| CMS Manual System | **Department of Health & Human Services (DHHS)** |
|---|---|
| Pub 100-04 Medicare Claims Processing | **Centers for Medicare & Medicaid Services (CMS)** |
| **Transmittal 1781** | **Date: July 29, 2009** |
| | **Change Request 6319** |

**NOTE: We are resending Transmittal 1781, dated July 29, 2009, because the Remark Code M78 was supposed to be replaced with Remark code N180 in the manual instruction also. The Transmittal Number, Date Issued and all other information in this instruction remain the same.**

**SUBJECT: Payment for Co-surgeons 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 a co-surgeon when the procedure is authorized for a co-surgeon and the person performing the surgery is a physician. This Change Request implements the reduction in payment for co-surgeon services.

**New / Revised Material**
**Effective Date: January 1, 2008**
**Implementation Date: July 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 |
| N | 4/250/250.10/Coding Co-surgeon Services Rendered in a Method II CAH |
| N | 4/250/250.10.1/Use of Payment Policy Indicators for Determining Procedures Eligible for Payment of Co-surgeons |
| N | 4/250/250.10.2/Payment of Co-surgeon Services Rendered in a Method II CAH |
| N | 4/250/250.10.3/Co-surgeon Medicare Summary Notice (MSN) and Remittance Advice (RA) Messages |
| N | 4/250/250.10.4/Review of Supporting Documentation for Co-surgeon 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: 1781 | Date: July 29, 2009 | Change Request: 6319 |
|---|---|---|---|

**NOTE: We are resending Transmittal 1781, dated July 29, 2009, because the Remark Code M78 was supposed to be replaced with Remark code N180 in the manual instruction also. The Transmittal Number, Date Issued and all other information in this instruction remain the same.**

**SUBJECT:** Payment for Co-Surgeons in a Method II Critical Access Hospital (CAH)

**Effective Date**: January 1, 2008

**Implementation Date:** July 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 co-surgeons when the procedure is authorized for co-surgeons and the person performing the service is a surgeon. This Change Request implements the reduction in payment for co-surgeon services.

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**.

**B. Policy:** Section 1834(g)(2)(B) of 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.

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 the 62 modifier (two surgeons) for co-surgeon services.

Each co-surgeon reports the same surgical procedure code with the 62 modifier. The potential exists that there may be only one line billed on a Method II CAH claim with the 62 modifier. This occurs when one of the co-surgeons reassigns their billing rights to the CAH and the other co-surgeon does not reassign their billing rights to the CAH. The claim for the co-surgeon that reassigned their billing rights to the CAH would be processed by the fiscal intermediary (FI)/A/B Medicare Administrative Contractor (MAC). The claim for the co-surgeon that did not reassign their billing rights to the CAH would be processed by the carrier/A/B MAC. The fiscal intermediary standard system (FISS) shall accept claims with one line with a surgical procedure code and the 62 modifier or two lines with the same surgical procedure code, line item date of service (LIDOS) and the 62

modifier. The FISS shall deny lines without the 62 modifier that have the same surgical procedure code and LIDOS when only one line is billed with the 62 modifier.

Payment for each co-surgeon is based on the lesser of the actual charges or 62.5% of the Medicare Physician Fee Schedule (MPFS) amount. For both surgeons to receive appropriate reimbursement, they must not be assisting each other, but performing distinct and separate parts of the same surgical procedure.

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 HCPCS/CPT code. The MPFSDB is located at http://www.cms.hhs.gov/apps/ama/license.asp?file=/pfslookup/02_PFSsearch.asp . The FIs and A/B MACs have access to the payment policy indicators via the Physician Fee Schedule Payment Policy Indicator File in the FISS.

Section 1862(a)(1)(A) of the Social Security Act (the Act) states that no payment shall be made for items or services which are not reasonable and necessary for the diagnosis or treatment of illness or injury.

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.

