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Implementation Date: April 6, 2009

Payment of Assistant at Surgery Services in a Method II Critical Access Hospital (CAH)

Provider Types Affected

Method II CAHs (to whom physicians and non-physician practitioners rendering assistant in surgery services have reassigned their billing rights) who bill Medicare Fiscal Intermediaries (FI) or Part A/B Medicare Administrative Contractors A/B MAC for such assistant at surgery services

What You Need to Know

CR 6123, from which this article is taken, implements the amount Medicare pays to providers who (having reassigned their billing rights to Method II CAHs render assistance at surgery services in that hospital.

The payment amount for a physician assisting at surgery is calculated as follows:

The facility specific Medicare Physician Fee Schedule (MPFS) amount **multiplied by** a 16 percent assistant at surgery reduction amount **minus** the deductible and coinsurance, then **multiplied by** 115 percent,

OR

((MPFS X .16) – (deductible and coinsurance)) X 1.15.

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The payment amount for a physician assistant (PA), nurse practitioner NP, or clinical nurse specialist (CNS) assisting at surgery is calculated as follows:
 The facility specific MPFS amount *multiplied by* a 16 percent assistant at surgery reduction amount *multiplied by* an 85 percent non-physician practitioner reduction *minus* the deductible and coinsurance, *then multiplied by* 115 percent,

OR

$((\text{MPFS} \times .16 \times .85) - (\text{deductible and coinsurance})) \times 1.15$.

Make sure that your billing staffs are aware of this method of calculating payment for assistance in surgery services.

Background

Physicians and non-physician practitioners billing on type of bill (TOB) 85X for professional services rendered in a Method II CAH have the option of reassigning their billing rights to that CAH. When they elect to reassign these billing rights, payment is made to the CAH for professional services (revenue codes (RC) 96X, 97X or 98X).

CR 6123, from which this article is taken, implements the payment amount for providers who (having reassigned their billing rights to Method II CAH) render assistance at surgery services.

CR6123 also updates *Medicare Claims Processing Manual* Chapter 4 (Part B Hospital (Including Inpatient Hospital Part B and OPPS)) by adding the following new sections:

- 250.9 (Coding Assistant at Surgery Services Rendered in a Method II CAH);
- 250.9.1 (Use of Payment Policy Indicators for Determining Procedures Eligible for Payment of Assistants at Surgery);
- 250.9.2 (Payment of Assistant at Surgery Services Rendered in a Method II CAH);
- 250.9.3 (Assistant at Surgery Medicare Summary Notice (MSN) and Remittance Advice (RA) Messages);
- 250.9.4 (Assistant at Surgery Services in a Method II CAH Teaching Hospital); and
- 250.9.5 (Review of Supporting Documentation for Assistant at Surgery Services in a Method II CAH).

CAH Impact Summary

Assistant at surgery services are those services rendered by physicians or non-physician practitioners who actively assist the physician in charge of performing a

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surgical procedure. When a Method II CAH bills for a surgical procedure on TOB 85X with RC 96X, 97X or 98X, and an appropriate assistant at surgery modifier (explained below), Medicare will pay the CAH for the assistant at surgery services it provides (if the rendering a physician or non-physician practitioner has reassigned their billing rights to the CAH).

You should be aware that Section 1862 of the Social Security Act (the Act) stipulates that payment can only be made for care that is reasonable and necessary; and specifically, Section 1862(15)(A) of the Act addresses the services of an assistant at surgery and when those services are statutorily excluded. In conformance with this stipulation, Medicare uses the payment policy indicators on the Medicare Physician Fee Schedule Database (MPFSDB) to determine if assistant at surgery services are reasonable and necessary for a specific HCPCS/CPT code. You can find the MPFSDB is located at http://www.cms.hhs.gov/apps/ama/license.asp?file=/pfslookup/02_PFSsearch.asp on the Centers for Medicare & Medicaid Services (CMS) website.

