bill to be processed under the appropriate rate year.

B. Medicare Quarterly Updates

The grouping software effective for Medicare on January 1 of each year is utilized throughout BWC's rate year. BWC's rule allows the agency to adopt technical corrections detailed in Medicare's correction notice rule. However, BWC does not recognize any other software or data updates made by Medicare throughout the BWC rate year. For example, BWC does not recognize the Medicare quarterly

provider-specific file updates or the quarterly addendum updates. All provisions adopted by BWC on May 1 remain effective throughout the entire BWC rate year.

C. *Quarterly HCPCS or CPT code Updates*

The grouping software effective for Medicare on January 1 of each year is utilized throughout BWC's rate year. BWC's rule allows the agency to adopt new codes as of January 1. However, BWC does not recognize any other code update made by Medicare or the AMA throughout the BWC rate year. All provisions adopted by BWC on May 1 remain effective throughout the entire BWC rate year.

D. *Non-Medicare Participating Hospitals*

OAC 4123-6-37.2 includes a provision for the reimbursement methodology to hospitals that do not participate in the Medicare program. In summary, hospitals that do not participate in the Medicare program are reimbursed through the same BWC-modified OPPS methodology with custom specifications of the pricing factors used to calculate reimbursement. Please refer to the section "Determining Hospital CCRs" in this document to determine the CCR and wage index for use in calculating reimbursement for non-Medicare participating hospitals.

E. *BWC Payment Adjustment Factor*

As previously mentioned in the payment calculations, the BWC payment adjustment factor (PAF) generally applies to the Medicare base rates. BWC utilizes different PAFs depending whether the hospital is classified as a children's hospital. OAC 4123-6-37.2 outlines the specific children's hospitals to which the children's PAF applies.

- 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
- Children's Medical Center of Dayton

For all hospitals other than children's, a separate PAF is utilized as depicted in the table on the next page.

RY 2024 Payment Adjustment Factors

Children's Hospital Factor	2.758
Non-Children's Hospital Factor	1.485

F. *Determining Hospital CCRs*

To assist BWC customers in bill pricing, BWC is provides a list of the applicable rate year outpatient cost-to-charge ratios (CCR) currently in BWC systems that are used for bill pricing. The file is an excel document titled *OPPS – Hospital Outpatient Cost-to-Charge Ratios* that can be downloaded from the Fee Schedules page on the BWC website.

If a hospital has not previously done business with BWC, the CCR associated with that hospital cannot be found in the *OPPS – Hospital Outpatient Cost-to-Charge Ratios* file. In those cases, the Medicare public files can be used to identify the hospital's outpatient CCR detailed below.

Identifying the hospital specific CCR in the Medicare Outpatient Provider Specific File (OPSF)

a) The hospital-specific Medicare CCRs for the BWC hospital outpatient prospective payment system (OPPS) methodology is obtained from the October outpatient provider specific file (OPSF) update as referenced in the final rule.

b) The OPSF can be found on the Medicare Web site: Home > Medicare > Prospective Payment Systems – General Information > Provider Specific Data for Public Use in Text Format. *Please note, Medicare does not maintain more than the most recent file in history, which may not represent the October file BWC is using.*

   Select the appropriate provider specific file. For BWC rate year beginning 5/1/24, select "Outpatient PSF." Users can convert this text file to an Excel file or other format for ease of use. Information about the formatting and data in the OPSF can be found in the Medicare Claims Processing Manual, Chapter 4, Section 50.1 at the following link. https://www.cms.gov/manuals/downloads/clm104c04.pdf The October 2023 OPSF update is used for the BWC rate year beginning May 1, 2024, and ending April 30, 2025. Subsequent Medicare OPSF updates from 2024 quarters are not used for pricing BWC outpatient bills.

c) BWC provides the October OPSF in tab 2 of the published 2024 Hospital Outpatient CCR file in excel, published on the BWC website. On tab 2, find the hospital using their numeric or alpha-numeric Medicare provider number, also known as the OSCAR number and/ or the National Provider ID (NPI).

In the example in the table below, the October or prior effective date would be 10/18/2023. The CCR to be used for dates of service on or after 5/1/2024 for 030093 is 0.155.