## 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 | |
| 6319.1 | Contractors shall accept co-surgeon services submitted on TOB 85X with RC 96X, 97X or 98X when one of the following conditions is present on the claim:<br>- only one claim line with a surgical HCPCS/CPT code has a modifier 62, or<br>- Two claim lines with the same surgical HCPCS/CPT code, LIDOS and modifier 62. | | | | | | X | | | | |
| 6319.2 | Contractors shall deny line items without the 62 modifier on TOB 85X with the same surgical HCPCS/CPT code and LIDOS on more than one claim line when only one claim line has the 62 modifier. | | | | | | X | | | | |
| 6319.2.1 | Contractors shall use the following Medicare Summary Notice (MSN) message when denying line items without the 62 modifier on claims with the same surgical HCPCS/CPT code and LIDOS on more than one line when only one line has the 62 modifier.<br><br>16.10 – Medicare does not pay for this item or service.<br><br>Spanish version:<br>Medicare no paga por este artículo o servicio. | 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 | |
| 6319.2.1.1 | Contractors shall use the following Remittance Advice (RA) Remark Code when denying line items without the 62 modifier on claims with the same surgical HCPCS/CPT code and LIDOS on more than one line when only one line has the 62 modifier.<br><br>N180 - This item or service does not meet the criteria for the category under which it was billed.. | X | | X | | | X | | | | |
| 6319.2.1.2 | Contractors shall use the following Group Code when denying line items without the 62 modifier on claims with the same surgical HCPCS/CPT code and LIDOS on more than one line when only one line has the 62 modifier.<br><br>CO – Contractual Obligation | X | | X | | | X | | | | |
| 6319.2.1.3 | Contractors shall use the following Claim Adjustment Reason Code when denying line items without the 62 modifier on claims with the same surgical HCPCS/CPT code and LIDOS on more than one line when only one line has the 62 modifier.<br><br>4 – The procedure code is inconsistent with the modifier used or a required modifier is missing. | X | | X | | | X | | | | |
| 6319.3 | Contractors shall deny co-surgeon services on TOB 85X with RC 96X, 97X or 98X and modifier 62 when the HCPCS/CPT code has a payment policy indicator of '0'.<br><br>Payment Policy Indicator 0 – Co-surgeons not permitted for this procedure. | | | | | | X | | | | |
| 6319.3.1 | Contractors shall use the following MSN message when denying co-surgeon services with a payment policy indicator of '0'.<br><br>15.12 – Medicare does not pay for two surgeons for this procedure.<br><br>Spanish version:<br>Medicare no paga por dos cirujanos para este procedimiento. | X | | X | | | X | | | | |
| 6319.3.2 | Contractors shall use the following RA Remark Code when denying co-surgeon services with a payment policy indicator of '0':<br><br>N431 – Service is not covered with this procedure. | 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 | |
| 6319.3.3 | Contractors shall use the following Group Code when denying co-surgeon services with a payment policy indicator of '0':<br><br>PR – Patient Responsibility | X | | X | | | X | | | | |
| 6319.3.4 | Contractors shall use the following Claim Adjustment Reason Code when denying co-surgeon services with a payment policy indicator of '0':<br><br>54 – Multiple physicians/assistants are not covered in this case. | X | | X | | | X | | | | |
| 6319.4 | Contractors shall suspend and assign a unique reason code in the 3XXXX series to co-surgeon services on TOB 85X with RC 96X, 97X or 98X and modifier 62 when the HCPCS/CPT code has a payment policy indicator of '1'.<br><br>Payment Policy Indicator 1 – Co-surgeons could be paid; supporting documentation is required to establish medical necessity of two surgeons for the procedure. | | | | | | X | | | | |
| 6319.4.1 | Contractors shall 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'. | X | | X | | | | | | | |
| 6319.4.1.1 | Contractors shall 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'.<br><br>**Note**: The reason code assigned in 6319.4 will be present on the claim. | X | | X | | | | | | | |
| 6319.4.2 | Contractors shall advise Method II CAHs 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'. | X | | X | | | | | | | |
| 6319.4.3 | Contractors shall deny co-surgeon services when the supporting documentation does not establish medical necessity when the payment policy indicator is '1'. | X | | X | | | | | | | |
| 6319.4.3.1 | Contractors shall use the following MSN message when denying medically unnecessary co-surgeon services with a payment policy indicator of '1' when an ABN was 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 | |
| | 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.<br><br>Spanish version:<br>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. | | | | | | | | | | |
| 6319.4.3.2 | Contractors shall use the following RA Remark Code when denying medically unnecessary co-surgeon services with a payment policy indicator of '1' when an ABN was issued:<br><br>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 | | | | | | | |
| 6319.4.3.3 | Contractors shall use the following Group Code when denying medically unnecessary co-surgeon services with a payment policy indicator of '1' when an ABN was issued :<br><br>PR – Patient Responsibility | X | | X | | | | | | | |
