MEDICAL ASSISTANCE BULLETIN

COMMONWEALTH OF PENNSYLVANIA ● DEPARTMENT OF PUBLIC WELFARE

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SUBJECT

Billing Procedures – Multiple Surgical, Surgical/Obstetrical and Anesthesia Procedures

BY

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Deputy Secretary for Medical Assistance Programs

PURPOSE:

The purpose of this bulletin is to instruct providers on correct billing procedures to follow when two or more surgical, surgical/obstetrical, anesthesia or assistant surgeon procedures are performed on the same day or during the same period of hospitalization.

SCOPE:

This bulletin applies to all physicians, dentists, podiatrists, outpatient hospital clinics, independent medical/surgical clinics, certified registered nurse practitioners, and certified registered nurse anesthetists enrolled in the Medical Assistance Program subject to the services they may provide as established by Medical Assistance Program regulations and the Medical Assistance Program Fee Schedule.

BACKGROUND/DISCUSSION:

The Department has been in increase in the number of claims that are rejecting with Remittance Advice Explanation Codes 509, 597, and 599. These Remittance Advice Explanation Codes deal with multiple surgical, surgical/obstetrical, anesthesia or assistant surgeon procedures performed by the same practitioner on the same day or during the same period of hospitalization. Also, providers are receiving incorrect payments for multiple surgical or anesthesia procedures performed on the same day during the same period of hospitalization. In most cases, these problems are due to incorrect completion of the Physician's Invoice or Medical Services/Supplies Invoice (MA 319).

Medical assistance regulations in Chapter 1150, Medical Assistance Program Payment Policies, mandate the following:

COMMENTS AND QUESTIONS REGARDING THIS BULLETIN SHOULD BE DIRECTED TO:

Division of Outpatient Programs
P.O. Box 8046
Harrisburg, Pennsylvania 17105

1-800-537-8862

1. **SURGICAL, SURGICAL/OBSTETRICAL PROCEDURES (APPLICABLE TO THE SURGEON AND ASSISTANT SURGEON)** - When two or more surgical or surgical/obstetrical procedures are performed by the same practitioner during the same period of hospitalization or on the same day, the practitioner will be reimbursed at 100% for the highest allowable payment for one procedure and 25% for the second highest paying procedure with no payment for additional procedures (1150.54(a)(5) and 1150.54(b)(2)).

2. **ANESTHESIA SERVICES** – When two or more surgical or surgical/obstetrical procedures are performed and anesthesia is provided by the same anesthesiologist during the same period of hospitalization, the anesthesiologist will be reimbursed at 100% for the highest allowable payment for one procedure and 25% for the second highest paying procedure with no payment for additional procedures (1150.52(c)).

EXCEPTIONS TO THE 100% - 25% PAYMENT POLICY INCLUDE:

(1) For a Vaginal Delivery and a Tubal Ligation performed on the same day or during the same period of hospitalization, the practitioner will be reimbursed at 100% of the established Medical Assistance Program fee for each of these procedures (Combination of procedure code 59410 and procedure codes 58600 thru 58605).

(2) For treatment of burs (procedure codes 16000 thru 16030) practitioners will be reimbursed at 100% of the established Medical Assistance Program fee for each procedure performed.

(3) When the established Medical Assistance Program fee for a single procedure exceeds the Department's maximum reimbursement limit to a practitioner ($1,000 during any one period of hospitalization or $500 per day for outpatient procedures) no additional payment will be made for a second procedure. NOTE: The $500 per day limitation on out-patient procedures does not apply to:

    1. Dentists
    2. Services provided in a short procedure unit or ambulatory surgical center (POS 12).

(4) Anesthesia (TOS 40) for the following dental procedure codes will be reimbursed at 100% of the established Medical Assistance Program Fee for each procedure performed:

    D2110 thru D2332
    D2910 and D2920
    D2980 thru D3331
    D7110 thru D7280

Billing incorrectly for multiple surgical, surgical/obstetrical or anesthesia procedures may not only cause provider claims to reject, but may cause claims to be paid incorrectly. For example, the first claim line to be processed by the Department's automated claims processing system will be recognized as the initial procedure and will be processed for payment at 100% of the Medical Assistance Program fee. If this was not the procedure with the highest Medical Assistance Program fee, the provider will not receive the maximum allowable reimbursement for the services provided.

PROCEDURE:

To ensure correct and maximum reimbursement for multiple surgical or anesthesia services providers must follow these procedures:

1. **DO NOT** bill for more than two surgical or surgical/obstetrical procedures (TOS 20, 30) assistant surgeon services (TOS 10), or anesthesia services (TOS 40) on the same day (outpatient) or during the same period of hospitalization (inpatient).

2. **DO NOT** bill for the second surgical or surgical/obstetrical procedure if the established Medical Assistance Program fee for the first procedure exceeds the maximum payment limitation of $1,000 for a period of hospitalization (inpatient) or $500 for a day (outpatient). NOTE: The $500 per day limitation on outpatient procedures does not apply to:

    1. Dentists
    2. Services provided in a short procedure unit or ambulatory surgical center (POS 12).

3. If more than two procedures are performed on the same day or during the same period of hospitalization, **ALWAYS** bill for the two procedures with the highest established Medical Assistance Program fees.

4. On the MA 319 invoice, **ALWAYS** list the procedure with the highest Medical Assistance Program fee on the first claim line. The procedure with the lower fee should be listed on the second claim line. This will ensure that you receive maximum payment.

5. When billing two units of service for the same procedure code provided on the same date of service, **ALWAYS** bill on one claim line showing a quantity of 2 in the Units of Service Field.

6. If for some reason you will for multiple procedures performed on the same day or during the same period of hospitalization on separate invoices, **ALWAYS** submit the invoice for the procedure with the highest Medical Assistance Program fee first. **DO NOT** submit an invoice for the second procedure until you receive a Remittance Advice Statement showing that the first procedure has been approved for payment. We suggest that whenever possible, multiple procedure be billed on a single invoice following the instruction in #3.

If providers submit incorrectly and receive 100% payment for the procedure with the lower fee, a claim adjustment must be prepared to return the payment received and, after the claim adjustment appears as a credit (CR) on a subsequent Remittance Advice Statement, a new invoice must be submitted following correct billing procedures. **PLEASE NOTE: ALL INVOICES AND CLAIM ADJUSTMENTS MUST BE RECEIVED WITHIN THE TIME LIMITATIONS ESTABLISHED IN CHAPTER 1101, SECTION 1101.68.**