



News Flash – The revised publication titled Medicare Billing Information for Rural Providers, Suppliers, and Physicians (October 2008), which consists of charts that provide Medicare billing information for Rural Health Clinics, Federally Qualified Health Centers, Skilled Nursing Facilities, Home Health Agencies, Critical Access Hospitals, and Swing Beds, is now available in downloadable format from the Centers for Medicare & Medicaid Services Medicare Learning Network at <http://www.cms.hhs.gov/MLNProducts/downloads/RuralChart.pdf> on the CMS website.

MLN Matters Number: MM6319 **Revised**

Related Change Request (CR) #: 6319

Related CR Release Date: July 29, 2009

Effective Date: January 1, 2008

Related CR Transmittal #: R1781CP

Implementation Date: July 6, 2009

Payment for Co-surgeons in a Method II Critical Access Hospital (CAH)

Note: This article was revised on July 29, 2009, to reflect a revision made to CR 6319. That CR was revised to replace a reference to Remark Code M78 with a reference to Remark Code N180 (page 3 of this article). The CR release date, transmittal number, and Web address for accessing CR 6319 were also revised. All other information remains the same.

Provider Types Affected

Method II CAHs billing Medicare Administrative Contractors (A/B MACs) and/or fiscal intermediaries (FIs) for physicians that have reassigned their billing rights to the CAH on type of bill 85X with revenue codes 96X, 97X, or 98X with modifier 62 for co-surgeon services rendered in a Method II CAH to Medicare beneficiaries.

Provider Action Needed

This article is based on Change Request (CR) 6319 and alerts providers that the Centers for Medicare & Medicaid Services (CMS) is issuing CR6319 to highlight the revisions to the Medicare Claims Processing Manual, Chapter 4 dealing with payment for co-surgeons in a Method II CAH.

Physicians billing on type of bill 85X for professional services rendered in a Method II CAH have the option of reassigning their billing rights to the CAH. When

Disclaimer

This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents. CPT only copyright 2008 American Medical Association.

the billing rights are reassigned to the Method II CAH, payment is made to the CAH for professional services (revenue codes 96X, 97X or 98X). Medicare makes a payment for a co-surgeon when the procedure is authorized for a co-surgeon and the person performing the surgery is a physician. CR 6319 **implements the reduction in payment for co-surgeon services**. See the “Key Points” section for specifics regarding the revisions and the impact on claims for co-surgeon services in a Method II CAH.

Background

When the billing rights are reassigned to the Method II CAH, payment is made to the CAH for professional services (revenue codes (RC) 96X, 97X or 98X). Under some circumstances, the skills of two surgeons (**each in a different specialty**) are required to perform surgery on the same patient during the same operative session. This may be required because of the complex nature of the procedure(s) and/or the patient’s condition.

Co-surgery refers to a single surgical procedure which requires the skill of two surgeons, each in a different specialty, performing parts of the same procedure simultaneously. It is not always co-surgery when two doctors perform surgery on the same patient during the same operative session. **Co-surgery has been performed if the procedure(s) performed is part of and would be billed under a single surgical procedure code.**

Medicare uses the payment policy indicators on the Medicare Physician Fee Schedule Database (MPFSDB) to determine if co-surgeon services are reasonable and necessary for a specific Healthcare Common Procedure Coding System/Current Procedural Terminology (HCPCS/CPT) code. The MPFSDB is located *at* www.cms.hhs.gov/apps/ama/license.asp?file=/pfslookup/02_PFSsearch.asp on the CMS website.

The revised Medicare Claims Processing Manual Chapter 4 (attached to CR 6319) outlines changes that impact five areas as follows:

1. Coding Co-surgeon Services Rendered in a Method II CAH;
2. Use of Payment Policy Indicators for Determining Procedures Eligible for Payment of Co-surgeons;
3. Payment of Co-surgeon Services Rendered in a Method II CAH;
4. Co-surgeon Medicare Summary Notice (MSN) and Remittance Advice (RA) Messages; and
5. Review of Supporting Documentation for Co-surgeon Services in a Method II CAH.

Disclaimer

This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents. CPT only copyright 2008 American Medical Association.