Column A	Column B	Column C	Column R
Medicare Number	**Effective Date**	**NPI**	**Operating CCR**
030093	10/06/2023	1588823553	0.143

d) Next, multiply the CCR by **1.16 (116% of cost),** if applicable for self-insured employers. Please note, the result of this calculation shall be capped at **0.600**. (See BWC rule OAC 4123-6-37.2 (B)(1)(a) each year to identify if the % or cap changed). Using the previous example from the above table to calculate the final CCR:

0.143 x 1.16 = 0.16588

The final CCR (.16588) is then multiplied by the allowed charges to arrive at the reimbursement rate. This reimbursement rate is then compared to the calculation of the billed charges multiplied by 0.60. If the above calculated reimbursement rate exceeds to same value capped at 0.60, the reimbursement rate is the capped value.

Example: Billed charges $100,500.

$100,500* 0.60 = $60,300 capped threshold.

$100,500* 0.16588= $16,671.

The hospital would be reimbursed $16,671 using this example as the payment rate did not exceed the capped threshold.

Identifying the CCR for a hospital not listed in the OPSF

Some hospitals will not be listed in the OPSF (e.g., new hospitals that have not yet submitted a cost report; critical access hospitals, etc.). In that case, OAC 4123-6-37.2 allows the self-insured employer paying under this methodology to utilize the appropriate urban or rural statewide average outpatient CCR instead of the hospital specific CCR in the calculation.

a) Identify the address for the physical location of the facility. Specifically, locate the correct county and state. A good resource for identifying the county is www.zipinfo.com.

b) Next, go to the FY2024 Hospital Outpatient Regulations and Notices | CMS page. Using the hospital's county and state, and name or provider number, use the Zip and Excel file labeled "Correction Notice Hospital Outpatient Prospective Payment System Impact File" located in the Related Links (2024 CN OPPS Facility-Specific Impacts) section to determine if the facility county is located in a designated urban core based statistical area (CBSA), according to the tab labeled "Crosswalk." **If the county has an assigned CBSA number, this is an urban facility**.

c) If the county is not located in an urban CBSA according to the Excel file labeled "County to CBSA Crosswalk File and Urban CBSAs and Constituent Counties for Acute Care Hospitals" then the facility is in a rural area. To locate the state rural CBSA number, utilize the tab labeled 'CBSA Cos. Cty'. Once the state has been identified, record the state CBSA number (it is 2 digits). **If the county has no CBSA number, this is a rural facility**.

d) Use the Statewide CCRs and Upper Limits file located on the Medicare OPPS annual policy files web page (Annual Policy Files | CMS) for the appropriate year (2024). There will be a zip file; access the Excel file within the zip.

e) Locate the state and urban or rural figure based on the urban/rural determination made during the CBSA assignment process. Use the CCR column for the appropriate year.

OHIO	RURAL	0.254
OHIO	URBAN	0.200

f) Multiply this number by 1.16, if applicable for self-insured employers. Please note the CCR used in this calculation should be capped at 0.600.

The final CCR is then multiplied by the allowed charges to arrive at the appropriate reimbursement rate.

Additional Resources

A. BWC OPPS Deviations

Medicare is the starting point for BWC's outpatient payment system, however there are many deviations within the BWC reimbursement methodology stakeholders should note. These deviations are summarized below.

Area	Medicare	Ohio BWC
Integrated Outpatient Code Editor (I/OCE)	Uses the I/OCE as published in the applicable Medicare quarterly program transmittal.	For RY2024, BWC will be using IOCE Version 25.0 found at the following link: I/OCE Quarterly Release Files | CMS for payment calculations. *BWC does not adopt the quarterly updates.* BWC bypasses 18 IOCE edits. OAC 4123-6-37.2 Appendix **Table 1** identifies those bypassed edits.
IOCE Quarterly Updates	CMS adopts quarterly updates to IOCE and pricing logic, which may include retrospective updates.	BWC does not adopt any quarterly updates to the January IOCE (v24.0 for RY2023) or pricing logic. OAC 4123-6-37.2 indicates no updates are made throughout the rate year.
Vocational rehabilitation services	Not included in the Medicare benefit package	Reimbursed via BWC specific W-local codes for vocational rehabilitation services. Example: work conditioning program, active treatment for each 15 minutes (W0710) OAC 4123-6-37.2 Appendix **Table 2** lists covered vocational rehabilitation services.
Fee schedule items with BWC rates	Coverage under Medicare and their rates.	Reimbursed via BWC specific rates and reimbursement methodologies. OAC 4123-6-37.2 Appendix **Table 3** lists these services.
Medicare non-covered services	Not reimbursed under OPPS	Includes a select set of Medicare non-covered services in its benefit package. Example: contact lens fitting (CPT code 92310) OAC 4123-6-37.2 Appendix **Table 4** lists these procedures and supplies.

