Ambulatory Surgery Center Services Table of Contents

John R. Kasich, Governor

John B. McCarthy, Director

Ohio Department of Medicaid

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Medicaid Handbook Transmittal Letters

MHTL 3351-15-01 (Ambulatory Surgery Center Eligibility Updates)

Medicaid Handbook Transmittal Letter (MHTL) No. 3351-15-01

April 14, 2015

TO: Eligible ASC Providers
Chief Executive Officers, Managed Care Plans (MCPs)
Directors, County Departments of Job and Family Services

FROM: John B. McCarthy, Director

SUBJECT: Ambulatory Surgery Center Eligibility Updates

Summary

This Medicaid Handbook Transmittal Letter (MHTL) provides information pertaining to the ambulatory surgery center (ASC) eligibility. Rule 5160-22-01 is being amended as a result of Ohio's five-year rule review.

Rule Changes

Rule 5160-22-01, "Ambulatory surgery center eligible providers," sets forth the standards for ambulatory surgery centers (ASCs) to become Medicaid providers and to be reimbursed for services. In order to participate in the Medicaid program an ASC must have a valid agreement with the Centers for Medicare and Medicaid Services (CMS) to provide ASC services in the Medicare program; therefore the references to the Code of Federal Regulations are unnecessary and are being removed. A line was also added to reference Medicaid's ASC reimbursement rule. There are no policy changes to this rule.

Access to Rules and Related Material

The main web page of the Ohio Department of Medicaid (ODM) includes links to valuable information about its services and programs; the address is http://medicaid.ohio.gov/.

ODJFS maintains an "electronic manuals" web page of ODJFS and Medicaid rules, manuals, transmittal letters, forms, and handbooks. The web address for this "eManuals" web page is http://emanuals.odjfs.state.oh.us/emanuals/.

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To receive automatic notification by e-mail when new Medicaid transmittal letters are published, interested parties may sign up at http://medicaid.ohio.gov/HOME/ODMEmailListSignup.aspx.

Additional Information

Questions pertaining to this letter should be addressed to:

hospital_policy@medicaid.ohio.gov

or

Ohio Department of Medicaid
Bureau of Health Plan Policy

Hospital Services
P.O. Box 182709
Columbus, OH 43218-2709
Telephone (800) 686-1516

MHTL 3351-09-02 (Community Provider Fee Decrease)

Medicaid Handbook Transmittal Letter (MHTL) No. 3351-09-02

January 8, 2010

TO: All Eligible Ambulatory Surgery Centers

Directors, County Departments of Job and Family Services

FROM: Douglas E. Lumpkin, Director

SUBJECT: Community Provider Fee Decrease

This letter provides information regarding the amendment of Ohio Administrative Code (OAC) rules 5101:3-1-60, 5101:3-4-21.2, 5101:3-5-02, 5101:3-5-04, 5101:3-10-05, 5101:3-10-26, 5101:3-12-05 and 5101:3-12-06. These rules are being amended to comply with provisions of Amended Substitute House Bill 1 which reduced expenditures to certain community providers by an aggregate amount of three percent effective for dates of service on and after January 1, 2010. Total annual savings as a result of these reductions are estimated at approximately $19,736,109.

OAC rule **5101:3-1-60**, entitled Medicaid Reimbursement, sets forth payment amounts for services provided by a number of different community provider types including: advance practice nurses, ambulance and ambulette providers, ambulatory health care clinics, ambulatory surgery centers, chiropractors, dentists, durable medical equipment suppliers, freestanding laboratories, independent diagnostic testing facilities, occupational therapists, opticians, optometrists, orthotists, physical therapists, physicians, podiatrists, portable x-ray suppliers, psychologists and prosthetists. The payment reductions affecting specific provider types reimbursed through this rule are outlined below.

Ambulance and ambulette providers bill and are reimbursed on the basis of Healthcare Common Procedural Coding System (HCPCS) codes. The reimbursement amount for each of the HCPCS codes billed by these providers has been reduced by three percent, resulting in annual savings of approximately $1,098,661.

Ambulatory surgery centers bill and are reimbursed on the basis of nine surgical groupings. The reimbursement amount for each of these nine groupings has been reduced by three percent, resulting in annual savings of approximately $82,260.

Chiropractors bill and are reimbursed on the basis of Current Procedural Terminology (CPT) codes. The reimbursement amount for each of the CPT codes billed by chiropractors has been reduced by three percent, resulting in annual savings of approximately $16,339.

Durable Medical Equipment (DME) suppliers bill and are reimbursed on the basis of HCPCS codes. The reimbursement amount for each of the adult incontinent garment HCPCS codes has been reduced by 10 percent resulting in an annual savings of approximately $1,253,824. The reimbursement amount for each of the HCPCS codes for orthotics and prosthetics has been reduced by three percent, resulting in annual savings of approximately $335,717.

Freestanding laboratories bill and are reimbursed on the basis of both CPT and HCPCS codes. The reimbursement amount for each CPT and HCPCS code billed by freestanding laboratories has been reduced by three percent, resulting in annual savings of approximately $569,824.

Therapy services including those provided by physical, occupational and speech therapists are billed and reimbursed on the basis of CPT codes. The reimbursement amount for each of the CPT codes billed by these practitioners has been reduced by three percent, resulting in annual savings of approximately $388,099.

Vision services provided by opticians, optometrists and physicians are billed and reimbursed on the basis of CPT codes. The reimbursement amount for each of the CPT vision codes billed by these practitioners has been reduced by three percent, resulting in annual savings of approximately $228,490.

In addition to the reductions identified above, the maximum amount Medicaid will reimburse for any CPT code (i.e., the ceiling price) has been reduced from 100 to 90 percent of the Medicare price. This reduction affects 606 CPT codes and results in annual savings of approximately $4,430,541. These 606 codes represent 10 percent of the 5,836 CPT codes billable to and reimbursed by Ohio Medicaid. Four hundred forty-five (74 percent) of the 606 codes were surgical codes, 94 (16 percent) were radiology codes, and 67 (11 percent) were medicine codes, of which 37 (55 percent) were cardiovascular in nature.

Providers of physician services bill and are reimbursed for the developmental testing of young children using CPT codes. The reimbursement amount for targeted developmental screening codes has been increased by 10 percent, resulting in an annual increase of expenditures of approximately $21,321.

Two unrelated changes are being made to the pricing in 5101:3-1-60 at this time to comply with recent findings by the Auditor of State. The reimbursement amount for HCPCS code E0305, bed side rails, is being decreased from $185.02 to $185.01. The reimbursement amount for HCPCS code E2366, wheelchair battery charger, is being increased from $202.00 to $210.90. The impact of these changes on annual expenditures will be negligible.

OAC rule **5101:3-4-21.2**, entitled Anesthesia Conversion Factors, sets forth payment amounts for services provided by anesthesiologists, anesthesia assistants and certified registered nurse anesthetists. These providers bill and are reimbursed on the basis of modifiers and conversion factors applied to CPT codes. The reimbursement rate for each of the conversion factors has been reduced by three percent, resulting in an annual savings of approximately $194,457.

OAC rule **5101:3-5-02**, entitled Dental Program: Covered Diagnostic Services and Limitations, sets forth the coverage criteria for oral examinations and diagnostic imaging in the dental program. Covered periodic oral examinations for adults age 21 years and older have been reduced from one every one hundred eighty days to one every 365 days, resulting in an annual savings of approximately $200,946.