Key Points Regarding Claims for Co-Surgeon Services in a Method II CAH

- Medicare will accept claims for co-surgeon services submitted on type of bill 85X with revenue code 96X, 97X, or 98X if it contains either one claim line with a surgical HCXPCS/CPT code and has the 62 modifier or two claim lines with the same surgical HCPCS/CPT code with the same line item date of service, and the 62 modifier on each line.
- In the situation just described where co-surgeon services are reported on two claim lines within the same claim, both lines must have the 62 modifier. Where only one line has the 62 modifier, Medicare will deny the line without the 62 modifier with the following messages:
 - Medicare Summary Notice (MSN) 16.10 indicating Medicare does not pay for this item or service;
 - Remittance Advice (RA) Remark Code N180, indicating This item or service does not meet the criteria for the category under which it was billed;
 - Group Code of CO showing contractual obligation; and
 - Claim Adjustment Reason Code (CARC) 4 denoting that the procedure code is inconsistent with the modifier used or a required modifier is missing.
- When billing for co-surgeon services, remember that Medicare will pay only when the services are rendered by two surgeons, each with a different specialty, and the claim carries modifier 62 to show there were two surgeons for co-surgery.
- The MPFSDB must reflect an acceptable payment policy indicator for the associated HCPCS/CPT code in order for the claim to be considered for payment. If the payment policy indicator is "0" indicating that co-surgeons are not permitted for that procedure, Medicare will deny the claim with the following:
 - MSN message 15.12, indicating Medicare does not pay for two surgeons for this procedure;
 - RA Remark Code N431 to show "service is not covered with this procedure";
 - A group code of PR, showing patient responsibility; and
 - A CARC of 54 to show "Multiple physicians/assistants are not covered in this case."

Disclaimer

This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents. CPT only copyright 2008 American Medical Association.

- Medicare contractors will develop co-surgeon services on TOB 85X with RC 96X, 97X or 98X and modifier 62 for the supporting documentation needed to establish medical necessity when the HCPCS/CPT code has a payment policy indicator of '1' showing that co-surgeons could be paid depending on supporting documentation.
- Medicare contractors will define the appropriate supporting documentation needed to establish medical necessity for co-surgeon services when the HCPCS/CPT code has a payment policy indicator of '1'.
- Method II CAHs should remember that they will be liable for non-covered co-surgeon services unless they issue an appropriate advance beneficiary notice (ABN) when the payment policy indicator is '1'.
- Medicare contractors will deny co-surgeon services when the supporting documentation does not establish medical necessity when the payment policy indicator is '1'.
- Medicare contractors will use the following messages when denying medically unnecessary co-surgeon services with a payment policy indicator of '1' when an ABN was issued:
 - An MSN message 36.1 - Our records show that you were informed in writing, before receiving the service that Medicare would not pay. You are liable for this charge. If you do not agree with this statement, you may ask for a review.
 - An RA Remark Code of M38 - The patient is liable for the charges for this service as you informed the patient in writing before the service was furnished that we would not pay for it, and the patient agreed to pay.
 - A group code of PR – Patient Responsibility
 - A CARC code of 54 – Multiple physicians/assistants are not covered in this case.
- Medicare contractors will use the following messages when denying medically unnecessary co-surgeon services with a payment policy indicator of '1' when an ABN was not issued:
 - MSN message 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

Disclaimer

This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents. CPT only copyright 2008 American Medical Association.

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 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.
 - Group code CO – Contractual Obligation.
 - CARC code 54 – Multiple physicians/assistants are not covered in this case.
- Medicare contractors will develop co-surgeon services on type of bill (TOB) 85X with RC 96X, 97X or 98X and modifier 62 to establish that the two specialty requirement is met when the HCPCS/CPT code has a payment policy indicator of '2'.
 - Medicare contractors will deny co-surgeon services when the two specialty requirement is not met, i.e., the two co-surgeons each have the same specialty. When denying such claims, Medicare will use the following messages:
 - MSN Message 21.21 – This service was denied because Medicare only covers this service under certain circumstances.
 - RA Remark Code N95 – The provider type/provider specialty may not bill this service.
 - Group code PR – Patient Responsibility.
 - CARC code 54 – Multiple physicians/assistants are not covered in this case.
 - Medicare contractors will return to provider (RTP) co-surgeon services submitted on TOB 85X with RC 96X, 97X or 98X when the HCPCS/CPT code billed with the 62 modifier has a payment policy indicator of '9', indicating the co-surgeon concept does not apply.

Disclaimer

This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents. CPT only copyright 2008 American Medical Association.

- Medicare contractors will determine if a clinician or a non-clinician medical reviewer should review the supporting documentation submitted for co-surgeon services.
- Medicare contractors will not search for and adjust claims that have been paid prior to the implementation date. However, they will adjust such claims that you bring to their attention.
- Finally, when Medicare pays for co-surgeon services, payment is the lesser of the actual charge or 62.5% of the MPFS payment minus deductible and coinsurance. Where payment rights are reassigned to a Method II CAH, that CAH is paid 115% of that lesser payment amount.

Additional Information

If you have questions, please contact your Medicare 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.

The official instruction (CR6319) issued to your Medicare FI or A/B MAC is available at <http://www.cms.hhs.gov/Transmittals/downloads/R1781CP.pdf> on the CMS website.

Disclaimer

This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents. CPT only copyright 2008 American Medical Association.