| 6319.4.3.4 | Contractors shall use the following Claim Adjustment Reason Code when denying medically unnecessary co-surgeon services with a payment policy indicator of '1' when an ABN was issued:<br><br>54 – Multiple physicians/assistants are not covered in this case. | X | | X | | | | | | | |
| 6319.4.4 | Contractors shall use the following MSN message when denying medically unnecessary co-surgeon services with a payment policy indicator of '1' when an ABN was not issued:<br><br>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) | 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 | |
| | 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.<br><br>Spanish version:<br><br>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. | | | | | | | | | | |
| 6319.4.4.1 | Contractors shall use the following RA Remark Code when denying medically unnecessary co-surgeon services with a payment policy indicator of '1' when an ABN was not issued:<br><br>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 | | | | | | | |
| 6319.4.4.2 | Contractors shall use the following Group Code when denying medically unnecessary co-surgeon services with a payment policy indicator of '1' when an ABN was not issued:<br><br>CO – Contractual Obligation | X | | X | | | | | | | |
| 6319.4.4.3 | Contractors shall use the following Claim | 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 | |
| | Adjustment Reason Code when denying medically unnecessary co-surgeon services with a payment policy indicator of '1' when an ABN was not issued:<br><br>54 – Multiple physicians/assistants are not covered in this case. | | | | | | | | | | |
| 6319.4.5 | Contractors shall pay for medically necessary co-surgeon services on TOB 85X with RC 96X, 97X or 98X and modifier 62 when the HCPCS/CPT code has a payment policy indicator of '1' based on the lesser of the actual charges or the reduced fee schedule amount as follows:<br><br>(facility specific Medicare physician fee schedule (MPFS) amount times co-surgery reduction % (62.5%) minus (deductible and coinsurance)) times 115% | | | | | | X | | | | |
| 6319.5 | Contractors shall suspend and assign a unique reason code in the 3XXXX series to co-surgeon services on TOB 85X with RC 96X, 97X or 98X and modifier 62 when the HCPCS/CPT code has a payment policy indicator of '2'.<br><br>Payment Policy Indicator 2 – Co-surgeons permitted; no documentation required if two specialty requirements are met. | | | | | | X | | | | |
| 6319.5.1 | Contractors shall develop co-surgeon services on TOB 85X with RC 96X, 97X or 98X and modifier 62 for the supporting documentation needed to establish that the two specialty requirement is met when the HCPCS/CPT code has a payment policy indicator of '2'.<br><br>**Note:** The reason code in 6319.5 will be present on the claim. | X | | X | | | | | | | |
| 6319.5.2 | Contractors shall deny co-surgeon services when the two co-surgeons each have the same specialty. | X | | X | | | | | | | |
| 6319.5.2.1 | Contractors shall use the following MSN message when denying co-surgeon services with a payment policy indicator of '2' when the two co-surgeons each have the same specialty:<br><br>21.21 – This service was denied because Medicare only covers this service under certain circumstances. | 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:<br>Este servicio fue denegado porque Medicare solamente lo cubre bajo ciertas circunstancias. | | | | | | | | | | |
| 6319.5.2.2 | Contractors shall use the following RA Remark Code when denying co-surgeon services with a payment policy indicator of '2' when the two co-surgeons each have the same specialty:<br>N95 – The provider type/provider specialty may not bill this service. | X | | X | | | | | | | |
| 6319.5.2.3 | Contractors shall use the following Group Code when denying co-surgeon services with a payment policy indicator of '2' when the two co-surgeons each have the same specialty:<br><br>PR – Patient Responsibility | X | | X | | | | | | | |
| 6319.5.2.4 | Contractors shall use the following Claim Adjustment Reason Code when denying co-surgeon services with a payment policy indicator of '2' when the two co-surgeons each have the same specialty:<br><br>54 – Multiple physicians/assistants are not covered in this case. | X | | X | | | | | | | |
| 6319.5.3 | Contractors shall pay for co-surgeon services on TOB 85X with RC 96X, 97X or 98X and modifier 62 when the HCPCS/CPT code has a payment policy indicator of '2' and the two specialty requirement is met based on the lesser of the actual charges or the reduced fee schedule amount using the payment methodology outlined in BR 6319.4.5. | | | | | | X | | | | |
| 6319.6 | Contractors shall 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'.<br><br>Payment Policy Indicator 9 - concept does not apply | X | | X | | | X | | | | |
| 6319.7 | Contractors shall determine if a clinician or a non-clinician medical reviewer shall review the supporting documentation submitted for co-surgeon services. | X | | X | | | | | | | |
| 6319.8 | 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 | |
| 6319.9 | 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.<br>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: |
|---|---|
| | |

