CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 2333	**Date: October 28, 2011**
	Change Request 7587

SUBJECT: Payment for Multiple Surgeries in a Method II Critical Access Hospital (CAH)

I. SUMMARY OF CHANGES: This instruction implements the multiple procedure payment reduction policy for CAH method II providers.

EFFECTIVE DATE: April 1, 2012
IMPLEMENTATION DATE: April 2, 2012

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
N	4/Table of Contents
N	4/250.15/Coding and Payment of Multiple Surgeries Performed in a Method II CAH

III. FUNDING:
For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs):
No additional funding will be provided by CMS; Contractor activities are to be carried out within their operating budgets.

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: 2333	Date: October 28, 2011	Change Request: 7587

SUBJECT: Payment for Multiple Surgeries in a Method II Critical Access Hospital (CAH)

Effective Date: **April 1, 2012**
Implementation Date: April 2, 2012

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 code (RC) 96X, 97X, or 98X) based on the Medicare Physician Fee Schedule (MPFS) supplemental file.

Multiple surgeries are separate procedures performed by a single physician or physicians in the same group practice on the same patient at the same operative session or on the same day for which separate payment may be allowed. Co-surgeons, surgical teams, or assistants-at-surgery may participate in performing multiple surgeries on the same patient on the same day.

Medicare pays for multiple surgeries by ranking from the highest MPFS amount to the lowest MPFS amount. When the same physician performs more than one surgical service at the same session, the allowed amount is 100% for the surgical code with the highest MPFS amount. The allowed amount for the subsequent surgical codes is based on 50% of the MPFS amount. In addition, special endoscopic pricing rules are applied prior to the multiple surgery rules, if applicable. CAH Method II providers may review the multiple surgery and special endoscopic pricing rules in Pub. 100-04, Chapter 12, Section 40.6. In addition, section 40.6.D addresses rare situations where the above payment rules may be bypassed using modifier 22. Providers shall be aware that CAH claims billed with Modifier 22 may be subject to medical review.

This instruction implements the above payment logic in the Fiscal Intermediary Shared System (FISS) for CAH Method II providers to mirror the logic historically applied to physicians and non-physician practitioners that bill their own services to the Multi-Carrier System (MCS).

B. Policy: 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.

Medicare uses the payment policy indicators on the MPFS to determine if a multiple procedure is authorized for a specific HCPCS/CPT code. The MPFS is located at http://www.cms.hhs.gov/apps/ama/license.asp?file=/pfslookup/02_PFSsearch.asp . The fiscal intermediaries (FIs) and A/B Medicare Administrative Contractors (MACs) have access to the payment policy indicators via the Physician Fee Schedule Payment Policy Indicator File in the fiscal intermediary shared system.

NOTE: There are no policy changes attached to the change in this manual section. It was updated for clarification purposes only.

II. BUSINESS REQUIREMENTS 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	
7587.1	Contractors shall identify TOB 85x with revenue codes 96x, 97x and/or 98x that contain more than one line item with CPT/HCPCS codes assigned a payment policy indicator equal to 2 and/or 3 on the PFS Payment Policy Indicator File.						X				
7587.1.1	Contractors shall continue to reimburse based on lesser of the fee amount or the provider submitted charges.						X				
7587.1.2	Contractors shall pay the service line that yields the highest reimbursement at 100%.						X				
7587.1.3	Contractors shall pay the additional service lines at 50%.						X				
7587.1.3.1	Contractors shall use the T/R indicator field on claim page 30 to identify service lines that have received the multiple surgery reduction.						X				
7587.2	Contractors shall apply the special endoscopy pricing methodology based off direction provided in the attached document.						X				
7587.3	Contractors shall apply the deductible and coinsurance based on the reduced amount.						X				
7587.4	Contractors shall continue to apply the 115% add on after the deductible and coinsurance.						X				
7587.5	Contractors shall use the following claim adjustment reason code on the remittance advice notice for service lines for which they have applied the multiple surgery and/or special endoscopic payment methodologies. **59** - Processed based on multiple or concurrent procedure rules. (For example multiple surgery or diagnostic imaging, concurrent anesthesia.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	X		X			X				
7587.6	Contractors shall use the group code "CO" contractual obligation, on the remittance advice notices when the multiple surgery and/or special endoscopic payment methodologies are applied.	X		X			X				
7587.7	Contractors shall use the following message on the Medicare Summary Notice for claims for which MPFS methodology was applied.	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	
	30.1 The approved amount is based on a special payment method. OR 30.1 La cantidad aprobada está basada en un método especial de pago.										
7587.8	Contractors shall exclude claim lines containing Modifier 22 from the multiple surgery payment methodology.						X				
7587.9	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							

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	
7587.10	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							

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	

IV. SUPPORTING INFORMATION

Section A: For any recommendations and supporting information associated with listed requirements, use the box below: N/A

Use "Should" to denote a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

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

V. CONTACTS

Pre-Implementation Contact(s):
Cindy Pitts at Cindy.Pitts@cms.hhs.gov or Jason Kerr at Jason.Kerr@cms.hhs.gov

Post-Implementation Contact(s):
Contact your Contracting Officer's Technical Representative (COTR) or Contractor Manager, as applicable.

