CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 1620	**Date: OCTOBER 24, 2008**
	Change Request 6123

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

I. SUMMARY OF CHANGES: Physicians and non-physician practitioners 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 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 payment for an assistant at surgery 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). This Change Request (CR) implements the reduction in payment for assistant at surgery services. Please note that a revision to §250.5 in Chapter 4 of Pub.100-04 is included with this CR. There are no policy changes attached to the change in this manual section. It was updated for clarification purposes only.

New / Revised Material
Effective Date: January 1, 2008
Implementation Date: April 6, 2009

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	Chapter / Section / Subsection / Title
R	4/Table of Contents
R	4/250/250.5/Medicare Payment for Ambulance Services Furnished by Certain CAHs
N	4/250/250.9/Coding Assistant at Surgery Services Rendered in a Method II CAH
N	4/250/250.9.1/Use of Payment Policy Indicators for Determining Procedures Eligible for Payment of Assistants at Surgery
N	4/250/250.9.2/Payment of Assistant at Surgery Services Rendered in a Method II CAH
N	4/250/250.9.3/Assistant at Surgery Medicare Summary Notice (MSN) and Remittance Advice (RA) Messages
N	4/250/250.9.4/Assistant at Surgery Services in a Method II CAH

	Teaching Hospital
N	4/250/250.9.5/Review of Supporting Documentation for Assistant at Surgery Services in a Method II CAH

III. FUNDING:
SECTION A: For Fiscal Intermediaries and Carriers:
No additional funding will be provided by CMS; Contractor activities are to be carried out within their operating budgets.

SECTION B: For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

Business Requirements

Manual Instruction

**Unless otherwise specified, the effective date is the date of service.*

Attachment - Business Requirements

Pub. 100-04	Transmittal: 1620	Date: October 24, 2008	Change Request: 6123

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

Effective Date: January 1, 2008

Implementation Date: April 6, 2009

I. GENERAL INFORMATION

A. 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 the CAH. 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).

Medicare makes payment for an assistant at surgery 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). This Change Request implements the reduction in payment for assistant at surgery services.

B. Policy: Section 1834(g)(2)(B) of the Social Security Act (the Act) states that professional services included within outpatient CAH services, shall be paid 115 percent of such amounts as would otherwise be paid under this part if such services were not included in the outpatient CAH services.

Section 1848(i)(2)(B) of the Act stipulates that in the case of a surgical service furnished by a physician, if payment is made separately under this part for the services of a physician serving as an assistant at surgery, the payment amount shall not exceed 16 percent of the fee schedule amount.

Section 1833(a)(1)(O)(ii) of the Act states that in the case of a PA, NP or CNS the amounts paid for serving as an assistant at surgery shall be the lesser of the actual charge or 85 percent of the amount that would otherwise be recognized if performed by a physician who is serving as an assistant at surgery. The payment methodology for these services has been codified in regulations found at 42 CFR 414.52(d) and 414.56(c).

Section 1862 of the Act stipulates that no payment can be made for care that is not reasonable and necessary. Specifically, Section 1862(15)(A) addresses services of an assistant at surgery and when those services are statutorily excluded.

As stated in 42 CFR 414.40, CMS establishes uniform national definitions of services, codes to represent services, and payment modifiers to the codes. This includes the use of payment modifiers for assistant at surgery services.

Modifier 80 (assistant surgeon), 81 (minimum assistant surgeon), or 82 (when qualified resident surgeon not available) is used to bill for assistant at surgery services. When billed without modifier AS (PA, NP or CNS services for assistant at surgery) the use of these modifiers indicates that a physician served as the assistant at surgery.

Modifier AS is billed to indicate that a PA, NP or CNS served as the assistant at surgery. Modifier 80, 81 or 82 must also be billed when modifier AS is billed. Claims submitted with modifier AS and without modifier 80, 81 or 82 are returned to the provider (RTPd).

