



## Payment of Assistant at Surgery Services in a Method II Critical Access Hospital (CAH) – JA6123

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**Key Words** MM6123, CR6123, R1620CP, Payment, Assistant, Surgery, CAH

**Contractors Affected**

- Fiscal Intermediaries
- Part A/B Medicare Administrative Contractors

**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 FIs or A/B MACs for such assistant at surgery services



- Change Request (CR) 6123 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.
- CR6123 also updates the *Medicare Claims Processing Manual*, Chapter 4 (Part B Hospital (Including Inpatient Hospital Part B and OPSS)) by adding new sections. These new sections are added as attachments to CR6123.

### New Sections

- Provider Needs to Know...**
- CR6123 adds the following sections to the adding the following new sections to the *Medicare Claims Processing Manual*, Chapter 4 (Part B Hospital (Including Inpatient Hospital Part B and OPSS)):
    - 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 surgical procedure.
- When a Method II CAH bills for a surgical procedure on type of bill (TOB) 85X with revenue code (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 physician or non-physician practitioner has reassigned their billing rights to the CAH).
- Section 1862 of the Social Security Act (the Act) stipulates that payment can only be made for care that is reasonable and necessary. 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 the above 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 Healthcare Common Procedure Coding System (HCPCS) / Current Procedural Terminology (CPT) code.

### **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 Code of Federal Regulations 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, providers should use modifier 80 (assistant surgeon), 81 (minimum assistant surgeon), or 82 (when qualified resident surgeon not available).
- Providers should also use modifier AS to indicate that a PA, NP or CNS served as the assistant at surgery. When modifier AS is used, modifier 80, 81, or 82 must also be used, because using these modifiers without modifier AS indicates that a physician served as the surgical assistant. Claims that are submitted with modifier AS and without modifier 80, 81 or 82 will be returned.

### **Payment Amount Calculation**

- Section 1834(g)(2)(B) of 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 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*

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

- 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*
- ((MPFS X .16 X .85) – (deductible and coinsurance)) X 1.15.*
- 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 claims for assistant at surgery services that are 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" (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 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 providers issue an appropriate ABN, they 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 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

- 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 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 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.
- Providers should 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 are submitted 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.

**Background**

Physicians and non-physician practitioners billing on 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 (RC 96X, 97X or 98X).

**Operational Impact**

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 are brought to their attention.

**Reference Materials**

The related MLN Matters article can be found at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6123.pdf> on the CMS website.

The MPFSDB is located at [http://www.cms.hhs.gov/apps/ama/license.asp?file=/pfslookup/02\\_PFSsearch.asp](http://www.cms.hhs.gov/apps/ama/license.asp?file=/pfslookup/02_PFSsearch.asp) on the CMS website.

The official instruction (CR6123) issued regarding this change may be found at <http://www.cms.hhs.gov/Transmittals/downloads/R1620CP.pdf> on the CMS website.

The assistant at surgery payment policy indicators for HCPCS/CPT can be found on the MPFSDB at [http://www.cms.hhs.gov/apps/ama/license.asp?file=/pfslookup/02\\_PFSsearch.asp](http://www.cms.hhs.gov/apps/ama/license.asp?file=/pfslookup/02_PFSsearch.asp) on the CMS website.

Providers may 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 and located at <http://www.cms.hhs.gov/Transmittals/downloads/R1574CP.pdf>, for more information about the file layout used in processing CAH professional services' claims.

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