OAC rule **5101:3-5-04**, entitled Dental Program: Covered Preventive Services and Limitations, sets forth the coverage criteria for preventive services in the dental program. Covered dental prophylaxis for adults age 21 years and older has been reduced from one every one hundred eighty days to one every 365 days, resulting in an annual savings of approximately $491,720.

OAC rule **5101:3-10-05**, entitled Reimbursement for Covered Services, sets forth among other things the manner in which providers may bill and be reimbursed for DME. Some DME items are not reimbursed according to the prices listed in 5101:3-1-60 but are instead reimbursed at the lesser of the provider's usual and customary charge or 75 percent of the list price presented to the department. This reimbursement level has been reduced by three percent, to 72 percent of the list price. When no list price is presented to the department, DME items are reimbursed at the lesser of the provider's usual and customary charge or one hundred fifty percent of the provider's invoice price less any discounts or applicable rebates. This reimbursement level has been reduced by three percent, to one hundred forty-seven per cent of the invoice price. These reductions in the percents paid of list and invoice prices are estimated to result in annual savings of approximately $272,067.

OAC rule **3-10-26**, entitled Enteral Nutritional Products, sets forth coverage criteria and reimbursement policies for enteral nutrition products. Some enteral nutrition products are not reimbursed according to the prices listed in 5101:3-1-60 but are instead reimbursed at the supplier's average wholesale price minus twenty percent. This figure has been reduced to minus twenty-three percent of the supplier's average wholesale price, resulting in annual savings of approximately $285,921.

OAC rule **5101:3-12-05**, entitled Reimbursement: Home Health Services, sets forth payment amounts for home health nursing, home health nursing aide, physical therapy, occupational therapy, and speech-language pathology. Home health service providers bill and are reimbursed on the basis of HCPCS codes. The reimbursement rate for each of these codes has been reduced by three percent, resulting in an annual savings of approximately $5,676,688.

OAC rule **5101:3-12-06**, entitled Reimbursement: Private Duty Nursing Services, sets forth payment amounts for private duty nurses. Private duty nurses bill and are reimbursed using a single HCPCS code. The

reimbursement amount for this code has been reduced by three percent, resulting in an annual savings of approximately $4,231,876.

Web Page:

The Ohio Department of Job and Family Services maintains an "electronic manuals" web page of the department's rules, manuals, letters, forms, and handbooks. The URL for this "eManuals" page is http://emanuals.odjfs.state.oh.us/emanuals/.

Providers may view documents online by:

(1) Selecting the "Ohio Health Plans - Provider" folder;

(2) Selecting the appropriate service provider type or handbook;

(3) Selecting the "Table of Contents";

(4) Selecting the desired document type;

(5) Selecting the desired item from the "Table of Contents" pull-down menu.

Most current Medicaid maximum reimbursement rates are listed in rule **5101:3-1-60** or in Appendix DD to that rule. Providers may view these rates by:

(1) Selecting the "Ohio Health Plans - Provider" folder;

(2) Selecting "General Information for Medicaid Providers";

(3) Selecting "General Information for Medicaid Providers (Rules)";

(4) Selecting "5101:3-1-60 Medicaid Reimbursement" from the "Table of Contents" pull-down menu.

The Legal/Policy Central - Calendar site (**http://www.odjfs.state.oh.us/lpc/calendar/**) is a quick reference for finding documents that have recently been published. This site also provides a link to a listing of ODJFS manual transmittal letters (**http://www.odjfs.state.oh.us/lpc/mtl/**). The listing is categorized by letter number and subject, and a link is provided to each easy-print (PDF) document.

To receive electronic notification when new Medicaid transmittal letters are published, subscribe at: **http://www.odjfs.state.oh.us/subscribe/**.

Questions:

Questions pertaining to this letter should be addressed to:

Ohio Department of Job and Family Services

Office of Ohio Health Plans, Bureau of Provider Services

P.O. Box 1461

Columbus, OH 43216-1461

Telephone 800-686-1516

MHTL 3351-09-01

Medical Handbook Transmittal Letter (MHTL) No. 3351-09-01

May 22, 2009

TO: All Eligible Ambulatory Surgery Center (ASC) Providers

Directors, County Departments of Job and Family Services

FROM: Douglas E. Lumpkin, Director

SUBJECT: Proposed Amendment of Rules 5101:3-4-23, 5101:3-22-02 and 5101:3-22-03 of the Administrative Code

The following rules are being proposed for amendment pursuant to Section 119.032 of the Revised Code, which requires the review of all state agency rules within a five year period.

Rule 5101:3-4-23 entitled: "Covered ambulatory surgery center (ASC) surgical procedures" describes reimbursement to physicians for covered ASC procedures, ASCs for a facility fee for covered ASC surgical procedures, and physicians for the professional component of other covered services personally performed by the physician. Change to the proposed rule deletes a reference to the C.F.R.

Rule 5101:3-22-02 entitled: "Covered ambulatory surgery center services" identifies covered ASC surgical procedures, noncovered ASC surgical procedures and covered ASC facility services. Change to the proposed rule is stylistic (the ASC acronym is added to the rule tagline and a semicolon is added to one item in a series) and deletes a reference to the C.F.R.

Rule 5101:3-22-03 entitled: "Reimbursement of facility services in an ambulatory surgery center" identifies payment for facility services, laboratory services, radiological services, and diagnostic and therapeutic procedures. Change to this rule is stylistic (the ASC acronym is added to the rule tagline and the spelling of Administrative is corrected).

Web Page:

The Ohio Department of Job and Family Services maintains an "electronic manuals" web page of the department's rules, manuals, letters, forms, and handbooks. The URL for this "eManuals" page is http://emanuals.odjfs.state.oh.us/emanuals/.

Providers may view documents online by:

(1) Selecting the "Ohio Health Plans - Provider" folder;

(2) Selecting the appropriate topic from the document list; and

(3) Selecting the desired item from the "Table of Contents" pull-down menu.

Most current Medicaid maximum reimbursement rates are listed in rule 5101:3-1-60 or in Appendix DD to that rule. Providers may view these rates by:

(1) Selecting the "Ohio Health Plans - Provider" folder;

(2) Selecting "General Information for Medicaid Providers"; and

(3) Selecting "5101:3-1-60 Medicaid Reimbursement" from the "Table of Contents" pull-down menu.

The Legal/Policy Central - Calendar site (**http://www.odjfs.state.oh.us/lpc/calendar/**) is a quick reference for finding documents that have recently been published. This site also provides a link to a listing of ODJFS manual transmittal letters (**http://www.odjfs.state.oh.us/lpc/mtl/**). The listing is categorized by letter number and subject, and a link is provided to each easy-print (PDF) document.

MHTL 3351-04-01

Medical Handbook Transmittal Letter (MHTL) No. 3351-04-01

April 22, 2004

TO: All Ambulatory Surgical Centers
Directors, County Departments of Job and Family Services
Medical Assistance Coordinators

FROM: Thomas J. Hayes, Director

SUBJECT: Covered Procedures Appendix and Billing Updates

The purpose of this Medical Handbook Transmittal Letter (MHTL) is to notify ASC providers of updates to the **ASC Covered Surgical Procedure Appendix**. In addition, this MHTL provides billing updates and instructions.