Section 1842(b)(7)(D) stipulates that no payment shall be made for the services of assistant at surgery with respect to a surgical procedure if a hospital has a training program relating to the medical specialty required for the surgical procedure and a qualified individual on the staff of the hospital is available to provide such services. Fiscal intermediaries (FIs) and A/B Medicare Administrative Contractors (MACs) shall 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.

Payment may be made for the services of assistants at surgery in teaching hospitals not withstanding the availability of a qualified resident to furnish the services. There may be exceptional medical circumstances (emergency, life threatening situations such as multiple traumatic injuries) which require immediate treatment. There may be situations in which the medical staff may find that exceptional medical circumstances justify the services of a physician assistant at surgery even though a qualified resident is available.

Payment may also be made for the services of assistants at surgery in teaching hospitals, if 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.

Claims shall 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 shall also determine if a clinician or non-clinician medical reviewer shall review assistant at surgery services.

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. The MPFSDB is located at http://www.cms.hhs.gov/apps/ama/license.asp?file=/pfslookup/02_PFSsearch.asp .

Please note that a revision to §250.5 in Pub.100-04 is included with this CR. There are no policy changes attached to the change in this manual section. It was updated for clarification purposes only.

II. BUSINESS REQUIREMENTS TABLE

Use"Shall" to denote a mandatory requirement

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
6123.1	Contractors shall 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'.						X				

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
	Payment Policy Indicator 0 – Payment restriction for assistant at surgery applies to this procedure unless supporting documentation is submitted to establish medical necessity.										
6123.1.1	Contractors shall define the appropriate supporting documentation needed to establish medical necessity for assistant at surgery services when the HCPCS/CPT code has a payment policy indicator of '0'.	X		X							
6123.1.1.1	Contractors shall develop assistant at surgery services on TOB 85X with RC 96X, 97X or 98X and modifier AS, 80, 81 or 82 for the supporting documentation needed to establish medical necessity when the HCPCS/CPT code has a payment policy indicator of '0'. **NOTE**: The reason code assigned in 6123.1 will be present on the claim.	X		X							
6123.1.2	Contractors shall 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, or 81 when the HCPCS/CPT code has a payment policy indicator of '0' or '2' and the intern to bed ratio is greater than 0. Payment Policy Indicator 2 – Payment restrictions for assistant at surgery does not apply to this procedure. Assistant at surgery may be paid. **NOTE**: Teaching hospitals are identified by an intern to bed ratio greater than 0.						X				
6123.1.2.1	Contractors shall define the appropriate supporting documentation needed to establish 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 when the HCPCS/CPT code has a payment policy indicator of '0' or '2' and the intern to bed ratio is greater than 0.	X		X							
6123.1.2.2	Contractors shall develop for the supporting documentation needed to determine that one of	X		X							

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
	the following conditions was present on claims submitted on TOB 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' or '2' and an intern to bed ratio greater than 0: - exceptional medical circumstances justify the services, or - the primary surgeon has an across the board policy of never involving residents in the preoperative, operative or postoperative care of his patients. **NOTE**: The reason code assigned in 6123.1.2 will be present on the claim.										
6123.1.3	Contractors shall advise Method II CAHs that they will be liable for non-covered assistant at surgery services unless they issue an appropriate advance beneficiary notice (ABN) when the payment policy indicator is '0' or '2'. **NOTE**: The ABN pertains to claims denied under business rules (BRs) 6123.1 through 6123.1.2.2 for payment policy indicator '0'. For payment policy indicator '2' BRs 6123.1.2 through 6123.1.2.2 apply.	X		X							
6123.1.4	Contractors shall deny assistant at surgery services when the supporting documentation does not establish medical necessity, exceptional medical circumstances or that the physician has an across the board policy of never involving residents in the preoperative, operative or postoperative care of his patients.	X		X							
6123.1.4.1	Contractors shall use the following MSN message when denying non-covered assistant at surgery services with a payment policy indicator of '0' or '2' and an ABN was issued: 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.	X		X							

