AUTHENTICATED,
OHIO LEGISLATIVE SERVICE
COMMISSION
DOCUMENT #294564

Ohio Administrative Code

Rule 5160-4-22 Surgical services.

Effective: January 1, 2022

(A) Coverage.

(1) In general, payment may be made to an eligible provider for performing a medically necessary surgical procedure on a medicaid-eligible individual. The following limitations, however, apply.

(a) No separate payment is made to the provider of a surgical service for local infiltration, the administration of general anesthesia or sedation, normal uncomplicated preoperative and postoperative care, or any procedure that is performed incidental to or as an integral part of the operation. On claims, providers should report comprehensive surgical services; they are not to itemize or "unbundle" individual components.

(b) Certain characteristics of a surgical procedure performed on the same patient by the same provider may affect how it is reported on a claim and how payment for it is made.

(i) The Ohio department of medicaid (ODM) recognizes five groups of surgical procedures defined by a particular characteristic:

(A) Multiple procedures, for which payment is reduced when more than one is performed;

(B) Bilateral procedures, for which payment is adjusted when they are performed on both body parts of a corresponding pair;

(C) Co-surgery procedures, for which payment is split between two surgeons, each in a different specialty, who perform parts of the same procedure simultaneously.

(D) Assistant-at-surgery procedures, for which payment is reduced when they are performed by an assistant at surgery; and

(E) Procedures performed on fingers, toes, eyelids, or coronary arteries.

(ii) In assigning covered procedures to these groups, ODM follows the policies of the medicare program except when otherwise noted in this rule.

(2) Payment may be made for a co-surgery procedure only if the following conditions are met:

(a) The procedure can be performed only by surgeons;

(b) Not more than two surgeons submit a claim for the procedure; and

(c) Manual review of supporting documentation is not necessary to establish the need for two surgeons.

(3) Payment for an assistant-at-surgery procedure is subject to the following constraints:

(a) No additional payment is made for the services of more than one assistant at surgery during an operation, regardless of the extent of the surgery;

(b) Payment may be made for an assistant-at-surgery procedure performed in a teaching hospital only if at least one of the following conditions is met:

(i) The surgeon who performed the assistant-at-surgery procedure was neither a resident nor an intern, and this fact is attributable to either of the following reasons:

(A) The primary surgeon does not customarily use residents or interns for any part of the particular surgical procedure (including preoperative and postoperative care); or

(B) No resident in a training program in a medical specialty appropriate to the surgical procedure was available to serve as an assistant at surgery.

(ii) The assistant-at-surgery procedure constituted concurrent care for a medical condition that necessitated active treatment during surgery by physicians of more than one specialty;

(iii) During surgery, complex medical procedures were performed that involved a team of physicians; or

(iv) Exceptional medical circumstances warranted an assistant at surgery.

(4) Payment for physician visits in addition to surgery is addressed in rule 5160-4-06 of the Administrative Code.

(5) Certain types of surgery are often supplemented by the use of a cast, splint, strap, or other traction device. For initial application and removal that is performed in conjunction with covered musculoskeletal surgery, payment for the surgery includes the application and removal procedures, all materials (casting components, splints, or straps), and incidental supplies. In all other circumstances, the following provisions apply:

(a) Payment for the work depends on the nature and purpose of the procedure.

(i) For initial application and removal that is not performed in conjunction with surgery (e.g., the casting or strapping of a sprained joint), payment may be made for an appropriate evaluation and management service;

(ii) For necessary replacement, payment may be made for an appropriate casting/strapping procedure; and

(iii) For necessary repair, payment may be made for an appropriate evaluation and management service.

(b) Separate payment may be made for materials only if the service was rendered in a non-hospital setting.

(c) No separate payment is made for incidental supplies.

(B) Claim payment. Payment for a surgical procedure is the lesser of two figures:

(1) The provider's submitted charge; or

(2) A percentage of the medicaid maximum amount specified in rule 5160-1-60 of the Administrative Code or in appendix DD to that rule, determined in the following manner:

(a) For a procedure that is not performed incidental to or as an integral part of an operation and that is not subject to multiple-procedure payment reduction, one hundred per cent;

(b) For a procedure that is subject to multiple-procedure payment reduction, the relevant percentage from the following list:

(i) For a primary procedure (i.e., the procedure with the highest maximum amount listed in rule 5160-1-60 of the Administrative Code or in appendix DD to that rule), one hundred per cent;

(ii) For a secondary procedure (i.e., the procedure with the next highest maximum amount listed in rule 5160-1-60 of the Administrative Code or in appendix DD to that rule), fifty per cent; or

(iii) For any other procedure, twenty-five per cent;

(c) For a co-surgery procedure, sixty two and a half per cent per surgeon;

(d) For a bilateral procedure, one hundred fifty per cent; or

(e) For an assistant-at-surgery procedure, twenty-five per cent.