Appendix Update

Minor revisions were made to the ASC Covered Surgical Procedure Appendix to accurately reflect the level of payment for procedures performed in an ASC. The updated appendix may be viewed on our website at: http://emanuals.odjfs.state.oh.us/emanuals/medicaid/ASC.

Claims Processing and Billing Updates

The department has taken steps to prevent inappropriate payment of ASC multiple surgery claims. These claims are now being manually priced until a automated process is put in place. In accordance with rule 5101:3-22-03, when more than one covered procedure is performed in a single operative session, the primary procedure is reimbursed at 100% of the surgical group rate, the secondary procedure is reimbursed at 50% of the surgical group rate, and any subsequent procedures are reimbursed at 0% of the surgical group rate.

It has come to the department's attention that some ASC providers are using a 50 modifier with bi-lateral surgery codes when billing for facility services. A 50 modifier may be used for billing professional claims, but should not be used to bill for ASC facility services. Billing a 50 modifier for an ASC facility service will result in payment at 150% of the professional rate instead of the appropriate ASC multiple surgery rate.

ASC facility payment for intraocular lenses is included in the reimbursement of the associated surgery. ASC facilities should bill only the appropriate CPT code for the surgery. They should not bill V2630, V2631, or V2632 for separate reimbursement of intraocular lenses. These codes are no longer set to pay in the claims processing system.

If an ASC provider believes that an improper payment of a claim has occurred, an adjustment may be requested by submitting a copy of the applicable remittance advice along with a completed adjustment request form (JFS 06767).

To obtain a copy of the rules and future program updates:

The handbook updates that are announced in this Medical Handbook Transmittal (MHTL) can be found on our website at: http://emanuals.odjfs.state.oh.us/emanuals or if you do not have internet access you may request a paper copy of this notice and the ASC Covered Surgical Procedure Appendix by completing the attached JFS 03400.

Questions pertaining to this MAL should be addressed to:

The Bureau of Plan Operations

Provider Network Management Section

P.O. Box 1461

Columbus, Ohio 43216-1461

Toll-free number: 1-800-686-1516

MHTL 3351-03-01

Medicaid Handbook Transmittal Letter (MHTL) # 3351-03-01

December 9, 2003

TO: All Providers of Ambulatory Surgical Center Services
Directors, County Department of Job and Family Services
Medical Assistance Coordinators

FROM: Thomas Hayes, Director

SUBJECT: Update to ASC Covered Procedures and Group Classifications

The purpose of this Medicaid Handbook Transmittal Letter (MHTL) is to announce a ninth surgical group classification, and to inform providers of changes that have been made to the list of payable ASC procedures. The department has amended chapter 5101:3-22 to add a ninth surgical group classification for covered ASC procedures. The ninth surgical group was added to maintain consistency with Medicare surgical group classifications and will be effective January 1, 2004.

In April 2003, CMS made changes to the list of Medicare payable ASC surgical procedures. The department is adopting these changes for the Medicaid program. As a result, effective January 1, 2004, several codes will become payable ASC procedures and other codes will no longer be payable ASC procedures. For your reference, a list of newly opened codes can be found in Attachment 1, and a list of the closed codes can be found in Attachment 2. The attachments also include effective dates and ASC group designations for each code. A list of payable ASC procedures and their group designations is contained in Appendix A of the ASC handbook. **Both attachments and an updated version of Appendix A can be found at the following website: http://dynaweb.odjfs.state.oh.us:6336/dynaweb/medicaid.**

The department may begin to consider opening additional codes as payable ASC procedures in spring of 2004. Covered ASC surgical procedures must meet certain standards to be considered. They must be commonly performed on an inpatient basis in hospitals, but may be safely performed in an ASC. They must be a type of procedure that is not commonly or safely performed in a physician's office. They are limited to procedures that do not generally exceed 90 minutes and generally require a dedicated operating room and a post-operative recovery room. They should not exceed a total of 4 hours recovery or convalescent time. If the covered surgical procedure requires anesthesia, the anesthesia must be local or regional or general anesthesia of 90 minutes or less duration. Covered procedures may not be of the type that generally result in extensive blood loss, require major or prolonged invasion of body cavities, directly involve major blood vessels or are generally emergency or life-threatening in nature. If there are procedure codes that you believe meet these guidelines and are not already included in Appendix A, you may send your suggestion and a justification to the following address for consideration.

Attn: Covered ASC Procedure Policy Review

Bureau of Health Plan Policy

30 East Broad St., 27th Floor

Columbus, OH 43215

Requesting updates to this manual

The manual updates that are announced in this MHTL can be found at on our website at: http://dynaweb.odjfs.state.oh.us:6336/dynaweb/medicaid or if you do not have internet access you may request a paper copy of the rules by completing the attached JFS 03400. If you have received ONLY a paper copy of this MHTL and you wish to be notified in the future by e-mail of program updates the week that they are published, please send an email to: provider_subscribe@odjfs.state.oh.us and include your provider number.

Questions pertaining to this MHTL should be addressed to:

Bureau of Plan Operations

The Provider Network Management Section

P.O. Box 1461

Columbus, Ohio 43216-1461

In-state toll free telephone number 1-800-686-1516

Out-of-state telephone number 1-614-728-3288

Attachment 1 - New Payable ASC Surgical Procedures

Attachment 2 - ASC Surgical Procedures That Are No Longer Payable

MHTL 3351-01-02

Medicaid Handbook Transmittal Letter (MHTL) 3351-01-02

February 5, 2002

TO: All Providers of Ambulatory Surgical Center Services
Directors, County Departments of Jobs and Family Services
Medical Assistance Coordinators

FROM: Thomas J. Hayes, Director

SUBJECT: HANDBOOK UPDATE FOR 2002 HCPCS CHANGES

2002 HCPCS HANDBOOK UPDATE

The purpose of this Medicaid Handbook Transmittal Letter (MHTL) is to announce the implementation of the 2002 HCPCS (including CPT and alpha-numeric) codes and to transmit to providers of ASC services a new Appendix A listing the payable ASC procedures.

2002 HCPCS

On January 1, 2002, the Department will begin accepting the 2002 HCPCS codes effective for services rendered on and after that date. To give providers time to make the transition to the 2002 HCPCS codes, the Department will continue to accept the 2001 codes for services rendered through March 31, 2002. Providers may choose to bill either the 2001 codes or the 2002 codes during the transition period from January 1, 2002 to March 31, 2002. Beginning April 1, 2002, the 2001 codes will no longer be accepted to report services on and after that date.

Ambulatory Surgical Center Services Handbook Update

The following is a summary of the policy handbook changes that have been made effective for January 1, 2002, and are incorporated into the attached consolidated Chapter 3351 of the Provider Handbook.

Policy Update:

- New Payable ASC Codes Appendix A

  The Department has updated its list of payable ASC surgical procedures. A revised Appendix A is attached to this MHTL. The following procedure codes which are replacement codes for certain CPT codes which were deleted, have been added to the list of covered ASC surgical services effective of services provided on or after January 1, 2002.

