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 billed using the most comprehensive surgical procedure code(s). This means procedures that are incidental to, or performed as an integral part of the comprehensive surgical service(s), must not be billed in component parts or "unbundled." ~~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) Surgical codes subject to multiple surgery pricing are ~~contained~~ indicated in the ~~appendices~~ appendix to this rule. Multiple surgery pricing will apply to the procedures indicated with an "x" in the corresponding column for multiple surgery in the appendix ~~A~~ to this rule ~~and appendix B 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 codes subject to multiple surgery pricing may not be billed with

multiple units. Billing a multiple surgery code with more than one unit will result in a denial of that line. Each surgery subject to multiple surgery pricing must be billed on a separate line using the most comprehensive surgical procedure code.

~~(3)~~(4) Surgical procedure codes that are not considered multiple surgery and are not bundled into the reimbursement of another surgical procedure billed 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~~ indicated with an "x" in the multiple surgery column of the appendix ~~A~~ to this rule ~~and appendix B to this rule~~.

~~(4)~~(5) ~~Effective October 15, 2006, the department will recognize~~ The Ohio department of job and family services (ODJFS) allows 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) Surgical codes subject to bilateral surgery pricing are contained in the appendices to this rule. Bilateral surgery pricing will apply to procedures indicated with an "x" in the corresponding column for bilateral surgery in the appendix ~~A~~ to this rule. ~~and appendix B to this rule.~~

(2) Bilateral procedures, when performed bilaterally, should be billed ~~to the department~~ with the bilateral surgery code on a single line with the modifier 50 ~~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 on a single line with the 50 modifier.

(4) Surgical codes that are considered bilateral codes but are performed unilaterally on only one side of the body should be billed on one line unmodified or on one line with either the LT or the RT modifier indicating the side of the body on which the procedure was performed.

(5) Surgical codes that are considered bilateral codes but are performed more than

once on one or each side of the body and/or body part indicated by the code definition must be billed using only the LT and RT modifiers on each line to demonstrate the procedure was performed more than once on one or each side.

(F) Surgical procedures that may be billed with site modifiers.

(1) Surgical procedures performed on fingers, toes, eyelids, or coronary arteries may be billed with site modifiers. Procedures that may be billed with site modifiers are indicated with an "x" in the corresponding column in the appendix to this rule.

(2) Surgical procedures performed on hands, feet, fingers, and/or toes may be billed modified or unmodified depending on the definition of the code and the site at which the procedure was performed. For example, if the code definition indicates the right thumb, the code defines the site of the procedure.

(a) Surgical procedures performed on only one body part, for example one finger or one hand, one toe or one foot, may be billed unmodified.

(b) Surgical procedures performed on more than one body part, according to the definition of the code, must be billed with the appropriate digit modifier for each finger or toe, and/or with the LT modifier for each left hand or left foot procedure, and/or with the RT modifier for each right hand or right foot procedure.

(3) Surgical procedures performed on eyelids may be billed using eyelid modifiers. An eyelid modifier is required if the surgery involves more than one eyelid. If the surgery was performed on only one eyelid (right or left side), the code must be billed using the appropriate eyelid modifier. If the surgical procedure was performed on both eyelids of one eye on a side, the code must be billed using the LT or the RT modifier demonstrating that the surgery was performed on both eyelids of one eye on a side.

(4) Surgical procedures performed on the coronary arteries may be billed using the appropriate coronary artery modifier to demonstrate which artery and side.

~~(F)~~(G) 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, more comprehensive, procedure only.

~~(G)~~(H) Assistant at surgery.

(1) Surgical codes subject to assistant at surgery pricing are contained in the ~~appendices~~ appendix to this rule. Assistant at surgery pricing will apply to procedures indicated with an "x" in the corresponding column for assistant at surgery in the appendix ~~A~~ to this rule ~~and appendix B 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, advanced practice 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 where a resident in a training program is 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)~~(I) Application of casts, splints, straps or other traction devices.

(1) Services listed in the musculoskeletal surgery section of the current procedural terminology (codes 20000 through 28899 and 29800 through 29999) 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 of the current procedural terminology (CPT) (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)~~ durable medical equipment (DME) 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~~ appropriate codes for casting materials.

Effective:

R.C. 119.032 review dates: 03/01/2015

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Certification

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Date

Promulgated Under:	119.03
Statutory Authority:	5111.02
Rule Amplifies:	5111.01, 5111.02, 5111.021
Prior Effective Dates:	6/3/83, 10/1/83 (Emer), 12/29/83, 1/1/86, 5/9/86, 6/16/88, 1/13/89 (Emer), 4/13/89, 9/1/89, 2/17/91, 12/1/92, 1/1/01, 10/1/03, 10/15/06, 12/29/06 (Emer), 3/29/07, 12/31/07 (Emer), 3/30/08, 12/31/08 (Emer), 3/31/09, 12/31/09 (Emer), 3/31/10