Ohio Administrative Code

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

Effective: January 1, 2024

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 (ODM) as described in this rule.

(A) Definitions, for the purposes of this rule the following meanings apply.

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

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

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

(5) "ASC invoice" is a bill submitted in accordance with Chapter 5160-1 of the Administrative Code, to ODM 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.

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

(7) "Diagnosis code" is the international classification of diseases (ICD) diagnosis code as identified

in rule 5160-1-19 of the Administrative Code.

(8) "Discounting factor" is a factor applicable for multiple significant procedures 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.

(9) "EAPG base rate" is the dollar value that is multiplied by the final EAPG relative weight for each EAPG on a claim to determine the total allowable medicaid payment for a visit. The EAPG base rate for ASCs is sixty-three and six tenths per cent of the statewide average outpatient hospital EAPG base rate. Hospital EAPG base rates are calculated as described in rule 5160-2-75 of the Administrative Code .

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

(11) "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 (ICD) diagnosis codes, current procedural terminology (CPT) procedural codes, and healthcare common procedure coding system (HCPCS) procedure codes.

(12) "Procedure code" is the CPT code or HCPCS code as identified in rule 5160-1-19 of the Administrative Code.

(13) "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 rule 5160-2-75 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 bill in accordance with rule 5160-1-19 of the Administrative Code. ODM 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 services.

(1) 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) Prior authorization (PA) is necessary for certain surgical CPT codes. The services needing PA are published 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 ASC EAPG relative weight for which the service was assigned by the EAPG grouper, rounded to the nearest whole cent;

(c) The result of paragraphs (D)(2)(a) and (D)(2)(b) of this rule times applicable discounting factor(s) as defined in paragraph ()(A)(8) 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.

(1) Payment for laboratory services.

(a) An ASC may be reimbursed for covered laboratory services actually performed.

(b) An ASC should 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 (D)(2)(c) of this rule.

(2) Payment for radiological services.

(a) An ASC may be reimbursed for covered radiological services actually performed.

(b) An ASC should not bill ODM for the professional component separately.

(c) Radiological services will be reimbursed the lesser of billed charges or the result of paragraph (D)(2)(c) of this rule.

(3) Payment for diagnostic and therapeutic procedures.

(a) An ASC may be reimbursed for the provision of diagnostic and therapeutic services when provided.

(b) An ASC should 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 (D)(2)(c) 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) 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 paragraphs (F)(1)(b) and (F)(1)(c) of this rule.

(b) Reimbursement for separately payable covered pharmaceuticals will be the lesser of billed charges or the payment amounts in the provider administered pharmaceutical fee schedule as published on ODM'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 may be made for all line items grouping to a DME EAPG type.

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

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

(3) Dental services

Reimbursement for claims assigned to a dental service EAPG type will be paid as follows:

(a) Reimbursement for dental services will be one thousand three hundred twenty-eight dollars.

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

(G) Risk corridors.

Effective for dates of services on or after the effective date of this rule, ODM will apply the following to ASC EAPG relative weights as described in paragraph (A)(13) of this rule:

(1) The EAPG relative weights were calculated to result in an increase of at least five per cent in payments compared to the prior prospective payment system; or

(2) The EAPG relative weights were calculated to result in no more than a fifteen per cent increase in payments compared to the prior prospective payment system.