CPT CODE	ASC GROUP
25024	3
25025	3
25275	4
25671	1
29805	3
29806	3
29807	3
29824	5

29900	3
29901	3
29902	3
36819	3
36820	3
46020	3
52001	2
53431	2
53444	2
53445	1
53446	1
54162	2
54163	2
54164	2
54512	2

- The following ASC codes have been closed and should not be used to bill for services rendered after 12-31-01

  Closed CPT Codes

  26585

  26597

  29815

  54510

Questions pertaining to this MHTL should be addressed to:

Bureau of Plan Operations

The Provider Network Management Section

P.O. Box 1461

Columbus, Ohio 43216-1461

In-state toll free telephone number 1-800-686-6108

Out-of-state telephone number 1-614-728-3288

MHTL 3551-01-01

Medicaid Handbook Transmittal Letter (MHTL) 3351-01-01

January 12, 2001

TO: All Providers of Ambulatory Surgical Center Services
Directors, County Department of Job and Family Services
Medical Assistance Coordinators

FROM: Jacqueline Romer-Sensky, Director

SUBJECT: HANDBOOK UPDATE FOR 2001 HCPCS CHANGES

2001 HCPCS HANDBOOK UPDATE

The purpose of this Medicaid Handbook Transmittal Letter (MHTL) is to announce the implementation of the 2001 HCPCS (including CPT and alpha-numeric) codes and to transmit to providers of ASC services a new Appendix A listing the payable ASC procedures.

2001 HCPCS Codes

On January 1, 2001, the Department began accepting the 2001 HCPCS codes effective for services rendered on and after that date. To give providers time to make the transition to the 2001 HCPCS codes, the Department will continue to accept the 2000 codes for services rendered through March 31, 2001. Providers may choose to bill either the 2000 codes or the 2001 codes during the transition period from January 1, 2001 to March 31, 2001. Beginning April 1, 2001, the 2000 codes will no longer be accepted to report services provided on and after that date.

Ambulatory Surgical Center Services Handbook Update

The following is a summary of the policy handbook changes that have been made effective for January 1, 2001 and are incorporated into the attached consolidated Chapter 3351 of the Provider Handbook. This MHTL and all changes made to the consolidated Chapter 3351 will be available on CD-ROM in February, 2001.

Policy Update:

- New Payable ASC Codes Appendix A

The Department has updated its list of payable ASC surgical procedures. A revised Appendix A is attached to this MHTL. The following procedure codes which are replacement codes for certain CPT codes which were deleted, have been added to the list of covered ASC surgical services effective for services provided on or after January 1, 2001:

CPT CODE	ASC GROUP
15757	3
15758	3
19290	1
19291	1
42500	3
44312	1
49421	1

47560	3
47561	3
49320	3
49321	4
49322	4
49650	4
49651	7
52351	3
52352	4
52353	4
52354	4
52400	3
58551	5
58555	1
58558	3
58559	2
58561	3
58563	4
58660	5
58661	5
58662	5
58670	4
58671	4
58672	5
58673	5
62310	1
62311	1
62318	1
62319	1

62350	2
62351	2
62360	2
62362	2
62365	2
62367	2
62368	2
64475	1
64476	1

Questions pertaining to this MHTL should be addressed to:

Bureau of Plan Operations

The Provider Network Management Section

P.O. Box 1461

Columbus, OH 43216-1461

In-state toll free telephone number 1-800-686-6108

Out-of-state telephone number 1-614-728-3288

Miscellaneous Medicaid Handbook Transmittal Letters

MHTL 3334-10-02

Medicaid Handbook Transmittal Letter (MHTL) No. 3334-10-02 (New 2010 HCPCS and CPT Codes and Policy Updates), is maintained in the General Information e-book.

Medical Assistance Letters

MAL 548

Medical Assistance Letter (MAL) No. 548

July 22, 2008

To: All Ambulatory Surgery Center Providers
Directors, County Departments of Job and Family Services
Medical Assistance Coordinators

From: Helen E. Jones-Kelley, Director

Subject: Fee Increases

Effective July 1, 2008

The purpose of this Medical Assistance Letter (MAL) is to announce the updates to Ohio Administrative Code (OAC) rule **5101:3-1- 60** titled *Medicaid Reimbursement*.

The Department is pleased to announce that the Ambulatory Surgery Center (ASC) facility payment rates will increase by 3% as part of the Governor's biennium budget. The rates will become effective for claims with dates of service on and after July 1, 2008.

ASC Group	Old Rate	Effective 07/01/08
1	$ 247.00	$ 254.41
2	$ 332.00	$ 341.96
3	$ 381.00	$ 392.43
4	$ 469.00	$ 483.07
5	$ 535.00	$ 551.05
6	$ 705.00	$ 726.15
7	$ 743.00	$ 765.29
8	$ 814.00	$ 838.42
9	$ 1,033.00	$ 1,063.99

These Medicaid changes are applicable to claims for consumers remaining in traditional Medicaid who have not transitioned to a Medicaid managed care plan (MCP). For claims for consumers in a Medicaid MCP, providers are reimbursed according to negotiated rates established between the MCP and the provider. MCP providers should refer to their contract with the MCP to determine how the Medicaid maximum updates and policy revisions in this MAL and in the Medicaid reimbursement rule 5101:3-1-60 will affect their MCP reimbursement. Contracting questions should be directed to the applicable MCP.

As mentioned in previous communications, the Department has made the decision not to adopt the Medicare revised payment system for services furnished in Ambulatory Surgery Centers at this time. Any future changes to the Medicaid payment system will be announced prior to implementation.

Web Page and Paper Distribution

The Ohio Department of Job and Family Services maintains an "electronic manuals" web page for the department's rules, manuals, letters, forms, and handbooks. The URL for this "eManuals" page is http://emanuals.odjfs.state.oh.us/emanuals.

Providers may view documents online by:

(1) Selecting "Ohio Health Plans - Provider" folder;

(2) Selecting "Ambulatory Surgery Center Services"; and,

(3) Selecting the desired item from the "Table of Contents" pull-down menu.

Providers may view current reimbursement rates online by:

(1) Selecting the "Legal Services" folder;

(2) Selecting "ODJFS Ohio Administrative Code"; and,

(3) Selecting "5101:3-1-60 Medicaid Reimbursement" from the "Table of Contents" pull-down menu.

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Questions pertaining to this letter should be addressed to:

Office of Ohio Health Plans

Provider Services Section

P.O. Box 1461

Columbus, OH 43216-1461

1-800-686-1516

MAL 543

Medical Assistance Letter (MAL) No. 543

January 9, 2008

TO: All Ambulatory Surgery Center Providers

Directors, County Departments of Job and Family Services

Medical Assistance Coordinators

FROM: Helen E. Jones-Kelley, Director

SUBJECT: 2008 HCPCS Update, Billing Crossover Claims for Colorectal Cancer Screening, and Clarification of the Disability Medical Assistance program

The purpose of this Medical Assistance Letter (MAL) is to announce the implementation of the 2008 HCPCS codes, to announce a new billing process that Ambulatory Surgery Centers (ASCs) should follow when submitting a bill for colorectal cancer screening procedures, and to clarify the Disability Medical Assistance program consumer eligibility requirements.

2008 HCPCS Covered Procedures Update

On January 1, 2008 the department will begin to accept the 2008 HCPCS codes effective for services on and after January 1, 2008. The department will not accept the 2007 codes that are obsolete according to the AMA for services rendered beyond December 31, 2007. These changes can be located in Appendix DD of Ohio Administrative Code (OAC) rule 5101: 3-1-60.