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
	Spanish version: 36.1 - Nuestros archivos indican que usted fue informado por escrito, antes de recibir el servicio, que Medicare no pagaría. Usted es responsable por esta cantidad. Si usted no está de acuerdo, usted puede pedir una revisión.										
6123.1.4.2	Contractors shall use the following Remittance Advice (RA) Remark Code when denying non-covered assistant at surgery services with a payment policy indicator of '0' or '2' and an ABN was issued: 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.	X		X							
6123.1.4.3	Contractors shall use the following Group Code when denying non-covered assistant at surgery services with a payment policy indicator of '0' or '2' and an ABN was issued : PR – Patient Responsibility	X		X							
6123.1.4.4	Contractors shall use the following Claim Adjustment Reason Code when denying non-covered assistant at surgery services with a payment policy indicator of '0' or '2' and an ABN was issued: 54 – Multiple physicians/assistants are not covered in this case.	X		X							
6123.1.5	Contractors shall use the following MSN message when denying non-covered assistant at surgery services with a payment policy indicator of '0' or '2' and an ABN was not issued: 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	X		X							

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
	responsibility. Spanish version: 36.2 - Aparentemente, usted no sabia que nosotros no pagamos por este servicio, por lo tanto usted no es responsable. Si usted le pagó al proveedor por este servicio debe enviarnos lo siguiente: (1) Copia de esta notificación; (2) Factura del proveedor; (3) El recibo o prueba de que usted le pagó. Debe enviar su petición por escrito dentro de 6 meses de la fecha de esta notificación. Servicios de este tipo prestados en el futuro serán su responsabilidad.										
6123.1.5.1	Contractors shall use the following RA Remark Code when denying non-covered assistant at surgery services with a payment policy indicator of '0' or '2' and an ABN was not issued: 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.	X		X							
6123.1.5.2	Contractors shall use the following Group Code when denying non-covered assistant at surgery services with a payment policy indicator of '0' or '2' and an ABN was not issued: CO – Contractual Obligation	X		X							
6123.1.5.3	Contractors shall use the following Claim Adjustment Reason Code when denying non-covered assistant at surgery services with a payment policy indicator of '0' or '2' and an ABN was not issued:	X		X							

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
	54 – Multiple physicians/assistants are not covered in this case.										
6123.1.6	Contractors shall pay for assistant at surgery services performed by physicians on TOB 85X with RC 96X, 97X or 98X and modifier 80, 81, or 82 when the HCPCS/CPT code has a payment policy indicator of '0' or '2' based on the lesser of the actual charges or the reduced fee schedule amount as follows: ((facility specific Medicare physician fee schedule (MPFS) amount times assistant at surgery reduction (16%)) minus (deductible and coinsurance)) times 115%						X				
6123.1.7	Contractors shall pay for assistant at surgery services performed by a PA, NP or CNS on TOB 85X with RC 96X, 97X or 98X and modifiers AS and 80, 81 or 82 when the HCPCS/CPT code has a payment policy indicator of '0' or '2' based on the lesser of the actual charges or the reduced fee schedule amount as follows: ((facility specific MPFS) amount times assistant at surgery reduction (16%) times non-physician practitioner reduction % (85%)) minus (deductible and coinsurance)) times 115%						X				
6123.2	Contractors shall deny 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 '1'. Payment Policy Indicator 1 – Statutory payment restrictions for assistants at surgery applies to this procedure.						X				
6123.2.1	Contractors shall use the following MSN message when denying assistant at surgery services with a payment policy indicator of '1'. 15.11 – Medicare does not pay for an assistant surgeon for this procedure/surgery. Spanish version: 15.11 - Medicare no paga por el asistente del	X		X			X				