BWC Hospital Outpatient Local Codes	Not included in the Medicare benefit package.	BWC-specific local codes reimbursable through the payment rule. Example: CARF accredited/Hospital Based Chronic Pain Program/day. (Code W1000) OAC 4123-6-37.2 Appendix **Table 5** lists these services.
Base payment for inpatient-only services covered in the hospital outpatient setting	Not included in the Medicare benefit package.	Selected joint replacement procedures approved to be reimbursed via the OPPS. OAC 4123-6-37.2 Appendix **Table 6** lists these services with each reimbursement methodology.
Revenue codes	Coverages under Medicare rules.	OAC 4123-6-37.2 Appendix **Table 7** lists all applicable revenue codes, outpatient coverages, and requirements for reporting a corresponding CPT/HCPCS code.
BWC MUE values	Medicare publishes outpatient MUE values	OAC 4123-6-37.2 Appendix **Table 8** lists BWC's customized MUE values for outpatient services. These values incorporate all deviations in the BWC benefit plan.
Payment status indicator A Items – fee schedule items	Reimbursed under the Medicare clinical lab fee schedule, Medicare physician fee schedule, durable medical equipment fee schedule or carrier priced	Reimbursed under the Medicare clinical lab fee schedule, Medicare physician fee schedule or BWC's customized fee schedule. OAC 4123-6-37.2 Appendix Tables list BWC's customized fee schedule. **Table 9** indicates any coverage restrictions for these services, if applicable.
Therapy services	Coverages under Medicare rules.	Codes listed in OAC 4123-6-37.2 Appendix **Table 10** are "always therapy" or "sometimes therapy" services. All always therapy codes require the use of a discipline specific modifier -GN, -GO, or -GP as permitted by scope of practice and clinical editing, except when 97750 is authorized by the MCO for an occupationally focused FCE. Sometimes therapy codes require the use of a discipline specific modifier

		when performed by a physical therapist, athletic trainer, occupational therapist, or speech therapist.

B. Status Indicators

BWC recognizes the Medicare OPPS status indicators to facilitate payment. BWC uses the January outpatient addendum files for the respective rate year to recognize the Medicare status indicators assigned to each service. The table below describes the status indicators that is associated to a specific reimbursement methodology.

Status Indicator	Reimbursement Methodology	Notes
G, H, K, R, S, T, U, V	APC	Service separately payable and is paid at APC rate (with IOCE editing logic applied).
A	Fee Schedule	Service is paid at the Medicare fee schedule amount. Depending on the code, this may be the Medicare Clinical Lab fee schedule amount; or the Medicare Physician fee schedule amount.
F, L, C	Reasonable cost	Service paid at line charge multiplied by hospital cost to charge ratio (CCR).
P	APC	Partial hospitalization - one payment is provided for all partial hospitalization services provided on each day.
Q1, Q2, Q3, Q4	APC or Packaged	Service considered 'conditionally packaged' and may or may not be separately payable, depending on the additional services submitted on the bill.
J1, J2	APC	Services which may be paid at 'comprehensive' APC. Comprehensive APC's provide separate payment to status indicator J1/J2 line and all other services are packaged on bill.
E1, E2, M, Y, B, D	Not payable	Service not reimbursable via OPPS.
N	Packaged	Service is not separately payable and packaged with another payable service on the bill.

C. Clinical Edits for All Medical Bills

Prior to pricing medical bills, MCOs' and BWC's bill processing systems apply general clinical editing to all incoming bills.

a. Claim Number Validation

BWC's system ensures the claim number submitted on the bill corresponds to a valid injured worker claim number.

b. Provider Number Validation

BWC's system validates that the provider number submitted on a hospital type bill corresponds to a hospital provider type.

c. Revenue Center Code Validation

Revenue code accepted by BWC are detailed in Table 2 of the Appendix of OAC 4123-6-37.1. Non-covered revenue codes are denied by BWC.

d. Diagnosis Validation

BWC's system ensures the principal diagnosis on the inpatient bill meets one of the following criteria:

i. Allowed in the injured worker's claim,
ii. In the same diagnosis grouping diagnosis grouping as an allowed condition in the claim, or
iii. The bill contains an override code applied by the MCO to indicate the diagnosis is not allowed in the claim, but the bill may be paid according to policy.

e. Duplicate Check

BWC's system also checks for duplicate bills. If an incoming bill is a duplicate of a bill that is paid or in process, the incoming bill is denied.