The following procedure codes have been added to the Ambulatory Surgery Center fee schedule:

Code	ASC Indicator
49441	1
49446	1
50386	1
51102	1
32550	2
50385	2
20555	3
24357	3
24358	3
24359	3
27726	3
29904	3
29905	3
29906	3

41019	3
55920	3
27416	5
27769	5
28446	5
67041	5
67042	5
67043	5
67113	5
29828	9
29907	9

The following procedure codes have been deleted from the Ambulatory Surgery Center fee schedule:

Code	ASC Indicator
32000	1
51005	1
51010	1
32002	2
32005	2
32020	2
43750	2
24350	3
24351	3
24352	3
24354	3
24356	3
52510	3
67038	5

Claims Processing and Billing Updates

The new billing process is only applicable for colorectal cancer screening services rendered to dually eligible consumers (Medicare/Medicaid), submitted to Medicare for primary payment, then to the Ohio Department of Job and Family Services (ODJFS) for the payment of the Medicare co-insurance.

Effective January 1, 2007, the Medicare co-insurance changed for colorectal cancer screening procedures G0105 - colonoscopy on individual at high risk and G0121- colonoscopy on individual not meeting criteria for high risk. Also, effective January 1, 2008, the Medicare co-insurance will change for an additional colorectal cancer screening procedure G0104 - flexible sigmoidoscopy. Medicaid will now be responsible for a co-insurance of 25% rather than the previous co-insurance of 20% of a crossover claim from Medicare to Medicaid. As a result of this change, ASCs will experience a denial for the co-insurance charges. The denial will be indicated as a CAS 2 with a Remark N14. This change in co-insurance amounts applies to ASC charges only and not physician charges.

To obtain payment for a denial of the Medicare co-insurance, complete ODJFS 6653 Medical Claim Review Request Form. In block six (6) of the ODJFS 6653 form (explanation of request), type or hand write in large print "ASC Crossover with 25% Medicare co-insurance." The ODJFS 6653 form can be found at http://www.odjfs.state.oh.us/forms/inter.asp. Additionally, the Medicare co-insurance charges must be billed on an ODJFS 6780 Medicare Crossover Claim Form. Billing instructions for completing this form can be found at http://emanuals.odjfs.state.oh.us/emanuals under Ohio Health Plans Provider Billing Instructions Link- BIN.1002.2 Instructions for Completing the JFS 6780. Attach the completed 6780 Medicare crossover claim and a copy of the explanation of Medicare benefits (EOMB) to the ODJFS 6653 form to show the co-insurance amount, the HCPCS billed to Medicare and the HCPCS paid by Medicare. The address of where to submit the information is located on the back of the ODJFS 6653 form.

ODJFS is working on a solution that will streamline the process; however, until the solution has been implemented providers need to follow this process.

The department has made the decision not to adopt the Medicare revised payment system for services furnished in Ambulatory Surgery Centers beginning in calendar year 2008. Any future changes to the Medicaid payment system will be announced prior to implementation.

Disability Medical Assistance Program

The Disability Medical Assistance (DMA) program is a state-administered program with no federal funding. This program has a limited service plan and consumers in this program are not eligible to receive services in an ASC. ODJFS has realized that services have been provided to DMA consumers in ASCs. Please note that Ambulatory Surgery Centers are not eligible for reimbursement for services provided to DMA consumers.

Web Page and Paper Distribution:

The Ohio Department of Job and Family Services maintains an "electronic manuals" web page for the department's rules, manuals, letters, forms and handbooks. The URL is for this "eManuals" page is http://emanuals.odjfs.state.oh.us/emanuals/.

Providers may view documents online by:

(1) Selecting the "Ohio Health Plans - Provider" folder;

(2) Selecting "Ambulatory Surgery Center Services"; and

(3) Selecting the MAL 543 from the "Table of Contents" pull-down menu.

Providers may view the current reimbursement rates online by:

(1) Selecting the "Legal Services" folder;

(2) Selecting "ODJFS Ohio Administrative Code"; and

(3) Selecting "5101:3-1-60 Medicaid Reimbursement" from the "Table of Contents" pull- down menu.

The Legal/Policy Central - Calendar site (http://www.odjfs.state.oh.us/lpc/calendar) is a quick reference for finding documents that have been recently published. This site also provides a link to a listing of ODJFS manual transmittal letters (http://www.odjfs.state.oh.us/lpc/mtl). The listing is categorized by letter number and subject, and a link is provided to each easy-print (PDF) document.

Paper Distribution:

Providers will receive one printed copy of this letter and an accompanying JFS 03400, "Ohio Department of Job and Family Services, Service Provider Update Request Form." Providers may request a second printed copy of this letter with all attachments by completing the JFS 03400 and returning it to the Ohio Department of Job and Family Services in accordance with the instructions at the top of the form.

Questions pertaining to this letter should be addressed to:

Office of Ohio Health Plans

Provider Services Section

P.O. Box 1461

Columbus, OH 43216-1461

Toll Free Telephone Number 1-800-686-1516

MAL 532

Medical Assistance Letter (MAL) 532

June 7, 2007

To: Ambulatory Surgery Centers, Ambulance Providers, Durable Medical Equipment Providers, Home Health Agencies, Hospices, Independent Diagnostic Testing Facilities, Independent Laboratories, Independent X-Ray and Other Accredited Home Care Agencies

Trading Partners and Tape Intermediaries

Directors, County Departments of Job and Family Services

Medical Assistance Coordinators

From: Helen E. Jones-Kelley, Director

Re: Information Providers Must Know about the National Provider Identifier (NPI) in Order to Get Paid

NPI……GET IT.....SHARE IT.....USE IT

The purpose of this Medical Assistance Letter (MAL) is to inform ambulatory surgery centers, ambulance providers, durable medical equipment providers, home health agencies, hospices, independent diagnostic testing facilities, independent laboratories, independent x-ray and other accredited home health agencies that are enrolled in the Ohio Medicaid program and do business with ODJFS that they are required to obtain a National Provider Identifier (NPI) by May 23, 2007. An NPI for the provider types listed in this MAL is a unique, ten-digit, entity type 2 identifier that providers receive from the National Plan and Provider Enumeration System (NPPES). Upon receipt of their NPI and until January 1, 2008, providers that conduct business with Medicaid in an electronic format (i.e., submit EDI claims, receive electronic remittance advices and/or communicate electronically with trading partners and payers) must submit both their individual NPI number and their current individual Medicaid provider number (now referred to as the Medicaid legacy number or Ohio Medicaid legacy number) in accordance with the Ohio Medicaid EDI companion guide and/or the instructions contained in this MAL.* This is to create an association between these two numbers.

Providers MUST enumerate through NPPES, disclose their NPIs to ODJFS and bill ODJFS using both their NPI and Medicaid legacy identifiers. This MAL provides direction to providers on enumerating through NPPES, disclosing your NPI to ODJFS, and billing ODJFS using your NPI.*

Provider claims received by ODJFS before January 1, 2008 that contain a valid Ohio Medicaid legacy number, or both a valid NPI and valid Ohio Medicaid legacy number in the required provider fields, will continue to be accepted and processed. Claims submitted without an Ohio Medicaid legacy number (i.e., submitted only with an NPI number) prior to January 1, 2008 will be rejected or denied.*

Provider claims submitted to ODJFS on or after January 1, 2008 will be denied if the provider's NPI number is not in the required field(s) on the claim. Provider claims submitted on or after May 23, 2008 will not require the Ohio Medicaid legacy number if ODJFS has a record of your NPI number and has linked the NPI to your Ohio Medicaid legacy number.

