CSI - Ohio

The Common Sense Initiative

Business Impact Analysis

Agency Name: Ohio Department of Medicaid (ODM)

Regulation/Package Title: Surgical Services

Rule Number(s):

Amendment: 5160-4-22

Date: March 3, 2017

Rule Type:

- ☐ New
- ☑ Amended
- ☑ 5-Year Review
- ☐ Rescinded

The Common Sense Initiative was established by Executive Order 2011-01K and placed within the Office of the Lieutenant Governor. Under the CSI Initiative, agencies should balance the critical objectives of all regulations with the costs of compliance by the regulated parties. Agencies should promote transparency, consistency, predictability, and flexibility in regulatory activities. Agencies should prioritize compliance over punishment, and to that end, should utilize plain language in the development of regulations.

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Regulatory Intent

1. **Please briefly describe the draft regulation in plain language.**
   Please include the key provisions of the regulation as well as any proposed amendments.

   Current rule 5160-4-22, "Surgical services," sets forth provisions for coverage of and payment for professional surgical services.

   The Department is proposing a change in the method and standard for setting payment rates for surgical services through the adoption of a modifier (modifier 62) for surgical operations when two or more surgeons of different specialties contribute to one operative session and each separately submits claims to the department for their services. The department is adopting this method for paying co-surgery surgical services to align with Medicare and allow these services to be billed and paid correctly as co-surgery services rather than billed as assistant-at-surgery services.

   The proposed amendments also remove the language from paragraph (A)(4) of the rule, which states that "payment for the surgical treatment of obesity requires prior authorization." This language was added in error when this regulation was previously rule-filed. This language in the rule regarding prior authorization is inaccurate as the Ohio Department of Medicaid does not require a professional surgical provider to obtain a prior authorization for their professional surgical services. The prior authorization language can be found in ODM's hospital OAC Rule 5160-2-03, which requires the hospital facility to obtain any needed prior authorization before a surgery is performed.

2. **Please list the Ohio statute authorizing the Agency to adopt this regulation.**

   Section 5164.02 of the Ohio Revised Code.

3. **Does the regulation implement a federal requirement? Is the proposed regulation being adopted or amended to enable the state to obtain or maintain approval to administer and enforce a federal law or to participate in a federal program?**
   If yes, please briefly explain the source and substance of the federal requirement.

   No.

4. **If the regulation includes provisions not specifically required by the federal government, please explain the rationale for exceeding the federal requirement.**

   These payment policies are not required by federal law, but they do fall within the federal authority granted to states in administering the Medicaid program.

5. **What is the public purpose for this regulation (i.e., why does the Agency feel that there needs to be any regulation in this area at all)?**

   The public purpose for this regulation is to update and correct coverage and payment policies for professional surgical services.

6. **How will the Agency measure the success of this regulation in terms of outputs and/or outcomes?**

   The success of the regulation will be measured by the extent to which claims for co-surgeries are paid correctly when submitted in the Medicaid Information Technology System (MITS).

Development of the Regulation

7. **Please list the stakeholders included by the Agency in the development or initial review of the draft regulation.**
   If applicable, please include the date and medium by which the stakeholders were initially contacted.

   The proposed rule went through the public-comment process known as Clearance after the initial draft rule amendments were shared with stakeholders. Additionally, on October 24, 2016, an informal email was sent to the Ohio State Medical Association (OSMA), the Ohio Association of Advanced Practice Nurses (OAAPN), and the Ohio Association of Physician Assistants (OAPA) sharing the proposed changes and to let each association know that rule 5160-4-22 will be proposed for amendment and open for five-year rule review. Additional time was provided beyond the public review process to allow stakeholders adequate time to review and comment.

8. **What input was provided by the stakeholders, and how did that input affect the draft regulation being proposed by the Agency?**

   OSMA, OAAPN, and OAPA responded to ODM noting no concerns with the proposed rule amendments. The OAAPN stated they found the proposed rule revisions helpful.

9. **What scientific data was used to develop the rule or the measurable outcomes of the rule? How does this data support the regulation being proposed?**

   The use of scientific data is not applicable in this context of this rule.

10. **What alternative regulations (or specific provisions within the regulation) did the Agency consider, and why did it determine that these alternatives were not appropriate? If none, why didn't the Agency consider regulatory alternatives?**

    The regulation describes ODM's coverage and payment policies for professional surgical services. No other rules describe these provisions, therefore no regulatory alternative is readily apparent.

11. **Did the Agency specifically consider a performance-based regulation? Please explain.** ***Performance-based regulations define the required outcome, but don't dictate the process the regulated stakeholders must use to achieve compliance.***

    The concept of performance-based regulation does not apply to this rule.

12. **What measures did the Agency take to ensure that this regulation does not duplicate an existing Ohio regulation?**

    Rules involving Medicaid providers are housed exclusively within agency 5160 of the Ohio Administrative Code. Within this division, rules are generally separated out by topic. It is clear which rules apply to each provider type and item or service. In this instance, there was no duplication.

13. **Please describe the Agency's plan for implementation of the regulation, including any measures to ensure that the regulation is applied consistently and predictably for the regulated community.**

    The policies set forth in this rule will be incorporated into the Medicaid Information Technology System (MITS) as of the effective date of this rule. It therefore will be applied by the Department's electronic claim-payment system automatically and consistently whenever an appropriate provider submits a claim for an applicable services.

