5160-22-01 **Ambulatory surgery center (ASC) services: provider eligibility, coverage, and reimbursement.**

Effective for dates of service on or after the effective date of this rule, eligible ambulatory surgery centers as defined in paragraphs (A)(1) and (B) of this rule are subject to the enhanced ambulatory patient grouping system (EAPG) and prospective payment methodology utilized by the Ohio department of medicaid as described in this rule.

(A) Definitions.

(1) An "ambulatory surgery center (ASC)" is any distinct entity that operates exclusively for the purpose of providing surgical services to patients not requiring hospitalization.

(2) "Enhanced ambulatory patient grouping (EAPG)" is a group of outpatient procedures, encounters, or ancillary services, which reflect similar patient characteristics and resource utilization and which incorporate the use of "International Classification of Diseases" diagnosis codes, CPT code set and healthcare common procedure coding system (HCPCS) procedure codes.

(3) "EAPG grouper" is the software provided by 3M health information systems to group outpatient claims based on services performed and resource intensity.

(4) "Default EAPG settings" are the default EAPG grouper options in 3M's core grouping software for each EAPG grouper version.

(5) "Discounting factor" is a factor applicable for multiple significant procedures ~~and/or~~or repeated ancillary services designated by default EAPG settings or both. The appropriate percentage (fifty or one hundred per cent) will be applied to the highest weighted of the multiple procedures or ancillary services payment group.

(a) "Full payment" is the EAPG payment with no applicable discounting factor.

(b) "Consolidation factor" is a factor of zero per cent applicable for services designated with a same procedure consolidation flag or clinical procedure consolidation flag by the EAPG grouper under default EAPG settings.

(c) "Packaging factor" is a factor of zero per cent applicable for services designated with a packaging flag by the EAPG grouper under default EAPG settings.

(6) "ASC invoice" is a bill submitted in accordance with Chapter 5160-1 of the Administrative Code, to the department for services rendered to one eligible medicaid beneficiary on one or more date(s) of service. For an invoice

encompassing more than one date of service, each date will be processed separately as an individual claim.

(7) "ASC claim" encompasses the ASC services rendered to one eligible medicaid beneficiary on one date of service at an ASC facility.

(8) "Procedure code" is the current procedural terminology (CPT) codes ~~and~~or healthcare common procedure coding system (HCPCS) as identified in rule 5160-1-19 of the Administrative Code.

(9) "Diagnosis code" is the "International Classification of Diseases" codes as ~~indentified~~identified in rule 5160-1-19 of the Administrative code.

(10) "Relative weight" is a factor specific to each EAPG that represents that EAPG's relative cost compared to an average case. The relative weights for EAPGs are calculated as described in paragraph (F) of rule 5160-2-75 of the Administrative Code.

(11) "EAPG base rate" is the dollar value that shall be multiplied by the final EAPG weight for each EAPG on a claim to determine the total allowable medicaid payment for a visit. The EAPG base rate for ASCs is eighty per cent of the statewide average outpatient hospital EAPG base rate. Hospital EAPG base rates are calculated as described in paragraph (D) of rule 5160-2-75 of the Administrative Code.

(12) "ASC facility services" are items and services furnished by an ASC in connection with a covered ASC surgical procedure.

(13) "ASC Cost-to-charge ratio" is eighty per cent of the statewide average outpatient cost-to-charge ratio as calculated in rule 5160-2-22 of the Administrative Code.

(B) Eligible ASC providers.

(1) All ASCs that have a valid agreement with the centers for medicare and medicaid services (CMS) to provide services in the medicare program are eligible to become medicaid providers upon execution of the "Ohio Medicaid Provider Agreement."

(2) ASC providers must bill in accordance with rule 5160-1-19 of the Administrative Code. The department will reimburse an ASC for properly submitted claims for facility services furnished in connection with covered surgical procedures when the services are provided by an eligible ASC provider to an eligible medicaid recipient. Reimbursement for covered ASC facility services will be paid in accordance with paragraph (D) of this rule.

(C) Covered ASC ~~facility~~ services.

(1) ~~Facility services~~Services include but are not limited to:

(a) Nursing, technician, and related services;

(b) Use of the ASC facilities;

(c) Drugs, biologicals (e.g., blood), surgical dressings, splints, casts and appliances, and equipment directly related to the provision of the surgical procedure;

(d) Diagnostic or therapeutic services or items directly related to the provisions of a surgical procedure;

(e) Administrative, record keeping, and housekeeping items and services;

(f) Materials for anesthesia;

(g) Intraocular lenses; and

(h) Supervision of the services of an anesthetist by the operating surgeon.

(2) Services covered in an ASC are listed on the department's web site http://www.medicaid.ohio.gov/.

(3) Prior Authorization (PA) will be required for certain surgical CPT codes. The services that require PA are listed on the department's web site, http://www.medicaid.ohio.gov/, in accordance with section 5160.34 of the Revised Code.

(D) EAPG payment formula.

