



State of New Jersey
Department of Human Services
Division of Medical Assistance and Health Services

MEDICAID ALERT

July 1993

TO: Physicians, Podiatrists, and Independent Clinics

SUBJECT: Claims for Multiple Surgical Procedures

EFFECTIVE: Immediately

PURPOSE: To expedite the processing of claims for multiple surgical procedures performed on the same day on a Medicaid recipient, the Division of Medical Assistance and Health Services and its fiscal agent, Paramax/Unisys have automated the pricing of these claims for physician and independent clinic services. Paramax/Unisys will release all in process multiple surgery claims in the near future. A remittance message will appear on the Remittance Advice which reflects these released claims.

ACTION: Under existing New Jersey Medicaid policy, physicians, podiatrists, and independent clinic providers (excluding Ambulatory Surgical Centers (ASCs) and Federally Qualified Health Centers (FQHCs)) are reimbursed according to the pricing policy when billing for multiple surgical procedures during the same operative session, as follows:

1. The primary surgical procedure is reimbursed at 100% of the Medicaid Maximum Fee Allowance. The highest reimbursed procedure is always assumed to be the primary procedure.
2. The secondary surgical procedure(s) is reimbursed at 50% of the Medicaid Maximum Fee Allowance;
3. A maximum reimbursement threshold for any operative session is 200% of the Medicaid Maximum Fee Allowance for the primary surgical procedure; and
4. Incidental surgical procedures are not reimbursed in addition to any primary and/or secondary surgical procedures.

For Ambulatory Surgical Centers, the maximum threshold for any operative session is 150% of the Medicaid Maximum Fee Allowance for the primary surgical procedure. (See N.J.A.C. 10:66-1.7(c)2ii(1). For Federally Qualified Health Centers (FQHCs), this policy has no impact on the reimbursement of an encounter rate regardless of the number of surgical procedures.

Unique edit codes have been assigned to specific multiple surgery pricing conditions. The edit codes and their descriptions as they will appear on your Remittance Advice, are listed below with a brief explanation.

901 - Multiple Surgery - Paid as Primary Procedure

This claim has been determined to be the primary procedure and is paid at 100% of the Medicaid allowable amount or billed charges, whichever is the lower.

902 - Multiple Surgery - Paid as Secondary Proc, Max 200% of Primary

This claim has been determined to be a secondary procedure of a surgical session on the same date of service, and is paid at 50% of the Medicaid allowable amount. Reimbursement may be less than 50% of the Medicaid allowable amount if the sum of the reimbursement for procedures performed during the same surgical session exceeds 200% of the Medicaid Allowable amount for the primary procedure.

903 - Mult Surg - Prim Proc Fee Reduced By Prior Paid Claim

This claim has been determined to be the primary procedure of a surgical session. The claim previously identified and paid as the primary procedure is now considered the secondary procedure based on the Medicaid allowable amount. Therefore, this claim is reduced by 50% of the previously paid amount.

904 - Multiple Surgery - \$0 Paid, 200% Limit Exceeded

This claim has been determined to be a secondary procedure of a surgical session on the same date of service. However, the Medicaid maximum payment threshold of 200% of the primary procedure has already been reached; therefore, no payment is being made for this claim.

905 - Multiple Surgery - Reduced By Incidental Procedure

This claim has been determined to be the primary procedure of a surgical session on the same date of service. However, it has been determined that an incidental/non-allowed procedure was previously paid. Therefore, this claim has been reduced by the previously paid amount.

906 - Multiple Surgery - \$0 Paid, Incidental Procedure

This claim has been determined to be an incidental/non-allowed procedure to the primary procedure of a surgical session on the same date of service. Therefore, no payment is made on this claim.

907 - Mult Surg - 1st Unit Primary, Addt'l as Secondary -
200% Max

This claim has been determined to be a primary procedure with multiple units of service. One unit is priced as the primary procedure and the remaining units are priced as secondary procedures. The total amount paid for all procedures is limited to 200% of the Medicaid allowable amount for the primary procedure.

All multiple surgical claims which will be released and processed will be considered to have been performed during the same operative session. This action may result in the processing and payment of claims at 50% of the Medicaid Fee Allowance or at zero (\$0) reimbursement if the maximum threshold of reimbursement of 200% of the primary procedure's Medicaid Maximum Fee Allowance was met. For Ambulatory Surgical Centers, this activity may result in the processing of payment of claims at zero (\$0) reimbursement if the maximum threshold of reimbursement of 150% of the primary procedure's Medicaid Maximum Fee Allowance was met. If a claim is paid erroneously because it is an incidental procedure or is priced above the allowed amount, the processed claim may contain a negative payment amount to recoup the difference.

If these claims represent services which are part of separate operative procedure(s) at a second operative session, the following new billing instructions must be followed:

1. For each claim line approved (paid) by Paramax/Unisys, submit an MMIS Claim Adjustment Request Form (FD-999). Explain in Field 5 (Description of the Problem) that separate surgical procedures were performed during a second surgical session. Attach a copy of the original claim form and identify one line item with a procedure performed during the second surgical session. Affix the "WB" modifier to the procedure code on this line. Complete the remainder of the FD-999 according to the instructions in the Fiscal Agent Billing Supplement. Repeat this process with a new FD-999 and new copy of the claim for each additional procedure to be adjusted.

As an alternative, you may identify the procedures performed at the second surgical session on a copy of the Remittance Advice (RA); attach the copy of the RA to a single FD-999 form; and request voids for the paid claims. Then, the procedures may be billed together on a new claim, including "WB" on every line.

2. For claims not previously submitted to Paramax/Unisys, providers must use the modifier "WB" when billing for surgical procedure(s) performed during a second surgical session.

If you have any questions regarding this issue, please contact Paramax/Unisys Provider Services Unit at 1-800-776-6334.

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(GREEN TAB MARKED "4")**