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
	cirujano por este procedimiento/cirugía.										
6123.2.2	Contractors shall use the following Remittance Advice (RA) Remark Code when denying assistant at surgery services with a payment policy indicator of '1': N425 – Statutorily Excluded Services	X		X			X				
6123.2.3	Contractors shall use the following Group Code when denying assistant at surgery services with a payment policy indicator of '1': PR – Patient Responsibility	X		X			X				
6123.2.4	Contractors shall use the following Claim Adjustment Reason Code when denying assistant at surgery services with a payment policy indicator of '1': 54 – Multiple physicians/assistants are not covered in this case.	X		X			X				
6123.3	Contractors shall RTP assistant at surgery services performed by a PA, NP, or CNS on TOB 85X with RC 96X, 97X or 98X with modifier AS and without modifier 80, 81 or 82 when the HCPCS/CPT code has a payment policy indicator of '0' or '2'.	X		X			X				
6123.4	Contractors shall RTP assistant at surgery services submitted 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'. Payment Policy Indicator 9 - concept does not apply	X		X			X				
6123.5	Contractors shall determine if a clinician or non-clinician medical reviewer shall review the supporting documentation submitted for assistant at surgery services.	X		X							
6123.6	Contractors shall not search for and adjust claims that have been paid prior to the implementation date. However, contractors shall adjust claims brought to their attention.	X		X							
6123.7	Contractors shall educate providers that the assistant at surgery payment policy indicators for HCPCS/CPT codes can be found on the Medicare Physician Fee Schedule Database at	X		X							

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
	http://www.cms.hhs.gov/apps/ama/license.asp?file=/pfslookup/02_PFSsearch.asp .										
6123.7.1	Contractors shall provide a direct link to the Medicare Physician Fee Schedule Database on their Web site.	X		X							
6123.8	Contractors shall give users entry and update capability for all fields on the Physician Fee Schedule Payment Policy Indicator File.	X		X			X				

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
6123.9	A provider education article related to this instruction will be available at http://www.cms.hhs.gov/MLNMattersArticles/ shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web site and include information about it in a listserv message within one week of the availability of the provider education article. In addition, the provider education article shall be included in your next regularly scheduled bulletin. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.	X		X							

IV. SUPPORTING INFORMATION

Section A: For any recommendations and supporting information associated with listed requirements, use the box below:
Use "Should" to denote a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:
All	CR6013 – Physician Fee Schedule Payment Policy Indicator File Record Layout for Use in Processing Method II Critical Access Hospital (CAH) Claims for Professional Services
All	CR6176 – Update to the Intern to Bed Ratio for Method II Teaching Critical Access Hospitals

X-Ref Requirement Number	Recommendations or other supporting information:
	(CAHs)

Section B: For all other recommendations and supporting information, use this space: N/A

V. CONTACTS

Pre-Implementation Contact(s): Susan Guerin at susan.guerin@cms.hhs.gov or 410-786-6138

Post-Implementation Contact(s): Appropriate Regional Office

VI. FUNDING

Section A: For *Fiscal Intermediaries (FIs), Carriers, and Regional Home Health Intermediaries (RHHIs)*:

No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

Section B: *For Medicare Administrative Contractors (MACs)*:

The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

Medicare Claims Processing Manual
Chapter 4 - Part B Hospital
(Including Inpatient Hospital Part B and OPPS)

Table of Contents

(Rev. 1620, 10-24-08)

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

250.9.5 Review of Supporting Documentation for Assistants at Surgery Services in a Method II CAH

250.5 - Medicare Payment for Ambulance Services Furnished by Certain CAHs

(Rev. 1620; Issued: 10-24-08; Effective: 01-01-08; Implementation: 04-06-09)

*Medically necessary a*mbulance services furnished on or after December 21, 2000, by CAHs *with a hospital-based ambulance service are* paid *based* on *100 percent of* reasonable cost *if the 35 mile rule for cost-based payment is met.*

Section 205 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act (BIPA) of 2000 exempts certain CAHs from the current Medicare ambulance cost per trip payment limit as well as from the ambulance fee schedule. Section 205(a) of BIPA states:

> The Secretary shall pay the reasonable costs incurred in furnishing ambulance services if such services are furnished (A) by a CAH (as defined in §1861(mm)(1)), or (B) by an entity that is owned and operated by a CAH, but only if the CAH or entity is the only provider or supplier of ambulance services that is located within a 35-mile drive of such CAH.