D. Provider-Based Billing

BWC aligns with Medicare regarding the billing requirements of outpatient provider-based departments.[3] A provider-based hospital outpatient department may be on the main hospital campus, or it may be off-campus. When off-campus, the hospital would apply

[3]Billing Requirements for OPPS Providers with Multiple Service Locations https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE18002.pdf

one of two provider-based modifiers -PO or -PN to signify the provider-based status. The modifiers should be reported with every HCPCS code for all outpatient hospital items and services performed in off-campus provider-based departments of a hospital, except dedicated emergency departments or when the provider-based department is located on the campus (within 250 yards) of the hospital, or a remote location of the hospital as defined under 42 CFR 413.65.

BWC follows Medicare's site neutrality reimbursement methodology and requires items and services furnished at an off-campus outpatient provider-based department of a hospital require the use of the appropriate billing modifiers as applicable to reflect the billing of services as a provider-based facility for all HCPCS. The preamble of the appendix to OAC 4123-6-37.2 indicates the required modifiers for provider-based billing and their respective reimbursement impacts.

- Beginning in rate year 2022, the full Medicare methodology was phased-in over two years for excepted facilities. Therefore, excepted services reported with modifier -PO rendered at off-campus provider-based facilities will be reimbursed at 70% of the outpatient payable amount for 2022. For 2023 and beyond, excepted services will be reimbursed at 40% of the outpatient payable amount.
- Reimbursement of services provided at non-excepted, off-campus provider-based departments is 40% of the outpatient payable amount of services billed with modifier -PN.
- Items and services furnished by off-campus provider-based emergency departments must be reported with modifier -ER. Reimbursement is 100% of outpatient payable amount.
- The modifiers are required to be reported on each billed line, when applicable, although not all of the services are subject to the reduction. Payment will not be further adjusted for services paid under another fee schedule, such as clinical laboratory tests.

When a hospital is billing provider-based, they are billing G0463 facility (overhead) charge for hospital outpatient clinic visit or assessment and management of a patient. Prior to CMS' adoption of G0463, hospitals used to report evaluation and management services when reporting a service provided by a physician or practitioner at a hospital outpatient department. When the service is provided at an off-campus location for a provider-based department, the hospital is expected to append modifier -PN or -PO to the G0463. When applicable, BWC expects to receive two bills for the same date of service for provider-based

services. The hospital would bill G0463 (the appending of the modifier is dependent upon the hospital outpatient department location compared to the main hospital) and the physician practice (owned and operated by the hospital) bills for a clinic visit (99201-99205, or 99211-99215) for the same date of service. The physician practice is billing on the CMS 1500 using the corresponding provider-based place of service (19 or 22).

BWC, managed care organizations or SI employers may request additional information from any facility billing as provider-based to determine whether the facility meets the Medicare criteria for provider-based status as stipulated in OAC 4123-6-37.2 (C). This information may include an attestation by the facility to support the billing of G0463.

Validation may include review of:

- G0463 without a modifier (PO or PN) when the physician-owned clinic is billing for the corresponding evaluation and management service and is located off-campus. Please note, the physician does not bill modifier -PO or -PN but would identify the place of service using 19 or 22.
- G0463 (with or without a modifier) is billed for the same date of service as the hospital-owned physician's clinic billing for the evaluation and management service using place of service 11.
- G0463 (with or without a modifier) when there is no corresponding evaluation and management service for the same date of service.

During validation BWC, the MCO or SI employer may ask the hospital to clarify the location's address and provider-based status to determine what service is associated with the billing of the G0463, to determine if the billing is appropriate or requires the modifier -PO or -PN.

E. Provider Billing and Reimbursement Manual

BWC's Provider Billing and Reimbursement Manual (BRM) contains additional resources for customers regarding policies related to reimbursement of medical services. The BRM can be accessed on BWC's Web site.