14. Provide a summary of the estimated cost of compliance with the rule. Specifically, please do the following:

a. Identify the scope of the impacted business community;

This rule affects ODM providers of professional surgical services.

b. Identify the nature of the adverse impact (e.g., license fees, fines, employer time for compliance); and

The adverse impact contained in the current rule requires prior authorization for the surgical treatment of obesity. The prior authorization language is being removed from the proposed rule since this language does not accurately describe ODM's policy. ODM does not require professional providers of surgical services to request prior authorization. Rather, the hospital facility must obtain prior authorization from ODM for the facility's payment.

c. Quantify the expected adverse impact from the regulation.
The adverse impact can be quantified in terms of dollars, hours to comply, or other factors; and may be estimated for the entire regulated population or for a "representative business." Please include the source for your information/estimated impact.

Each prior authorization request takes about 15 minutes to complete. The prior authorization requirement for obesity services is being removed from the proposed rule, because it does not apply to professional providers of surgical services. Instead, the prior authorization requirement falls on the facility in which these surgical services are being performed. The requirement for the facility is addressed in a separate OAC rule, 5160-2-03, which speaks to the conditions and limitations to hospital services.

15. Why did the Agency determine that the regulatory intent justifies the adverse impact to the regulated business community?

The adverse impact contained in the current rule is being removed from the proposed rule.

Regulatory Flexibility

16. Does the regulation provide any exemptions or alternative means of compliance for small businesses? Please explain.

This rule outlines actions providers of professional surgical services must take in order to receive Medicaid payment. The requirements are applied uniformly and no exception is made based on an entity's size.

17. How will the agency apply Ohio Revised Code section 119.14 (waiver of fines and penalties for paperwork violations and first-time offenders) into implementation of the regulation?

The rule imposes no sanctions on providers.

18. What resources are available to assist small businesses with compliance of the regulation?

Providers that submit claims through an electronic clearinghouse (a "trading partner") can generally rely on the clearinghouse to know current Medicaid claim-submission procedures.

Information sheets and instruction manuals on various claim-related topics are readily available on the Medicaid website.

Policy questions may be directed via e-mail to the Non-Institutional Benefit Management section of ODM's policy bureau at noninstitutional_policy@medicaid.ohio.gov.

The Bureau of Provider Services renders technical assistance to providers through its hotline, (800) 686-1516.

5160-4-22 **Surgical services.**

(A) Coverage.

(1) In general, payment may be made to an eligible provider for performing a medically necessary surgical procedure on an eligible recipient. 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 must not 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 department recognizes ~~four~~ 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 among two surgeons when performed. Co-surgery refers to a single surgical procedure which requires the skill of two surgeons, each in a different specialty, performing parts of the same procedure simultaneously.

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

~~*(d)*~~*(e)* Procedures performed on fingers, toes, eyelids, or coronary arteries.

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

(2) The following constraints apply to payment for co-surgery procedures:

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

(b) No more than two surgeons can submit a claim for a co-surgery procedure; and

(c) The department covers co-surgery procedures that may be submitted directly, meaning the procedure does not require manual review of supporting documentation to establish that two surgeons are necessary.

~~(2)~~(3) The following constraints apply to payment for assistant-at-surgery procedures:

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

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

(i) The service performed is medically necessary, the physician who performs it is primarily engaged in the field of surgery, and the primary surgeon does not use residents or interns for any part of the surgical procedure (including preoperative and postoperative care);

(ii) The service constitutes concurrent care for a medical condition that requires the presence of and active treatment by a physician of another specialty during surgery;

(iii) Complex medical procedures are performed that require a team of physicians; or

(iv) Exceptional medical circumstances warrant an assistant at surgery; and

(c) No payment is made for an assistant at surgery in a teaching hospital if the following two conditions are met:

(i) The hospital has a training program in the medical specialty required for the surgical procedure; and

(ii) A resident in that training program is available to serve as an assistant at surgery.

~~(3)~~(4) ~~Payment for the surgical treatment of obesity requires prior authorization~~.

~~(4)~~(5) Payment for physician visits in addition to surgery is addressed in rule 5160-4-06 of the Administrative Code.

~~(5)~~(6) 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 percent per surgeon;

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

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

Effective:

Five Year Review (FYR) Dates:

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Certification

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Date

Promulgated Under:	119.03
Statutory Authority:	5164.02
Rule Amplifies:	5164.02
Prior Effective Dates:	4/1/1977, 12/21/1977, 12/30/1977, 1/8/1979, 2/1/1980, 9/20/1984 (Emer), 12/17/1984, 5/19/1986, 7/1/1987, 4/1/1988, 9/1/1989, 5/25/1991, 3/19/1992, 12/1/1992, 12/30/1992 (Emer), 12/31/1992 (Emer), 4/1/1993, 12/30/1993 (Emer), 3/31/1994, 9/30/1994 (Emer), 12/30/1994 (Emer), 12/30/1994, 3/30/1995, 8/1/1995, 12/29/1995 (Emer), 3/21/1996, 12/31/1996 (Emer), 3/22/1997, 8/1/1997, 12/31/1997 (Emer), 3/19/1998, 12/31/1998 (Emer), 3/31/1999, 3/20/2000, 12/29/2000 (Emer), 1/1/2001, 3/30/2001, 1/1/2003, 4/14/2003, 1/2/2004 (Emer), 4/1/2004, 10/1/2004, 11/15/2004, 9/1/2005, 12/30/2005 (Emer), 3/27/2006, 7/1/2006, 7/15/2006, 1/1/2007, 7/25/2007, 12/31/2007 (Emer), 3/30/2008, 7/1/2008, 11/13/2008, 12/31/2008 (Emer), 3/31/2009, 7/1/2009, 10/1/2009 (Emer), 12/29/2009, 3/31/2010, 4/28/2010 (Emer), 7/26/2010, 12/30/2010 (Emer), 3/30/2011, 8/2/2011, 9/1/2011, 12/30/2011 (Emer), 3/29/2012, 12/31/2012 (Emer), 3/28/2013, 12/18/13 (Emer), 3/27/14, 12/31/14 (Emer), 7/3/2015