Those CAHs that meet the 35 mile rule for cost-based payment shall report condition code B2 (CAH ambulance attestation) on their bills.

When the 35 mile rule for cost-based payment is not met, CAHs with a hospital-based ambulance service are paid based on the ambulance fee schedule.

250.9 – Coding Assistant at Surgery Services Rendered in a Method II CAH

(Rev. 1620; Issued: 10-24-08; Effective: 01-01-08; Implementation: 04-06-09)

An assistant at surgery is a physician or non-physician practitioner who actively assists the physician in charge of the case in performing a surgical procedure.

Medicare makes payment for an assistant at surgery 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).

Assistant at surgery services rendered by a physician or non-physician practitioner that has reassigned their billing rights to a Method II CAH are payable by Medicare when the procedure is billed on type of bill 85X with revenue code (RC) 96X, 97X or 98X and an appropriate assistant at surgery modifier.

Under authority of 42 CFR 414.40, CMS establishes uniform national definitions of services, codes to represent services, and payment modifiers to the codes. This includes the use of payment modifiers for assistant at surgery services.

Modifier 80 (assistant surgeon), 81 (minimum assistant surgeon), or 82 (when qualified resident surgeon not available) is used to bill for assistant at surgery services. When billed without modifier AS (PA, NP or CNS services for assistant at surgery) the use of these modifiers indicate that a physician served as an assistant at surgery.

Modifier AS is billed to indicate that a PA, NP or CNS served as the assistant at surgery. Modifier 80, 81 or 82 must also be billed when modifier AS is billed. Claims submitted with modifier AS and without modifier 80, 81 or 82 are returned to the provider (RTPd).

250.9.1 – Use of Payment Policy Indicators for Determining Procedures Eligible for Payment of Assistants at Surgery

(Rev. 1620; Issued: 10-24-08; Effective: 01-01-08; Implementation: 04-06-09)

Medicare makes payment for an assistant at surgery when the procedure is authorized for an assistant and the person performing the service is a physician, PA, NP or a CNS.

Section 1862 of the Act stipulates that no payment can be made for care that is not reasonable and necessary. Specifically, Section 1862(15)(A) addresses services of an assistant at surgery and when those services are statutorily excluded.

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. The MPFSDB is located at http://www.cms.hhs.gov/apps/ama/license.asp?file=/pfslookup/02_PFSsearch.asp .

Since all of the information housed on the MPFSDB is not needed to process Method II CAH claims, the payment policy indicators that are needed are extracted on a quarterly basis for use in processing these claims and sent to the fiscal intermediaries on the Physician Fee Schedule Payment Policy Indicator File.

See the Physician Fee Schedule Payment Policy Record Layout in §250.2 for a description of the assistant at surgery payment policy indicators.

250.9.2 – Payment of Assistant at Surgery Services Rendered in a Method II CAH

(Rev. 1620; Issued: 10-24-08; Effective: 01-01-08; Implementation: 04-06-09)

Under Section 1834(g)(2)(B) of the Social Security Act (the Act) outpatient professional services performed in a Method II CAH are paid 115 percent of such amounts as would otherwise be paid under the Act if the services were not included in the outpatient CAH services.

Section 1848(i)(2)(B) of the Act stipulates that in the case of a surgical service furnished by a physician, if payment is made separately under the Act for the services of a physician serving as an assistant at surgery, payment shall not exceed 16 percent of the MPFS amount.

Payment for assistant at surgery services performed by a physician is calculated as follows:

((facility specific MPFS amount times assistant at surgery reduction % (16%)) minus (deductible and coinsurance)) times 115%

Section 1833(a)(1)(O)(ii) of the Act states that in the case of a PA, NP or CNS the amounts paid for serving as an assistant at surgery shall be the lesser of the actual charge or 85 percent of the amount that would otherwise be recognized if performed by a physician who is serving as an assistant at surgery. The payment methodology for these services has been codified in regulations found at 42 CFR 414.52(d) and 414.56(c).