* *See special instructions for paper and tape claims (below in this MAL).*

I. How do I get an NPI?

Providers can receive an NPI number by submitting an NPI application to NPPES. To obtain an NPI, providers should contact NPPES directly **at http://nppes.cms.hhs.gov or by phone at 1-800-465-3203 (or 1-800-692-2326 (TTY)).** Providers can apply for an NPI electronically or by paper.

When you apply for your NPI, ODJFS encourages you to submit the following information with your NPI application:

- Ohio Medicare legacy (PIN) number,
- Ohio Medicaid legacy number,

- taxonomy number, and
- employer identification number.

It is also important that you make it clear that you are applying for an NPI for a non-individual provider. A listing of taxonomy codes for non-individual providers can be found at **http://www.wpc-edi.com/codes/taxonomy**.

II. How must my NPI relate to my Medicaid legacy number?

If you received this MAL, at least once during the last twelve months you submitted a claim as one of the provider types specified in this MAL. When providers enroll to do business with ODJFS, they are issued a provider Medicaid legacy number. When providers subsequently submit claims for payment, ODJFS expects the billing provider and the pay to provider to be the same provider.

Services rendered by other practitioners employed by you or under contract with you should be billed under your NPI and your Medicaid legacy number (when both numbers are required). This directive applies as soon as you receive your NPI number and remains in effect after January 1, 2008.

Providers must submit only the non-individual NPI assigned to them with the Ohio Medicaid legacy number that was issued to them as a provider. Only one NPI number can be associated with your Ohio Medicaid legacy number. A provider's NPI should never be submitted to ODJFS with a Medicaid legacy number that belongs to any other provider.

III. How do I bill ODJFS using the NPI?

The billing instructions contained in this MAL are for the providers indicated in the heading of this MAL. Instructions for submitting the NPI are also contained in the ODJFS EDI 837 Professional Companion Guide, which is available at: **http://jfs.ohio.gov/OHP/providers/npi.stm** (see the box titled "Trading Partner").

Billing NPI on EDI 837 Professional Claims

The information in this section is technical but is intended to assist you in making the appropriate arrangements with your trading partner to receive your NPI number and to submit your NPI number on your EDI claims and other transactions. A copy of this MAL will also be issued to each EDI trading partner doing business with ODJFS.

The provider's NPI number must be entered in the primary identifier field on ASCII X12 837 health care transactions. The provider's NPI number must be sent with the XX qualifier in the NM108 and the NPI in the NM109 of the 2010AB (for the pay to provider information) loop and/or 2010AA (for the billing provider information) loop. Prior to January 1, 2008, the provider's Medicaid legacy provider number must also be sent with the 1D qualifier in the secondary identification qualifier location REF01 and the Medicaid legacy number in the secondary identification location REF02 of loops 2010AB and/or 2010AA.

The EDI standard does not require the rendering provider loop(s) to be completed if the rendering provider is the same as the pay to provider. For the provider types listed in this MAL billing Medicaid, the pay to provider and the rendering provider are always the same provider *(See special note for professional services billed by an ASC or Hospice, below)*. Do not send NPI information in the NM108 and NM109 nor the Medicaid legacy information in the REF01 and REF02 of the rendering provider loops (neither loop 2310B nor 2420B).

Special Note: When ASCs or hospice providers are billing for physician or advanced practice nurse (APN) professional services, the claim must be submitted in accordance with MAL 517 (group physicians) or MAL 529 (group APNs).

Billing on Paper Claims or by Tape

** Special Instructions for Paper and Tape formats*

ODJFS is no longer accepting tape formats.

Beginning May 23, 2007, ODJFS will start to accept the Center for Medicare and Medicaid Services (CMS) 1500 (08/05) paper form (also referred to as the ***new*** CMS 1500). Providers may continue to send the CMS 1500 (12-90) paper form (also referred to as the ***old*** CMS 1500).

Providers using the old CMS 1500 (required until announced) must submit a Medicaid legacy number wherever a provider number (identifier) is required on the claim. Submitting an NPI number on the old CMS 1500 will cause the claim to reject or may cause the claim to pay inappropriately.

Providers submitting the new CMS 1500 must submit both the NPI and the Medicaid legacy number (identifier) in accordance with the ODJFS New CMS 1500 (08/05) Billing Instructions.

IV. Why am I required to get an NPI?

The Code of Federal Regulations, CFR 45, Subpart D, Section 162.410 (a) (1) through (a) (6), requires providers to obtain an NPI, to use it on all standard transactions where a provider identifier is required, and to disclose their NPI, when requested, to any entity that needs the NPI to identify that provider in a standard transaction, including standard transactions sent to any health plan (i.e., Medicaid, Medicare or any other health plan). ODJFS must also comply with the federal regulations.

V. Am I required to share my NPI number with ODJFS?

Yes, the provider must disclose to ODJFS the NPI number that has been assigned to the provider. If you do not disclose your NPI to ODJFS, ODJFS will not be able to recognize you as a valid Medicaid provider. This could cause your claims to deny.

Instructions on how to disclose your NPI information to ODJFS can be obtained under "SHARE IT!" from the following site: **http://jfs.ohio.gov/OHP/providers/npi.stm**.

VI. Am I required to share my NPI with other entities?

Yes, as stated in Section V, you are required to disclose your NPI, when requested, to any entity that needs the NPI to identify the provider in a standard transaction. This includes disclosing your NPI to Medicaid, Medicare, other health plans and other health care providers.

VII. As an ambulatory surgery center, how do I bill for a physician?

You should bill for a physician as if you were a group physician practice. (Please refer to MAL 517, directive for physician groups.) On the claim form, where it asks for the physician group NPI number, use your ASC NPI number. Where it asks for the individual rendering physician's NPI number, use the surgeon's or anesthesiologist's NPI number as appropriate.

VIII. As a hospice, how do I bill for a physician or APN who is an employee of the hospice?

As mentioned in Section VIII above, bill as if you were a group physician practice. (Please refer to MAL 517, directive for physician groups.) On the claim form, where it asks for the physician group NPI number, use your hospice NPI number. Where it asks for the individual rendering physician's NPI number, use the rendering physician's or APN's NPI number as appropriate.

IX. I heard that the date for NPI implementation has been extended. Is that true?

No, the law still requires providers of health care and health (except small) plans to be in compliance with the NPI regulations on May 23, 2007. However, for a 12 month period, CMS will not impose penalties on covered health plans that deploy contingency plans (in order to ensure the smooth flow of payments) if they have made reasonable efforts to become compliant and to facilitate the compliance of their providers and trading partners.

X. Has ODJFS deployed a contingency plan?

Yes, ODJFS has deployed a contingency plan as detailed in this MAL.

XI. What is meant by a dual identifier period?

A dual identifier period is the time period in which a health plan can require both the NPI and the plan's legacy (or proprietary) number on claim formats and may deny claims that are missing the plan's legacy number.

The purpose of the dual identifier period is to give health plans and providers the opportunity to assure the provider will get paid without interruption once NPI is fully implemented. It is in the provider's best interest to have a significant volume of claims that have both identifiers and have been submitted early enough for ODJFS to assist the provider in correcting any NPI-related billing problems, prior to the end of the ODJFS dual identifier period.

