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Ohio Administrative Code

Rule 5160-4-25 Laboratory and radiology services.

Effective: January 1, 2017

(A) Coverage.

(1) Total (global) procedure. Payment may be made to a practitioner for performing both the professional and technical components of a radiology or imaging procedure if two conditions are met:

(a) The technical component was not performed in a hospital setting (i.e., an inpatient hospital, an outpatient hospital, or a hospital emergency department); and

(b) The practitioner who submitted the claim either performed the professional component or has an employment or written contractual arrangement with the practitioner who performed the professional component.

(2) Technical component. Payment may be made to a practitioner for performing only the technical component of a radiology or imaging procedure if three conditions are met:

(a) The professional component was performed by another practitioner;

(b) The technical component was not performed in a hospital setting; and

(c) The practitioner who submitted the claim either performed the technical component or employs the practitioner who performed the technical component.

(3) Professional component.

(a) Payment may be made to a practitioner for performing only the professional component of a radiology or imaging procedure if the professional component represents either of two services:

(i) The initial interpretation of a radiology or imaging procedure; or

(ii) The interpretation by a specialist of a radiology or imaging procedure that has already been interpreted by another practitioner (e.g., a treating physician).

(b) No payment is made for the interpretation by a non-specialist of a radiology or imaging procedure that has already been interpreted by a specialist.

(4) Mammography services.

(a) Payment for screening mammography may be made at the following frequencies:

(i) For an individual who is at least thirty-five years of age but less than forty, once; and

(ii) For an individual who is at least forty years of age, once per twelve months.

(b) Payment for diagnostic mammography may be made for an individual, regardless of age, who shows clinical symptoms of breast cancer or who is at high risk for developing breast cancer.

(5) No separate payment is made for supplies used in connection with a radiology or imaging procedure performed in a hospital setting.

(6) No separate payment is made for conscious sedation administered in connection with a radiology or imaging procedure.

(B) Claim payment.

(1) For a covered radiology or imaging procedure or radiology or imaging procedure component performed by a non-hospital provider, payment is the lesser of the submitted charge or the product of the following two figures:

(a) The maximum payment amount listed in appendix DD to rule 5160-1-60 of the Administrative Code; and

(b) The relevant percentage indicated by the 'prof/tech split' entry listed in appendix DD to rule 5160-1-60 of the Administrative Code.

(2) If more than one advanced imaging procedure (e.g., computed tomography, magnetic resonance imaging, ultrasound) is performed by the same provider or provider group for an individual patient in the same session, then the procedure with the highest payment amount specified in appendix DD to rule 5160-1-60 of the Administrative Code is considered to be the primary procedure. The payment amount for a covered advanced imaging procedure is the lesser of the submitted charge or a percentage of the amount specified in appendix DD to rule 5160-1-60 of the Administrative Code, determined in the following manner:

(a) For a primary procedure, it is one hundred per cent.

(b) For each additional total procedure, it is fifty per cent.

(c) For the technical component alone of each additional procedure, it is fifty per cent.

(d) For the professional component alone of each additional procedure, it is ninety-five per cent.