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

(A) Eligible ASC providers.

(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) 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".

(3) The department will reimburse an ASC 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 (E) of this rule.

(B) Covered ASC surgical procedures.

(1) "Covered ASC surgical procedures" are procedures designated in appendix DD to rule 5160-1-60 of the Administrative Code.

(2) Covered ASC procedures shall be listed under the column headings "Current ASC Group" and "Previous ASC Group" in appendix DD to rule 5160-1-60 of the Administrative Code and classified into nine surgical groups.

(3) The inclusion of any procedure as a covered ASC surgical procedure determines that reimbursement for facility services may be paid to an ASC and does not preclude its coverage in an inpatient or outpatient hospital setting.

(C) Noncovered ASC surgical procedures.

A facility fee is not reimbursable to an ASC for the following procedures:

(1) Surgical procedures not designated as covered ASC surgical procedures in appendix DD to rule 5160-1-60 of the Administrative Code; and

(2) Surgical procedures, regardless of their designation in appendix DD to rule 5160-1-60 of the Administrative Code, that are not covered services as described in either rule 5160-2-03 or rule 5160-4-28 of the Administrative Code.

(D) Covered ASC facility services.

"ASC facility services" are items and services furnished by an ASC in connection

with a covered ASC surgical procedure. Facility services include but are not limited to:

(1) Nursing, technician, and related services;

(2) Use of the ASC facilities;

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

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

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

(6) Materials for anesthesia;

(7) Intraocular lenses; and

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

(E) Payment for facility services.

(1) Payment for facility services is based on a reimbursement rate for each surgical group classification, referred to as the surgical group rate, as determined by the department.

(2) Maximum reimbursement for facility services furnished with a covered surgical procedure will be the provider's billed charges or one hundred per cent of the surgical group rate as specified in paragraph (E) of rule 5160-1-60 of the Administrative Code, whichever is less.

(3) When more than one covered procedure is performed in a single operative session, payment for facility services will be based on one hundred per cent of the highest paying surgical group rate to which one of the covered procedure codes is assigned and fifty per cent of the next highest paying or identical surgical group rate to which one of the covered procedure codes is assigned for the secondary procedure. Any subsequent procedures will be reimbursed zero per cent of the surgical group rate.

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

An ASC may be reimbursed in addition to the facility fee for 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.

(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.

(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.

(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.

Effective:

Five Year Review (FYR) Dates:

_____

Certification

_____

Date

Promulgated Under:	119.03
Statutory Authority:	5164.02
Rule Amplifies:	5162.03, 5164.02