Payment for assistant at surgery services performed by a PA, NP, or CNS is calculated as follows:

((facility specific MPFS) amount times assistant at surgery reduction (16%) times non-physician practitioner reduction % (85%)) minus (deductible and coinsurance)) times 115%

250.9.3 – Assistant at Surgery Medicare Summary Notice (MSN) and Remittance Advice (RA) Messages

(Rev. 1620; Issued: 10-24-08; Effective: 01-01-08; Implementation: 04-06-09)

Contractors shall use the following MSN and RA messages when denying medically unnecessary assistant at surgery services for HCPCS/CPT codes with a payment policy indicator of '0' or '2' when an Advance Beneficiary Notice (ABN) was issued.

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.

Spanish version:

36.1 Nuestros archivos indican que usted fue informado por escrito, antes de recibir el servicio, que Medicare no pagaría. Usted es responsable por esta cantidad. Si usted no está de acuerdo, usted puede pedir una revisión.

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.

*The following MSN and RA messages are used when denying medically unnecessary assistant at surgery services for HCPCS/CPT codes with a payment policy indicator of '0' or '2' 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 3 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.

Spanish version:

36.2 Aparentemente, usted no sabia que nosotros no pagamos por este servicio, por lo tanto usted no es responsable. Si usted le pagó al proveedor por este servicio debe enviarnos lo siguiente: (1) Copia de esta notificación; (2) Factura del proveedor; (3) El recibo o prueba de que usted le pagó. Debe enviar su petición por escrito dentro de 6 meses de la fecha de esta notificación. Servicios de este tipo prestados en el futuro serán su responsabilidad.

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.

RA Group Code
CO – Contractual Obligation

RA Claim Adjustment Reason Code
54 – Multiple physicians/assistants are not covered in this case.

Contractors shall use the following MSN and RA messages when denying assistant at surgery services for HCPCS/CPT codes with a payment policy indicator of '1'.

MSN Message

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

Spanish version:

15.11 - Medicare no paga por el asistente del cirujano por este procedimiento/cirugía.

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.

250.9.4 – Assistant at Surgery Services in a Method II CAH Teaching Hospital

(Rev. 1620; Issued: 10-24-08; Effective: 01-01-08; Implementation: 04-06-09)

Section 1842(b)(7)(D) stipulates that no payment shall be made for the services of assistant at surgery with respect to a surgical procedure if a hospital has a training program relating to the medical specialty required for the surgical procedure and a qualified individual on the staff of the hospital is available to provide such services.

Fiscal intermediaries (FIs) and A/B MACs process assistant at surgery claims for services furnished in a teaching hospital through the use of modifier 82 which indicates that a qualified resident was not available. Modifier 82 is for use only when the basis for payment is the unavailability of qualified residents.

Payment may be made for the services of assistants at surgery in teaching hospitals not withstanding the availability of a qualified resident to furnish the services. There may be exceptional medical circumstances (emergency, life threatening situations such as multiple traumatic injuries) which require immediate treatment. There may be situations in which the medical staff may find that exceptional medical circumstances justify the services of a physician assistant at surgery even though a qualified resident is available.

Payment may also be made for the services of assistants at surgery in teaching hospitals, if 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.

Claims submitted by a Method II CAH teaching hospital on type of bill 85X with RC 96X, 97X or 98X and modifier AS, 80 or 81 are suspended for review by the FIs or A/B MAC when the HCPCS/CPT code has a payment policy indicator of '0' or '2'.

NOTE: *Teaching hospitals are identified by an intern to bed ratio greater than 0 (zero), this field is located on the Provider Specific File.*

250.9.5 – Review of Supporting Documentation for Assistant at Surgery Services in a Method II CAH

(Rev. 1620; Issued: 10-24-08; Effective: 01-01-08; Implementation: 04-06-09)

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. The FIs and A/B MACs shall also determine if a clinician or non-clinician medical reviewer shall review assistant at surgery services.