As a part of ODJFS' NPI contingency plan, ODJFS has extended its dual identifier period to December 31, 2007. During this extended period ODJFS requires both the Medicaid legacy identifier and the national provider identifier (NPI). Failure to continue to send the Medicaid legacy identifier during the ODJFS dual identifier period will result in non-payment or the rejection of claims.

Providers and trading partners will be notified in the event ODJFS believes the ODJFS dual identifier period can end sooner than December 31, 2007, or needs to be extended to the CMS approved date of May 23, 2008.

ODJFS appreciates the attention of the providers in this matter, and as a result of their cooperation anticipates a successful transition to NPI enumeration.

Questions pertaining to this MAL should be addressed to:

Bureau of Plan Operations

The Provider Services Section

P.O. Box 1461

Columbus, Ohio 43216-1461

Toll free telephone number 1-800-686-1516

You can also obtain information about NPI as it pertains to the Ohio Medicaid program at http://jfs.ohio.gov/OHP/providers/npi.stm

NPI……GET IT.....SHARE IT.....USE IT

MAL 522

Medical Assistance Letter No 522 (August 14, 2007 - Guidance on the Implementation of Employee Education about False Claims Recovery as provided in MAL 516), is maintained in the General Information e-book.

MAL 516

Medical Assistance Letter No 516 (November 9, 2006 - Employee Education About False Claims Recovery), is maintained in the General Information e-book.

MAL 497

Medical Assistance Letter (MAL) No. 497

February 1, 2006

TO: All Providers of Ambulatory Surgery Centers
Directors, County Department of Job and Family Services
Medical Assistance Coordinators

FROM: Barbara E. Riley, Director

SUBJECT: Ambulatory Surgery Center 2006 CPT Update

Effective January 1, 2006

The purpose of this Medical Assistance letter (MAL) is to notify the Ambulatory Surgical Centers (ASC) who provide services to Ohio's Medicaid consumers of the updates to CPT procedure codes.

The procedure codes to be **added** include:

Code	ASC indicator
15300	2
15301	1
15320	2
15321	1
15330	2
15331	1
15335	2
15336	1
37718	3
37722	3

Surgery codes that have been **deleted** that apply to ASCs include:

Code	ASC Indicator	Replacement Code (s)
15350	2	15300-15346
15351	2	15300-15346
16015	2	16020-16030
21493	3	Use proper E&M codes
21494	4	Use proper E&M codes
31585	1	Use proper E&M codes

31586	2	Use proper E&M codes
37720	3	37718 & 37722
37730	3	37718 & 37722
42325	2	None

The ASC indicator pricing and updates that are announced in this MAL can be found on our website at http://emanuals.odjfs.state.oh.us/emanuals/medicaid.

Questions pertaining to this MAL should be addressed to:

Bureau of Plan Operations

The Provider Network Management Section

P.O. Box 1461

Columbus, Ohio 43216

In-state toll free telephone number 1-800-686-1516

MAL 472

Medical Assistance Letter (MAL) # 472

September 14, 2004

TO: All Ambulatory Surgical Centers
Directors, County Departments of Job and Family Services
Medical Assistance Coordinators

FROM: Thomas J. Hayes, Director

SUBJECT: Ambulatory Surgical Centers Covered Procedures and Billing Reminders

The purpose of this Medical Assistance Letter (MAL) is to notify ASC providers of updates to the list of covered ASC surgical procedures and to provide reminders of correct billing procedures which were previously issued in Medical Handbook Transmittal Letter (MHTL) No. 3351-04-01.

Covered Procedures Update

Effective October 1, 2004, the Department has revised group classifications for forty-five procedures to reflect Medicare group classifications. For example, the Center for Medicaid and Medicare Services (CMS) has determined that some procedures are not appropriate in an ASC setting, so Medicaid ASC coverage has also been terminated. In addition, the department is reimbursing some procedures that were not previously covered in an ASC setting and changing group classifications for procedures that are currently covered. An updated listing of covered ASC surgical procedures may be viewed on our website at: http://emanuals.odjfs.state.oh.us/emanuals/medicaid/ASC.

Claims Processing and Billing

The department has taken steps to prevent inappropriate payment of ASC multiple surgery claims. These claims are now being manually priced until a automated process is put in place. In accordance with rule 5101:3-22-03, when more than one covered procedure is performed in a single operative session, the primary procedure is reimbursed at 100% of the surgical group rate, the secondary procedure is reimbursed at 50% of the surgical group rate, and any subsequent procedures are reimbursed at 0% of the surgical group rate. Multiple surgery procedures performed on the same date of service for the same recipient should be billed on the same claim form to facilitate proper pricing and reimbursement.

It has come to the department's attention that some ASC providers are using a 50 modifier with bi-lateral surgery codes when billing for facility services. A 50 modifier may be used for billing professional claims, but should not be used to bill for ASC facility services. Billing a 50 modifier for an ASC facility service will result in payment at 150% of the professional rate instead of the appropriate ASC multiple surgery rate.

If an ASC provider believes that an improper payment has occurred, an adjustment may be requested by submitting a copy of the applicable remittance advice along with a completed adjustment request form (JFS 06767).

To obtain a copy of the rules and future program updates:

The updates that are announced in this Medical Assistance Letter (MAL) can be found on our website at: http://emanuals.odjfs.state.oh.us/emanuals or if you do not have internet access you may request a paper copy of this notice and the ASC Covered Surgical Procedure Appendix by completing the attached JFS 03400.

Questions pertaining to this MAL should be addressed to:

The Bureau of Plan Operations

Provider Network Management Section

P.O. Box 1461

Columbus, Ohio 43216-1461

Toll-free number: 1-800-686-1516

Ambulatory Surgery Center Rules

5160-22-01 Ambulatory Surgery Center Eligible Providers

MHTL 3351-15-01

Effective Date: April 15, 2015

Most Current Prior Effective Date: **May 10, 2007**

(A) The department will reimburse an ambulatory surgery center (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 services will be paid according to rule 5160-22-03 of the Administrative Code.

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

(C) All ASCs that have a valid agreement with the Centers for Medicare and Medicaid Services (CMS) to provide services in the Medicare program ~~meet the standards provided in the 42 C.F.R. 416.20 to 416.49 (effective dates of these regulations are set forth below) and are certified for medicare participation by the Ohio department of health~~ are eligible to become medicaid providers upon execution of the "Ohio Medicaid Provider Agreement."

~~42 C.F.R. 416.20 effective May 20, 1991~~

~~42 C.F.R. 416.25 and 416.26 effective March 1, 1991~~

~~42 C.F.R. 416.30 and 416.35 effective August 2, 1996~~

~~42 C.F.R. 416.40 and 416.41 effective June 17, 1986~~

~~42 C.F.R. 416.42 effective November 13, 2001~~

~~42 C.F.R 416.43 and 416.44 effective September 22, 2006~~

~~42 C.F.R 416.45 to 416.49 effective February 28, 1992~~

Effective: 04/15/2015

Five Year Review (FYR) Dates: 01/12/2015 and 04/15/2020

Certification: CERTIFIED ELECTRONICALLY

Date: 03/24/2015

Promulgated Under: 119.03

Statutory Authority: 5164.02

Rule Amplifies: 5162.03, 5164.02

Prior Effective Dates: 3/20/84, 1/4/88, 2/17/91, 5/10/07

5160-22-02 Covered Ambulatory Surgery Center (ASC) Services

Formerly **5101:3-22-02 Covered Ambulatory Surgery Center (ASC) Services**

MHTL 3351-09-01

Effective Date: July 1, 2009

Most Current Prior Effective Date: **January 1, 2004**

(A) Covered ASC surgical procedures.