Payment

Medicare pays for a surgical assistant when the procedure is authorized for an assistant and the person performing the service is a physician, physician assistant (PA), nurse practitioner (NP) or a clinical nurse specialist (CNS).

To facilitate payment, CMS (under authority of 42 CFR Section 414.40) has established uniform national definitions of services, codes to represent services, and payment modifiers to the codes, to include the use of payment modifiers for assistant at surgery services.

To bill for these services, you should use Modifier 80 (assistant surgeon), 81 (minimum assistant surgeon), or 82 (when qualified resident surgeon not available). You should also use Modifier AS when you need to indicate that a PA, NP or CNS served as the assistant at surgery. Be aware that when you use Modifier AS, you must also use Modifier 80, 81, or 82 because using these modifiers without modifier AS indicates that a physician served as the surgical assistant. Claims that you submit with modifier AS and without modifier 80, 81 or 82 will be returned to you.

Payment Amount Calculation

Section 1834(g)(2)(B) of the Social Security Act (the Act) requires that professional services included within outpatient CAH services be paid at 115 percent of the amount that would otherwise be paid if such services were not included in the outpatient CAH services.

Other sections of the Act address the specific payment for surgical assistance:

- Section 1848(i)(2)(B) stipulates that if, for a physician-furnished surgery service, a separate payment is made to a physician providing surgical

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assistance, the fee schedule amount will not exceed 16 percent of the fee schedule amount; and

- Section 1833(a)(1)(O)(ii) states that when the surgical assistance is provided by a PA, NP or CNS, payment is the lesser of the actual charge, or 85 percent of the amount that would otherwise be paid to a physician serving as an assistant at surgery.

The payment amount for a physician assisting at surgery is calculated as follows:

The facility specific Medicare Physician Fee Schedule (MPFS) amount *multiplied by* a 16 percent assistant at surgery reduction amount *minus* the deductible and coinsurance, *then multiplied by* 115 percent,

OR

$((\text{MPFS} \times .16) - (\text{deductible and coinsurance})) \times 1.15$.

The payment amount for a PA, NP, or CNS assisting at surgery is calculated as follows:

The facility specific MPFS amount *multiplied by* a 16 percent assistant at surgery reduction amount *multiplied by* an 85 percent non-physician practitioner reduction *minus* the deductible and coinsurance, *and then multiplied by* times 115 percent,

OR

$((\text{MPFS} \times .16 \times .85) - (\text{deductible and coinsurance})) \times 1.15$.

You should be aware that FIs and A/B MACs will suspend and assign a unique reason code in the 5XXXX series to assistant at surgery services on TOB 85X with RC 96X, 97X or 98X and modifier AS, 80, 81 or 82 when the HCPCS/CPT code has a payment policy indicator of '0' (Payment restriction for assistants at surgery applies to this procedure unless supporting documentation is submitted to establish medical necessity). They will pay for these services when medical necessity has been established. Such payment will be based on the lesser of actual charges or the reduced MPFS amount determined by the formulas listed above.

FIs and A/B MACs will return to provider (RTP) claims for assistant at surgery services that you submit on TOB 85X with RC 96X, 97X or 98X and modifier AS, 80, 81 or 82 when the HCPCS/CPT code billed with the modifier has a payment policy indicator of '9' (concept does not apply).

Medicare Summary Notice (MSN) and Remittance Advice (RA) Messages

When denying non-covered assistant at surgery services for HCPCS/CPT codes with a payment policy indicator of "0" (Payment restriction for assistants at surgery

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applies to this procedure unless supporting documentation is submitted to establish medical necessity) or '2' (Payment restrictions for assistants at surgery does not apply to this procedure. Assistant surgery may be paid) when an Advance Beneficiary Notice (ABN) was issued, FIs and A/B MACs will use the following MSN and RA messages:

MSN Messages to the Beneficiary:

36.1 - Our records show you were informed in writing, before receiving the service, Medicare would not pay. You are liable for this charge. If you do not agree with this statement, you may ask for a review.

