

1. Venipuncture (HCPCS 36415) may be billed once per patient visit in addition to an office/hospital outpatient visit when the visit fulfills requirements of a visit and the sample is sent to an outside laboratory for processing;

2. Aspiration or injection into joints (HCPCS 20600-20610) may be billed with an office/hospital outpatient visit;

3. Medication injected into tendon sheaths, ligament trigger points or ganglion cysts (HCPCS 20550) may be billed with an office/hospital outpatient visit; and

4. Procedure codes listed in N.J.A.C. 10:54-9.4.

(c) In order to be properly reimbursed for the surgical procedure, the physician shall bill for the surgical procedure, rather than for the office or outpatient visit, in those instances where the surgical procedure fee exceeds the office or outpatient visit.

Recodified from N.J.A.C. 10:54-4.14 by R.1998 d.154, effective February 27, 1998 (operative March 1, 1998; to expire August 31, 1998). See: 30 N.J.R. 1060(a).

Former N.J.A.C. 10:54-4.15, Multiple surgical procedures; same session, recodified to N.J.A.C. 10:54-4.16.

#### 10:54-4.16 Multiple surgical procedures; same session

(a) Multiple surgical procedures during the same operative session shall be reimbursed as follows:

1. The primary surgical procedure shall be reimbursed at 100 percent of the Medicaid Maximum Allowable Fee;

2. The secondary surgical procedure(s) shall be reimbursed at 50 percent of the Medicaid Maximum Allowable Fee; and

3. The maximum reimbursement threshold for any operative procedure is 200 percent of the amount of the Maximum Fee Schedule of the primary surgical procedure.

(b) Incidental surgical procedures shall not be reimbursed in addition to any primary and/or secondary surgical procedure(s). A list of those procedure codes considered by the New Jersey Medicaid program to be incidental procedures is located in N.J.A.C. 10:54-9.11(b).

Recodified from N.J.A.C. 10:54-4.15 by R.1998 d.154, effective February 27, 1998 (operative March 1, 1998; to expire August 31, 1998). See: 30 N.J.R. 1060(a).

Former N.J.A.C. 10:54-4.16, Repeat or revisitation of the surgical procedure, recodified to N.J.A.C. 10:54-4.17.

#### 10:54-4.17 Repeat or revisitation of the surgical procedure

If the recipient is returned to the operative suite for a repeat or revisitation of the operation, by the same surgeon on the same day, the billing for the operative procedure shall include the "WB" modifier for the reimbursement for the second operative session. The use of this "WB" modifier permits separate reimbursement for the second operative session.

Recodified from N.J.A.C. 10:54-4.16 by R.1998 d.154, effective February 27, 1998 (operative March 1, 1998; to expire August 31, 1998). See: 30 N.J.R. 1060(a).

Former N.J.A.C. 10:54-4.17, Litigation or transection of fallopian tubes, recodified to N.J.A.C. 10:54-4.18.

#### 10:54-4.18 Litigation or transection of fallopian tubes

(a) Ligation or transection of fallopian tube(s), when done at the operative session (time) of a Caesarean Section or intra-abdominal surgery, shall be reimbursed by the New Jersey Medicaid program for additional reimbursement from the primary surgical procedure (Caesarean Section) or intra-abdominal surgery. The physician shall use HCPCS 58611 when billing for the ligation/transection of fallopian tube(s) done at the same operative session as the Caesarean Section or intra-abdominal surgery. Multiple surgery pricing shall not apply.

(b) The physician shall use HCPCS codes 58600 or 58605, when the ligation or transection of the fallopian tube(s) are not done at the same time as the operative session for intra-abdominal surgery. Multiple surgery pricing shall apply.

Recodified from N.J.A.C. 10:54-4.17 by R.1998 d.154, effective February 27, 1998 (operative March 1, 1998; to expire August 31, 1998). See: 30 N.J.R. 1060(a).

Former N.J.A.C. 10:54-4.18, Anesthesiology, recodified to N.J.A.C. 10:54-4.19.

#### 10:54-4.19 Anesthesiology

(a) Anesthesiologists shall be reimbursed for anesthesia services provided to a Medicaid recipient for the total of the anesthesia base units (ABUs) plus anesthesia time.

(b) The use of a HCPCS procedure code which has anesthesia base units (ABUs) assigned requires that the "AA" modifier be utilized to allow the claim to be processed to adjudication. The physician shall enter the HCPCS procedure code and the "AA" modifier in FIELD 24D on the claim form.

(c) An "AA" modifier shall be used for either:

1. Services performed by an anesthesiologist; or
2. Services performed by a Certified Nurse Anesthetist (CRNA) personally and directly supervised by an anesthesiologist.

(d) "Anesthesia time (A.T.))" means that period which includes:

1. Those professional activities of the anesthesiologist directly related to the pre-operative preparation of the patient in the operating room or pre-induction room preceding the proposed surgery;
2. Introduction of the anesthetic agent;
3. Continuous supervision during the surgery; and
4. Continuous supervision during the immediate post-operative period until release of the patient in a satisfac-

tory physiological state to a competent recovery room staff.

