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

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

(ii) In assigning procedures to these groups, the department follows the policies of the medicare program.

(2) 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) Payment for the surgical treatment of obesity requires prior authorization.

(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 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 bilateral procedure, one hundred fifty per cent; or

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

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