RA Remark Code

M38 - The patient is liable for charges for this service as you informed the patient in writing before the service was furnished that we could not pay for it, and the patient agreed to pay.

RA Group Code

PR – Patient Responsibility

RA Claim Adjustment Reason Code

54 – Multiple physicians/assistants are not covered in this case.

Unless you issue an appropriate ABN, you are liable for non-covered assistant at surgery services with a payment policy indicator of '0' or '2'. When denying non-covered assistant at surgery services for HCPCS/CPT codes with a payment policy indicator of '0' or '2' and an ABN was **not** issued, FIs and A/B MACs will use the following MSN and RA messages:

MSN Messages to the Beneficiary

36.2 - It appears that you did not know that we would not pay for this service, so you are not liable. Do not pay your provider for this service. If you have paid your provider for this service, you should submit to this office three things: (1) a copy of this notice, (2) your provider's bill, and (3) a receipt or proof that you have paid the bill. You must file your written request for payment within 6 months of the date of this notice. Future services of this type provided to you will be your responsibility.

RA Remark Code

M27 - The patient has been relieved of liability of payment of these items and services under the limitation of liability provision of the law. The provider is ultimately liable for the patient's waived charges, including any charges for coinsurance, since the items or services were not reasonable and necessary or constituted custodial care, and you knew or could reasonably have been expected to know, that they were not covered. You may appeal this determination. You may ask for an appeal regarding both

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the coverage determination and the issue of whether you exercised due care. The appeal request must be filed within 120 days of the date you receive this notice. You must make the request through this office.

RA Group Code

CO – Contractual Obligation

RA Claim Adjustment Reason Code

54 – Multiple physicians/assistants are not covered in this case.

When denying medically unnecessary assistant at surgery services for HCPCS/CPT codes with a payment policy indicator of '1' (Statutory payment restrictions for assistants at surgery applies to this procedure. Assistant at surgery may not be paid), FIs and A/B MACs will use the following MSN and RA messages:

MSN Message

15.11 – Medicare does not pay for an assistant surgeon for this procedure/surgery.

RA Remark Code

N425 – Statutorily Excluded Service

RA Group Code

PR – Patient Responsibility

RA Claim Adjustment Reason Code

54 – Multiple physicians/assistants are not covered in this case.

Teaching Hospitals Impact Summary

Providing assistant in surgery services in teaching has some specific requirements. In general, if a hospital has a training program relating to the medical specialty required for the surgical procedure, and a qualified resident is available to provide surgical assistance for a procedure, Section 1842(b)(7)(D) of the Social Security Act stipulates that no payment will be made for the services of a surgical assistant for the procedure. FIs and A/B MACs will process assistant at surgery services furnished in Method II teaching CAHs through the use of modifier 82, which indicates that a qualified resident surgeon was not available.

However, such payments can be made in teaching hospitals under certain circumstances such as exceptional medical circumstances (emergency, life threatening situations such as multiple traumatic injuries), which require immediate treatment; situations in which the medical staff may find that exceptional medical circumstances justify the services of a physician or non-physician provider to assist at surgery even though a qualified resident is available; or if the primary

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surgeon has an across-the board policy of never involving residents in the preoperative, operative, or postoperative care of his or her patients.

Claims will be suspended and developed when billed by Method II teaching CAHs with modifiers AS, 80 or 81 to determine if exceptional medical circumstances existed or the primary surgeon has an across-the board policy of never involving residents in the preoperative, operative, or postoperative care of his or her patients.

Given the absence of national policy on this provision, FIs and A/B MACs have the authority to establish procedures to define the appropriate supporting documentation needed to establish medical necessity, the existence of exceptional medical circumstances or to determine if the primary surgeon has an across the board policy of never involving residents in the preoperative, operative or postoperative care of his patients for assistant at surgery services. FIs and A/B MACs will also determine if a clinician or non-clinician medical reviewer will review assistant at surgery services.