(1) "Covered ASC surgical procedures" are procedures ~~that meet the standards described in 42 CFR 416.65(a) and (b) (dated October 1, 2002) (and are~~ designated in appendix DD ~~of~~to rule 5101:3-1-60 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 ~~of~~to rule 5101:3-1-60 of the Administrative Code, identified by number one, two, three, four, five, six, seven, eight or nine as described in paragraph (A)(2) of rule 5101:3-22-03 of the Administrative Code.

(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.

(B) 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 ~~of~~to rule 5101:3-1-60 of the Administrative Code; and

(2) Surgical procedures, regardless of their designation in appendix DD ~~of~~to rule 5101:3-1-60 of the Administrative Code, if they are not reimbursable under paragraphs (A)(1) to (A)(2)(g) of rule 5101:3-2-03 and rule 5101:3-4-28 of the Administrative Code.

(C) 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 provision of a surgical procedure;

(5) Administrative, recordkeeping, 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.

Effective: 07/01/2009

R.C. 119.032 review dates: 02/11/2009 and 07/01/2014

Certification: CERTIFIED ELECTRONICALLY

Date: 05/18/2009

Promulgated Under: 119.03

Statutory Authority: 5111.02

Rule Amplifies: 5111.01, 5111.02, 5111.021

Prior Effective Dates: 3/20/84, 1/4/88, 2/17/91, 12/29/95 (Emer), 5/21/96, 1/1/04

5160-22-03 Reimbursement of Facility Services in an Ambulatory Surgery Center (ASC)

Formerly **5101:3-22-03 Reimbursement of Facility Services in an Ambulatory Surgery Center (ASC)**

MHTL 3351-09-01

Effective Date: July 1, 2009

Most Current Prior Effective Date: **January 1, 2004**

(A) Payment for facility services.

(1) Payment for facility services is based on a reimbursement rate for each surgical group classification as determined by the department. The reimbursement rate will be called the surgical group rate.

(2) Covered ASC procedures will be classified into nine surgical groups numbered one, two, three, four, five, six, seven, eight or nine. The surgical group classification for each covered procedure is contained in appendix DD ~~of~~ torule 5101:3-1-60 of the Administrative Code.

(3) 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 (J) of rule 5101:3-1-60 of the Administrative Code, whichever is less.

(4) When more than one covered procedure is performed in a single operative session, reimbursement for facility services will be one hundred per cent of the surgical group rate for the primary procedure and fifty per cent of the surgical group rate for the secondary procedure. Any subsequent procedures will be reimbursed zero per cent of the surgical group rate.

(B) 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 using the appropriate ~~HCPCS~~healthcare common procedure coding system (HCPCS) codes, as defined in rule 5101:3-1-19.3 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 in accordance with Chapter 5101:3-11 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 may be reimbursed in addition to the facility fee for radiological procedures ~~they~~the ASC actually performed as long as the services are provided and billed in accordance with rule 5101:3-4-25 of the ~~Administative~~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 in accordance with rules 5101:3-4-11, 5101:3-4-16, 5101:3-4-17 and 5101:3-4-18 of the Administrative Code.

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

(c) An ASC may not bill for any service designated as a professional only service in the rules cited in paragraph (B)(3)(a) of this rule.

(C) 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: 07/01/2009

R.C. 119.032 review dates: 02/11/2009 and 07/01/2014

Certification: CERTIFIED ELECTRONICALLY

Date: 05/18/2009

Promulgated Under: 119.03

Statutory Authority: 5111.02

Rule Amplifies: 5111.01, 5111.02, 5111.021

Prior Effective Dates: 1/4/88, 2/17/91, 12/29/95 (Emer), 5/21/96, 1/1/04

5160-4-23 Covered Ambulatory Surgery Center (ASC) Surgical Procedures

Formerly **5101:3-4-23 Covered Ambulatory Surgery Center (ASC) Surgical Procedures**

5160-4-23 is maintained in the Physician Services Manual, located in the Ohio Health Plans - Provider collection.

Other Applicable Rules for ASC Providers

5160-21-01 Sterilization

Formerly **5101:3-21-01 Sterilization**

5160-21-01 is maintained in the Physician Services Manual, located in the Ohio Health Plans - Provider collection.

5160-11-03 Laboratory Services: Coverage and Limitations

Formerly **5101:3-11-03 Laboratory Services: Coverage and Limitations**

5160-11-03 is maintained in the Laboratory Services Manual, located in the Ohio Health Plans - Provider collection.

5160-11-10 Radiology Procedures that are Subject to the Clinical Laboratory Improvement Amendments (CLIA) Requirements

Formerly **5101:3-11-10 Radiology Procedures that are Subject to the Clinical Laboratory Improvement Amendments (CLIA) Requirements**

5160-11-10 is maintained in the Laboratory Services Manual, located in the Ohio Health Plans - Provider collection.

5160-4-16 Cardiovascular Diagnostic and Therapeutic Services

Formerly **5101:3-4-16 Cardiovascular Diagnostic and Therapeutic Services**

5160-4-16 is maintained in the Physician Services Manual, located in the Ohio Health Plans - Provider collection.

5160-4-17 Gastroenterology, Otorhinolaryngology, Endocrinology, Neurology and Special Dermatology Services

Formerly **5101:3-4-17 Gastroenterology, Otorhinolaryngology, Endocrinology, Neurology and Special Dermatology Services**

5160-4-17 is maintained in the Physician Services Manual, located in the Ohio Health Plans - Provider collection.

5160-4-18 Pulmonary Services

Formerly **5101:3-4-18 Pulmonary Services**

5160-4-18 is maintained in the Physician Services Manual, located in the Ohio Health Plans - Provider collection.

5160-4-25 Laboratory and Radiology Services

Formerly **5101:3-4-25 Laboratory and Radiology Services**

5160-4-25 is maintained in the Physician Services Manual, located in the Ohio Health Plans - Provider collection.

ASC Appendix

ASC Covered Surgical Procedures: Effective 4/1/10

This table contains **ASC Procedure Codes** (10000-69930).

Please note, this is a large PDF which may take longer to open.

ASC Covered Surgical Procedures: Effective 4/01/2008

This table contains **ASC Procedure Codes** (10000-69930).

Please note, this is a large PDF which may take longer to open.

ASC Covered Surgical Procedures: Effective 10/1/04 to 12/31/05

This table contains **ASC Procedure Codes** (10000-69930).

Please note, this is a large PDF which may take longer to open.

ASC Covered Surgical Procedures: Effective 4/1/04 to 9/30/04

This table contains **ASC Procedure Codes** (10000-69930).

Please note, this is a large PDF which may take longer to open.

ASC Facility Payment Rates

ASC Group	Rates for dates of service prior to Jan. 1, 2010.	Rates for dates of service on and after Jan. 1, 2010.
1	$ 254.41	$ 246.78
2	$ 341.96	$ 331.70
3	$ 392.43	$ 380.66
4	$ 483.07	$ 468.58
5	$ 551.05	$ 534.52
6	$ 726.15	$ 704.37
7	$ 765.29	$ 742.33
8	$ 838.42	$ 813.27
9	$ 1,063.99	$ 1,032.07

Billing Instructions

Click **here** to view the Billing instructions eManual.