VI. FUNDING

Section A: For *Fiscal Intermediaries (FIs), 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.

Attachment (1)

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

Table of Contents
(Rev. 2333, 10-28-11)

250.15 – Coding and Payment of Multiple Surgeries Performed in a Method II CAH

(Rev. 2333, Issued: 10-28-11, Effective: 04-01-12, Implementation: 04-02-12)

Multiple surgeries rendered by a physician that has reassigned their billing rights to a Method II CAH are payable by Medicare when the procedures are eligible and billed on type of bill 85x with revenue code (RC) 096x, 097x and/or 098x.

Multiple surgeries are separate procedures performed by a single physician or physicians in the same group practice on the same patient at the same operative session or on the same day for which separate payment may be allowed. Co-surgeons, surgical teams, or assistants-at-surgery may participate in performing multiple surgeries on the same patient on the same day.

Medicare pays for multiple surgeries by ranking from the highest MPFS amount to the lowest MPFS amount. When the same physician performs more than one surgical service at the same session, the allowed amount is 100% for the surgical code with the highest MPFS amount. The allowed amount for the subsequent surgical codes is based on 50% of the MPFS amount. In addition, special endoscopic pricing rules are applied prior to the multiple surgery rules, if applicable. CAH Method II providers may review the multiple surgery and special endoscopic pricing rules in Pub. 100-04, Chapter 12, Section 40.6. In addition, section 40.6.D addresses rare situations where the above payment rules may be bypassed using modifier 22. Providers shall be aware that CAH claims billed with Modifier 22 may be subject to medical review.

If multiple endoscopies are billed, special rules for multiple endoscopic procedures apply.

Medicare contractors shall perform the following actions when multiple CPT/HCPCS codes with a payment policy indicator of '3' (Special Rules for Multiple Endoscopies), with the same date of service, are present:

1. Identify if the billed codes share the same Endoscopic Base Code (using the Physician Fee Schedule Payment Policy Indicator File).

2. If the same base is shared, pay the full value of the highest valued endoscopy, plus the difference between the next highest and the base endoscopy.

EXAMPLE: In the course of performing a fiber optic colonoscopy (CPT code 45378), a physician performs a biopsy on a lesion (code 45380) and removes a polyp (code 45385) from a different part of the colon. The physician bills for codes 45380 and 45385. The value of codes 45380 and 45385 have the value of the diagnostic colonoscopy (45378) built in. Rather than paying 100 percent for the highest valued procedure (45385) and 50 percent for the next (45380), pay the full value of the higher valued endoscopy (45385), plus the difference between the next highest endoscopy (45380) and the base endoscopy (45378).

Assume the following fee schedule amounts for these codes:
45378 - $255.40
45380 - $285.98
45385 - $374.56

Pay the full value of 45385 ($374.56), plus the difference between 45380 and 45378 ($30.58), for a total of $405.14.

NOTE: If an endoscopic procedure with an indicator of '3' is billed with other procedures that are **not** endoscopies (procedures with an indicator of '2'), the standard multiple surgery rules apply. See BRs 7587.1-7587.5 for required actions.

3. Apply the following rules where multiple endoscopies are performed on the same day as unrelated endoscopies or other surgical procedures (indicator of '2'):

• Two unrelated endoscopies (e.g., 46606 and 43217): Apply the usual multiple surgery rules;

• Two sets of unrelated endoscopies (e.g., 43202 and 43217; 46606 and 46608): Apply the special endoscopy rules to each series and then apply the multiple surgery rules. Consider the total payment for each set of endoscopies as one service;

• Two related endoscopies and a third, unrelated procedure: Apply the special endoscopic rules to the related endoscopies, and, then apply the multiple surgery rules. Consider the total payment for the related endoscopies as one service and the unrelated endoscopy as another service.

• Two unrelated endoscopies and a third, unrelated procedure: Apply the multiple surgery rules.