Ohio Administrative Code

Rule 5160-18-01 Freestanding birth center services.

Effective: January 1, 2018

(A) Definitions.

(1) "Freestanding birth center (FBC)" has the same meaning as in 42 U.S.C. 1396d(l)(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.