Ohio Administrative Code

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

Effective: January 10, 2026

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 charge factor" is a factor specific to ASCs that is used to calculate reimbursement for pharmaceutical procedure codes described in paragraph (F)(1)(c) of this rule.

(4) "ASC EAPG base rate" is the dollar value that is multiplied by the final EAPG relative weight for each EAPG listed on a claim to determine the total allowable medicaid payment.

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

(6) "ASC invoice" is a bill submitted to ODM in accordance with Chapter 5160-1 of the Administrative Code for services rendered to one eligible medicaid recipient 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) "Default EAPG settings" are the default EAPG grouper options for each version of the core

grouping software by "Solventum" or its successors.

(8) "Diagnosis code" is the international classification of diseases (ICD) diagnosis code as identified in rule 5160-1-19 of the Administrative Code.

(9) "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.

(10) "EAPG grouper" is the software provided by "Solventum" or its successors 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 that reflect similar patient characteristics and resource utilization and 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 a 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 the EAPG's relative cost compared to an average case.

(B) ASC providers will 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 a surgical procedure;

(d) Diagnostic or therapeutic services or items directly related to the provision 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 of all paid line items on an ASC claim.

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

(a) The ASC EAPG base rate, multiplied by

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

(c) The product of paragraphs (D)(2)(a) and (D)(2)(b) of this rule is multiplied by applicable discounting factor(s), as defined in paragraph (A)(9) of this rule, and the result is 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 services, radiological services, 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.

(b) An ASC should not bill separately for the professional component of an anatomic 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.

(b) An ASC should not bill separately for the professional component of a radiological service.

(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 procedures.

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

(c) Diagnostic and therapeutic procedures will be reimbursed the result of paragraph (D)(2)(c) of this rule.

(4) An ASC may also be reimbursed for laboratory services, radiological services, and diagnostic and therapeutic procedures when 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 HCPCS 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 paid in accordance with paragraph (F)(1)(d) of this rule..

(d) Procedure codes described in paragraph (F)(1)(c) of this rule will be reimbursed the allowed charges for the detail line multiplied by sixty per cent of the ASC charge factor; then rounded to the nearest whole cent.

(2) Durable medical equipment (DME).

(a) Additional payments may be made for 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 DME 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 ASC claims assigned to a dental service EAPG type will be paid as follows:

(a) Reimbursement for dental services will be one thousand four hundred thirty dollars.

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

(G) Risk corridors.

(1) Effective for dates of service on or after January 1, 2024, ODM will apply the following to ASC EAPG relative weights as described in paragraph (A)(13) of this rule:

(a) The ASC 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

(b) The ASC 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.

(2) Effective January 1, 2026, the relative weights for ASCs are increased by 11.6 per cent.