STATE PLAN FOR MEDICAL ASSISTANCE
UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
STATE OF MARYLAND

2.a-1. Provider-Based Outpatient Oncology Facilities

A. Outpatient Oncology Facilities cover medically necessary facility services rendered to recipients in a free-standing Medicare-certified clinic including which are medically necessary, defined as diagnostic, curative, palliative, or rehabilitative services, when clearly related to the recipient's individual needs; and include:

(1) Radiation Therapy;
(2) Chemotherapy;
(3) IV Infusion;
(4) Blood transfusions;
(5) Medical supplies;
(6) Drugs; and
(7) Bone marrow biopsies

B. Specific requirements for participation in the Program as a Medicare-certified provider based outpatient oncology facility include all of the following:

(1) Be a Medicare-certified facility;
(2) Have clearly defined, written patient care policies; and
(3) Maintain adequate documentation of each recipient visit as part of the plan of care which at a minimum, shall include:

a) Date of service;
b) A description of the service provided; and
c) A legible signature and printed or typed name of the professional providing care, with the appropriate title;

C. Limitations
The following services are not covered:

(1) Any service or treatment that is not medically necessary;
(2) Experimental or investigational services;
(3) Services that are specifically included as part of another service; and
(4) Professional fees provided by physicians billed separately from the facility's charges.

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Specific Payment Procedures for Provider-Based Outpatient Oncology Facilities

A. The provider shall submit a request for payment in the format designated by the Department for dates of service on or after July 1, 2012.

B. Except for drugs which shall be billed to the Program using the National Drug Code (NDC) and the appropriate HCPCS, the Department shall reimburse the facility 80% of the Medicare clinic prospective rate which is based on a prospectively determined standard visit. The visit includes an overhead amount per procedure derived from an estimate of the cost. Under OPPS, CMS pays for clinic services on a rate per visit that varies according to the ambulatory payment classification (APC). Medicaid will continue to pay provider based outpatient oncology facilities the full annual deductible as well as the full 20% Medicare Part B coinsurance amount for all APG Medicare/Medicaid crossover claims.

C. The provider may not bill the program or the recipient for:

1. Completion of forms or reports;
2. Broken or missed appointment;
3. Services which are provided at no charge to the general public; or
4. Providing a copy of a recipient's medical record when requested by another licensed provider on behalf of the recipient.

D. The Program makes no direct payments to recipients.

E. The billing time limitations are set forth in Preface to Attachment 4.19B