(1) Total EAPG payment is the sum across all paid line items on an ASC claim

(2) The payment for a paid line on the claim is calculated as follows, except as described in paragraph (E) or (F) of this rule:

(a) The ASC EAPG base rate times;

(b) The EAPG relative weight for which the service was assigned by the EAPG grouper, rounded to the nearest whole cent;

(c) For EAPGs 00134 and 00149, the result of paragraph (D)(2)(b) of this rule multiplied by one hundred ten per cent, rounded to the nearest whole cent,

(d) The result of paragraphs (D)(2)(a) and (D)(2)(b) of this rule, or, for EAPGs 00134 and 00149, (D)(2)(a) to (D)(2)(c), times applicable discounting factor(s) as defined in paragraph (A)(5) of this rule, rounded to the nearest whole cent.

(E) Payment for laboratory services, radiological services, and diagnostic and therapeutic procedures.

An ASC may be reimbursed in addition to the facility fee for covered laboratory procedures, radiological procedures, and diagnostic and therapeutic procedures provided in connection with a covered ASC surgical procedure. ~~To be reimbursed for these services, ASC providers must bill in accordance with rule 5160-1-19 of the Administrative Code.~~

(1) Payment for laboratory services.

(a) An ASC ~~facility~~ may be reimbursed ~~in addition to the facility payment~~ for covered laboratory services they actually performed. ~~as long as the services are provided and billed in accordance with Chapter 5160-11 of the Administrative Code.~~

(b) An ASC may not bill separately for the professional component of an anatomical pathology procedure.

(c) Laboratory services will be reimbursed the lesser of billed charges or the result of paragraph ~~product of paragraphs (D)(2)(a), (D)(2)(b) and~~ (D)(2)(d) of this rule.

(2) Payment for radiological services.

(a) An ASC ~~facility~~ may be reimbursed ~~in addition to the facility payment~~ for covered radiological services they actually performed. ~~as long as the services are provided and billed in accordance with rule 5160-4-25 of the Administrative Code.~~

(b) An ASC may not bill the department for the professional component separately.

(c) Radiological services will be reimbursed the lesser of billed charges or the result of paragraph ~~product of paragraphs (D)(2)(a), (D)(2)(b) and~~ (D)(2)(d) of this rule.

(3) Payment for diagnostic and therapeutic procedures.

(a) An ASC may be reimbursed ~~in addition to the facility fee~~ for the provision of diagnostic and therapeutic services when provided. ~~and billed in accordance with rules 5160-4-11, 5160-4-16, 5160-4-17 and 5160-4-18 of the Administrative Code.~~

(b) An ASC may not bill separately for the professional component of a diagnostic and therapeutic procedure.

(c) Diagnostic and therapeutic services will be reimbursed the result of paragraph ~~product of paragraphs (D)(2)(a), (D)(2)(b) and~~ (D)(2)(d) of this rule.

(4) An ASC may also be reimbursed for laboratory, radiology and diagnostic and therapeutic services actually performed in the ASC in conjunction with covered services not eligible for an ASC facility payment.

(F) Items which may be paid outside of EAPG.

(1) Pharmaceuticals.

(a) ~~Additional payments~~Payments for covered pharmaceuticals will be made in accordance with the discounting factors as determined by the EAPG grouper. If no consolidation or packaging factors are assigned then the pharmaceutical line is separately payable and will pay according to paragraph (F)(1)(b) and (F)(1)(c) of this rule.

(b) Reimbursement for separately payable covered pharmaceuticals shall be the lesser of billed charges or the payment amounts in the provider administered pharmaceutical fee schedule as published on the department's web site, http://medicaid.ohio.gov/, at the rate in effect on the date of service.

(c) If a J-code or Q-Code, that is covered for ASC facilities and separately payable, is listed as "by report" in the provider-administered pharmaceutical fee schedule, the line will be multiplied by sixty per cent of the ASC cost-to-charge ratio.

(2) Durable medical equipment (DME).

(a) ~~Additional payments~~Payments for covered DME may be made for all line items grouping to EAPG code 01001, 01002, 01003, 01004, 01005, 01006, 01007, 01008, 01009, 01010, 01011, 01012, 01013, 01014, 01015, 01016, 01017, 01018, 01019, or 01020.

(b) Reimbursement for DME shall be the lesser of billed charges or the payment amounts in the medicaid non-institutional maximum payment schedule as published on the department's web site, http://medicaid.ohio.gov/, at the rate in effect on the date of service.

(c) ~~Additional payments~~Payments for DME will be made in accordance with the discounting factors as determined by the EAPG grouper.~~:~~

(3) Dental Services

(a) Payments for covered dental services may be made for all line items grouping to EAPG code 00350, 00351, 00352, 00353, 00354, 00355, 00356, 00357, 00358, 00359, 00360, 00361, 00362, 00363, 00364, 00365, 00366, 00367, 00368, 00369, 00370, 00371, or 00372.

(b) Reimbursement for dental services will be nine-hundred fifty-three dollars and sixty cents.

(c) Payments for dental services will be made in accordance with the discounting factors as determined by the EAPG grouper.

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