5101:3-4-22 **Surgical services.**

(A) The department will reimburse physicians for most surgical procedures. The surgical procedure includes the operation per se, local infiltration, metacarpal/digital block or topical anesthesia when used, and the normal uncomplicated preoperative and postoperative care. Payment for conscious sedation is bundled into the payment for the related surgical or radiological procedure and is not reimbursed separately by the department.

(B) Physicians will be reimbursed for physician visits in addition to the surgery only as detailed in rule 5101:3-4-06 of the Administrative Code.

(C) For the reimbursement of surgical services, the physician must bill the appropriate code for the surgical procedure(s). Each surgical procedure billed must be a separate procedure and not a minor surgical procedure performed as an integral part of a major surgical procedure (e.g., suturing of a surgical incision).

(D) Multiple surgeries.

(1) For claims submitted on or after ~~the effective date of this rule~~ January 1, 2007, multiple surgery pricing will apply to the procedures indicated with an "x" in the corresponding column for multiple surgery in appendix A to this rule.

(2) Reimbursement for multiple surgical procedures performed on the same patient by the same provider shall be the lesser of billed charges or:

(a) One hundred per cent of the medicaid maximum allowed for the primary procedure.

The primary procedure is considered to be the surgical procedure that has the highest medicaid maximum listed in appendix DD to rule 5101:3-1-60 of the Administrative Code.

(b) Fifty per cent of the medicaid maximum allowed for the secondary procedure.

(c) Twenty-five per cent of the medicaid maximum allowed for all subsequent (tertiary, etc.) procedures.

(3) Surgical procedure codes that are not considered multiple surgery will be paid at the lesser of the billed charge or the medicaid maximum regardless of whether the codes are submitted with another surgical procedure that had an "x" in the multiple surgery column of appendix A to this rule.

(4) Effective ~~with the date of this rule~~ October 15, 2006, the department will recognize the 51 modifier signifying a "multiple procedure." However usage of this modifier will not affect the level of reimbursement. If a claim is submitted with the 51 modifier but the surgical code is not marked as multiple surgery in appendix A to this rule, the claim with the 51 modifier will be denied.

(E) Bilateral procedures.

(1) For claims submitted on or after ~~the effective date of this rule~~ January 1, 2007, bilateral surgery pricing will apply to procedures indicated with an "x" in the corresponding column for bilateral surgery in appendix A to this rule.

(2) Bilateral procedures should be billed to the department using the appropriate code for the procedure modified by the modifier 50. For example, 6943350 would mean a tympanostomy was performed on both ears. Code 69433 billed without a modifier would mean the procedure was performed on one ear. If the procedure code is billed unmodified, the department will not reimburse for the procedure as a bilateral procedure.

(3) The medicaid maximum for bilateral procedures is one hundred fifty per cent of the medicaid maximum allowed for the same procedures performed unilaterally when the code is billed with the 50 modifier.

(F) Incidental procedures.

When incidental procedures are performed through the same incision, during the same operative session, the allowable fee shall be that of the major procedure only.

(G) Assistant at surgery.

(1) For claims submitted on or after ~~the effective date of this rule,~~ January 1, 2007 assistant at surgery pricing will apply to procedures indicated with an "x" in the corresponding column for assistant at surgery in appendix A to this rule.

(2) The billing by a surgical assistant shall be no greater than his/her customary charge for the professional work rendered.

(3) The department's payment for an assistant at surgery will be limited to the billed charge, or twenty-five per cent of the medicaid maximum allowed for the primary surgical procedure, whichever is lower.

(4) No assistant fees will be reimbursed for assistant-at-surgery services provided by a non-physician (e.g., registered nurses or physician assistants).

(5) Reimbursement will not be made for more than one assistant at surgery, regardless of the extent of surgery.

(6) Conditions for payment for assistants at surgery in a teaching hospital.

(a) Reimbursement will not be made for assistants at surgery in teaching hospitals with a training program relating to the medical specialty required for the surgical procedure and a resident in a training program available to serve as an assistant at surgery.

(b) Reimbursement for an assistant at surgery in a teaching hospital may be made only if the services:

(i) Are required due to exceptional medical circumstances;

(ii) Are performed by team physicians needed to perform complex medical procedures;

(iii) Constitute concurrent medical care relating to a medical condition that requires the presence of and active care by a physician of another specialty during surgery; or

(iv) Are medically required and are furnished by a physician who is primarily engaged in the field of surgery and the primary surgeon does not utilize residents and interns in the surgical procedure he or she performs (including preoperative and postoperative care).

(7) Billing assistant at surgery services.

For reimbursement, providers must bill the appropriate code for the primary surgical procedure modified by 80.

(H) Application of casts, splints, straps or other traction devices.

(1) Services listed in the musculoskeletal surgery section (codes 20000 through 28899 and 29800 through 29909) include the application and removal of the first cast, splint, strap or other traction device.

(2) The casting, splinting and strapping procedures listed at the end of the musculoskeletal surgery section (codes 29000 through 29799) may be billed only when the casting, splinting or strapping is performed as a replacement procedure during or after the period of follow-up care. A visit may not be billed with any of the casting, splinting or strapping codes.

(a) The casting codes include all professional services and supplies provided during the service.

(b) The splinting and strapping codes do not include the splints or straps (elastic bandages). Splints or straps may be billed as a DME (durable medical equipment) service, if it was medically necessary to replace the splint or strap.

(3) If a cast application, strapping or splinting is provided as an initial procedure in which no surgery code is applicable (e.g., the casting or strapping of a sprained ankle or knee), the provider must bill using the appropriate visit code. When this service is provided in a non-hospital setting, the provider may also be reimbursed for the cost of the cast, splint, or strap.

(a) For the strapping or splinting materials, the provider must bill the appropriate DME code in accordance with Chapter 5101:3-10 of the Administrative Code.

(b) For casting materials, the provider must bill the appropriate code for casting materials in appendix DD to rule 5101:3-1-60 of the Administrative Code. The provider must maintain, at a minimum, documentation that supports that the service was an initial cast application for a non-surgical service and the quantity and description of the casting supplies.

(4) When a cast has been damaged and it is medically appropriate to repair rather than to remove and replace the cast, the provider may bill and be reimbursed for an evaluation and management service. If the casting repair is performed in a non-hospital setting, the provider may also be compensated for the casting materials by billing one of the codes listed in paragraph (H)(3)(b) of this rule.

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Certification

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