(e) Anesthesia time shall be reported in 15 minute quantities (one unit equals 15 minutes). The anesthesiologist shall convert the anesthesia time into units and the number of unit(s) shall be entered in FIELD 24F on the claim form. Do not enter the time (hours and/or minutes) in the "units" field. The anesthesia time (hours and/or minutes) shall be entered at the bottom of "FIELD 24D-Description".

(f) Reimbursement for anesthesia shall be determined by the following, unless otherwise noted:

1. The anesthesia base units assigned to the HCPCS procedure code will be automatically added to the number of the units entered by the anesthesiologist in FIELD 24F at the time the claim is processed. The total of ABUs plus the number of units in FIELD 24F will be multiplied by the Medicaid fee per unit for the total Medicaid allowance. (Do not add anesthesia base unit(s) to the unit(s) of service reported in FIELD 24F.)

2. When multiple surgical procedures are rendered during the same operative session, only the one procedure code with the highest anesthesia base unit value shall be used in calculating and billing the anesthesia allowance.

Example: For multiple surgery reimbursement calculation, if multiple surgeries are performed in one operative session within the time span of the surgery (or anesthesia time (A.T.) listed as 2 hours and 45 minutes), the reimbursement should be calculated as follows: (B.U.V.) = 7 plus (A.T.) of 11 units = 18 units multiplied by dollar amount for specialist or non-specialist = Total Anesthesia Reimbursement.

3. A list of procedure codes which do not require the AA modifier when the physician's professional services are rendered by the anesthesiologist is located under anesthesia in N.J.A.C. 10:54-9.4, HCPCS.

4. The New Jersey Medicaid Management Information system (NJMMIS) does not recognize the CPT-4 anesthesia codes (00100-01999) as valid on the procedure code file. Therefore, claims submitted using these anesthesia codes, including automatic crossover claims from the Medicare Carrier will be suspended or denied. If a new HCFA 1500 claim form with an Explanation of Medicare Benefits (EOMB) notice attached is submitted, claims will be processed.

(g) Reimbursement for anesthesia services provided by Certified Registered Nurse Anesthetists (CRNA) shall be made, provided:

1. He or she is employed by a physician who is a specialist in anesthesia who is:

i. An approved provider in the New Jersey Medicaid program; and

ii. The person who submits the claim for services rendered; and

2. The CRNA's services were performed under the personal direction of the employer anesthesiologist throughout the period of anesthesia. (See N.J.A.C. 10:54-2.2(a) and (b) for rules related to personal direction of the CRNA, as applicable).

(h) The New Jersey Medicaid program shall not reimburse a CRNA directly, nor shall it reimburse charges submitted by an anesthesiologist for services rendered by a CRNA who is not in his or her employ, but is in the employ of a health care facility.

Recodified from N.J.A.C. 10:54-4.18 by R.1998 d.154, effective February 27, 1998 (operative March 1, 1998; to expire August 31, 1998). See: 30 N.J.R. 1060(a).

Former N.J.A.C. 10:54-4.19, Radiology; general, recodified to N.J.A.C. 10:54-4.20.

#### 10:54-4.20 Radiology; general

Radiological services shall ordinarily be provided only by a physician who is a specialist in radiology, nuclear medicine, and/or radiation oncology. However, a physician, other than one of those listed above, who is a specialist may provide radiological services which are related and limited to his or her own specialty field. (See N.J.A.C. 10:54-9.4, HCPCS for specific procedure codes and qualifiers for radiological services and the CPT-4.)

Recodified from N.J.A.C. 10:54-4.19 by R.1998 d.154, effective February 27, 1998 (operative March 1, 1998; to expire August 31, 1998). See: 30 N.J.R. 1060(a).

Former N.J.A.C. 10:54-4.20, Radiology; diagnostic imaging and ultrasound, recodified to N.J.A.C. 10:54-4.21.

#### 10:54-4.21 Radiology; diagnostic imaging and ultrasound

(a) Reimbursement for radiological services provided by a physician(s) other than those physicians listed in N.J.A.C. 10:54-4.19 shall be limited to diagnostic radiology of long bones and/or radiological chest examination, in emergency situations to the physician's own patients, in his or her own office.

(b) The fees for routine diagnostic radiology shall include usual contrast media, equipment, materials, consultation, and written reports to the referring physician.

1. For special high risk patients who require the use of low osmolar contrast material to prevent adverse reactions, reimbursement shall be based on the volume of contrast injected, as specified in N.J.A.C. 10:54-9.4, HCPCS.

(c) For diagnostic radiology when combined procedure codes are indicated, specific procedure codes shall not be reimbursed separately when performed in conjunction with other procedure codes and shall be denied if billed together, as follows: