

TO BE RESCINDED

5160-18-01 **Freestanding birth center services.**

(A) Definitions.

- (1) "Freestanding birth center (FBC)" has the same meaning as in 42 U.S.C. 1396d(1)(3)(B) (October 1, 2016).
- (2) "Independent practitioner" and "non-independent practitioner" have the same meaning as in rule 5160-4-02 of the Administrative Code.
- (3) "Low-risk expectant mother" has the same meaning as in rule 3701-83-33 of the Administrative Code.

(B) Provider requirements. Payment may be made to a FBC only if it meets the following criteria:

- (1) It holds a current license to perform FBC services issued by the appropriate authority in the state in which it is located;
- (2) It is operated in conformity with rules 3701-83-33 to 3701-83-42 of the Administrative Code; and
- (3) It is neither a hospital registered under section 3701.07 of the Revised Code nor an entity that is reviewed as part of a hospital accreditation or certification program.

(C) Coverage.

- (1) Facility services. Payment may be made to a FBC either for covered global obstetrical care (i.e., a bundled combination of antepartum, delivery, and postpartum services) or for covered discrete antepartum, delivery, and postpartum services, but not for both.
- (2) Professional services. Separate payment may be made to an independent practitioner, or to a FBC on behalf of either an independent practitioner or a non-independent practitioner, for the performance of the following services:
 - (a) Covered global obstetrical care or covered discrete antepartum, delivery, and postpartum services, but not both;
 - (b) Care of the newborn provided in accordance with rule 3701-83-36 of the Administrative Code;

- (c) A covered medicine, radiology, clinical laboratory, or evaluation and management (E&M) service or the administration of a pharmaceutical; or
- (d) The professional component of a covered service comprising both professional and technical components.

(D) Limitations.

- (1) Payment may be made for an antepartum, delivery, or postpartum service only if it meets the following criteria:
 - (a) It is provided to a low-risk expectant mother;
 - (b) It is covered in accordance with agency 5160 of the Administrative Code; and
 - (c) It is provided in accordance with rules 3701-83-34 to 3701-83-37 of the Administrative Code.
- (2) Payment will not be made for a service that is outside a practitioner's scope of practice.
- (3) Payment will not be made to a FBC (as the rendering provider) for performing the professional component alone of a covered service.
- (4) A practitioner and a FBC must not submit a claim for service that would result in duplicate payment.

(E) Claim payment. Payment for a covered item or service in the following list is the lesser of the submitted charge or the maximum amount established in accordance with the indicated paragraph of the Administrative Code:

- (1) Laboratory service — rule 5160-11-09;
- (2) Medical service or procedure — Chapter 5160-4 of the Administrative Code, for which maximum payment amounts are published in appendix DD to rule 5160-1-60 of the Administrative Code and coverage and payment policy is set forth in the following rules of the Administrative Code:
 - (a) Physician service — rule 5160-4-01;
 - (b) Physician assistant (PA) service — rule 5160-4-03;
 - (c) Advanced practice registered nurse (APRN) service — rule 5160-4-04;

- (d) Evaluation and management (E&M) service — rule 5160-4-06;
 - (e) Surgical service — rule 5160-4-22; or
 - (f) Radiology or imaging service — rule 5160-4-25;
- (3) Immunization, injection or infusion (including trigger-point injection), skin substitute, or provider-administered pharmaceutical — rule 5160-4-12 of the Administrative Code; or
- (4) Medical supply item — rule 5160-10-03 of the Administrative Code.

Effective:

Five Year Review (FYR) Dates: 10/14/2022

Certification

Date

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