Also, keep in mind that FIs and A/B MACs:

- Process assistant at surgery claims for services furnished in a teaching hospital through the use of modifier 82 to indicate that a qualified resident was not available. Modifier 82 is for use only when the basis for payment is the unavailability of qualified residents; and
- Will suspend for review and assign a unique reason code in the 5xxx series to claims that you submit on type of bill 85X with RC 96X, 97X or 98X and modifier AS, 80 or 81, when the HCPCS/CPT code has a payment policy indicator of '0' (Payment restriction for assistants at surgery applies to this procedure unless supporting documentation is submitted to establish medical necessity) or '2' (Payment restrictions for assistants at surgery does not apply to this procedure. Assistant surgery may be paid) and the intern to bed ratio is greater than 0 (teaching hospital). Once supporting documentation justifies the services of the assistant at surgery, the FI or A/B MAC will make payment on the claim.

Finally, you should know that FIs and A/B MACs will not search for, and adjust claims that have been paid prior to the implementation date, but will adjust claims that you bring to their attention

Additional Information

You can find more information about the payment of assistant at surgery services in a Method II CAH by going to CR 6123, located at <http://www.cms.hhs.gov/Transmittals/downloads/R1620CP.pdf> on the CMS website.

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You will find the updated updates *Medicare Claims Processing Manual* Chapter 4 (Part B Hospital (Including Inpatient Hospital Part B and OPPS)) Sections 250.9 (Coding Assistant at Surgery Services Rendered in a Method II CAH), 250.9.1 (Use of Payment Policy Indicators for Determining Procedures Eligible for Payment of Assistants at Surgery), 250.9.2 (Payment of Assistant at Surgery Services Rendered in a Method II CAH), 250.9.3 (Assistant at Surgery Medicare Summary Notice (MSN) and Remittance Advice (RA) Messages), and 250.9.4 (Assistant at Surgery Services in a Method II CAH Teaching Hospital).

As mentioned earlier, you can find the assistant at surgery payment policy indicators for HCPCS/CPT on the MPFSD at http://www.cms.hhs.gov/apps/ama/license.asp?file=/pfslookup/02_PFSsearch.asp on the CMS website.

You might also want to look at CR6013 – Physician Fee Schedule Payment Policy Indicator File Record Layout for use in Processing Method II CAH Claims for Professional Services), released May 16, 2008, for more information about the file layout used in processing CAH professional services' claims.

If you have any questions, please contact your FI or A/B MAC at their toll-free number, which may be found at <http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip> on the CMS website.

News Flash - "Flu season is here! Medicare patients give many reasons for not getting their annual flu shot, including—"It causes the flu"; "I don't need it"; "It has side effects"; "It's not effective"; "I didn't think about it"; "I don't like needles!" The fact is that every year in the United States, on average, about 36,000 people die from influenza. Greater than 90 percent of these deaths occur in individuals 65 years of age and older. You can help your Medicare patients overcome these odds and their personal barriers through patient education. Talk with your Medicare patients about the importance of getting an annual flu shot--and don't forget to immunize yourself and your staff. Protect yourself, your patients, and your family and friends. **Get Your Flu Shot – Not the Flu. Remember** - Influenza vaccine plus its administration are covered Part B benefits. Note that influenza vaccine is NOT a Part D covered drug. For information about Medicare's coverage of the influenza virus vaccine and its administration as well as related educational resources for health care professionals and their staff, see http://www.cms.hhs.gov/MLNProducts/Downloads/flu_products.pdf on the CMS website. To download the Medicare Part B Immunization Billing quick reference chart, go to http://www.cms.hhs.gov/MLNProducts/downloads/gr_immun_bill.pdf on the CMS website. A copy of this quick reference chart can be ordered, free of charge, by going to the MLN Products web page and clicking on "MLN Product Ordering Page" in the Related Links Inside CMS section of the web page.

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