Payment Policy

Subject: Outpatient Hospital Surgical Non Grouped Codes – OHIO ONLY

Policy

Effective January 1, 2014, CareSource will pay outpatient surgical claims for non-grouped codes as a percent of charges in accordance with the outpatient hospital and facility-specific cost to charge ratio.

Definitions

"**Cost to Charge Ratio**." Hospital and facility-specific cost-to-charge ratios are ratios that are computed from the relevant cost report and charge data determined at the time the cost report coinciding with the discharge is settled. These cost to charge ratios are applied to the covered charges for a case to determine whether the costs of the case exceed the fixed-loss outlier threshold. Payments for eligible cases are then made based on a marginal cost factor, which is a percentage of the costs above the threshold. CMS sets the reasonable parameters and the statewide cost-to-charge ratios in each year's annual notice of prospective payment rates published in the Federal Register in accordance with 42 CFR § 412.8(b)." *(from cms.gov)*

"**Current Procedural Terminology**" ("**CPT**") codes are numbers assigned to every task, medical procedure, and service a medical practitioner may provide to a patient. CPT codes are developed, maintained and updated annually, and copyrighted by the American Medical Association. *(From ama-assn.org)*

"**Grouped codes/Non grouped codes**." "Grouped codes" are CPT codes that are included in a standardized cost model by which different services and procedures are categorized together for the grouping of payments, and for an accurate reflection of the cost of services provided. Some CPT codes fall outside of these cost/payment groupings, and those CPT codes are commonly referred to as "non grouped codes." *(CareSource internal definition)*

*"***Outpatient surgical service**," means a claim that does not include chemotherapy, or emergency room codes modified by modifier -22, and that carries a CPT code that is in the range 10021-69990, and that is also published as a grouped outpatient surgical code. *(from OAC 5010:3-2-21)*

Provider Reimbursement Guidelines

If a claim is submitted to CareSource that carries a CPT code that is in the range 10021- 69990 that is not a grouped outpatient surgical code because the procedure is primarily performed on an inpatient basis, the claim will be paid a per cent of charges, to be determined by the Medicaid outpatient per cent as follows:

For outpatient services, the ratio used for outpatient non-groupables is the Medicaid-reported outpatient cost to charge ratio. Claims for outpatient surgery services must include all outpatient services performed on that date of service.

Related Policies & References

OAC 5160-2-22, “Hospital Services, Reasonable cost and cost-related reimbursement for hospital services.”

Ohio Department of Job and Family Services 02930, “Cost Report,” Schedule H, “Settlement Summary,” Sections I and II

State Exceptions

THIS POLICY IS FOR OHIO ONLY

Document Revision History

10/31/2013 – OAC Rule renumbered from “5101:3-2-22,” per Legislative Service Commission Guidelines.