**Section B: For all other recommendations and supporting information, use this space:**
For requirements 6013.3 and 6013.3.1 in CR 6013 – Physician Fee Schedule Payment Policy Indicator File Record Layout for Use in Processing Method II Critical Access Hospital (CAH) Claims for Professional Services

## 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) 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.

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

---

**Table of Contents**

***(Rev. 1781, 07-29-09)***

## *250.10 – Coding Co-surgeon Services Rendered in a Method II CAH*

***(Rev. 1781, Issued: 07-29-09; Effective: 01-01-08; Implementation: 07-06-09)***

*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****.*

*When two surgeons work together as primary surgeons performing distinct part(s) of a single reportable procedure, each surgeon shall report his/her distinct operative work by reporting the same surgical procedure code and the 62 modifier (two surgeons).*

*The potential exists that there may only be one line billed on a Method II CAH claim with modifier 62. This occurs when one of the co-surgeons reassigns their billing rights to the CAH and the other co-surgeon does not reassign their billing rights to the CAH. The claim for the co-surgeon that reassigned their billing rights would be processed by the fiscal intermediary (FI)/A/B Medicare Administrative Contractor (MAC). The claim for the co-surgeon that did not reassign their billing rights to the CAH would be processed by the carrier/A/B MAC. The fiscal intermediary standard system (FISS) will accept and process claims with one line with a surgical procedure code and modifier 62 or two lines with the same surgical procedure code, line item date of service (LIDOS) and modifier 62. The FISS shall deny line items without the 62 modifier on claims with the same surgical procedure code and LIDOS when only one line has the 62 modifier.*

*Co-surgeon services rendered by a physician that has reassigned their billing rights to a Method II CAH are payable by Medicare when the procedure is authorized for co-surgeons and is billed on type of bill 85X with revenue code (RC) 96X, 97X or 98X and the 62 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 co-surgeon services.*

## *250.10.1 – Use of Payment Policy Indicators for Determining Procedures Eligible for Payment of Co-surgeons*

***(Rev. 1781, Issued: 07-29-09; Effective: 01-01-08; Implementation: 07-06-09)***

*Section 1862 of the Social Security Act (the Act) stipulates that no payment can be made for care that is not reasonable and necessary for the diagnosis and treatment of illness or injury.*

*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 HCPCS/CPT code. The MPFSDB is located at* http://www.cms.hhs.gov/apps/ama/license.asp?file=/pfslookup/02_PFSsearch.asp . *The FIs and A/B MACs have access to the payment policy indicators via the Physician Fee Schedule Payment Policy Indicator File in the FISS.*

*See the Physician Fee Schedule Payment Policy Record Layout in §250.2 for a description of the co-surgeon payment policy indicators.*

## *250.10.2 – Payment of Co-surgeon Services Rendered in a Method II CAH*

***(Rev. 1781, Issued: 07-29-09; Effective: 01-01-08; Implementation: 07-06-09)***

*Under Section 1834(g)(2)(B) of 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.*

*Payment for co-surgeon services performed by a physician is based on the lesser of the actual charges or the reduced fee schedule amount (62.5%) and is calculated as follows: ((facility specific MPFS amount times co-surgery reduction % (62.5%)) minus (deductible and coinsurance)) times 115%*

## *250.10.3 – Co-surgeon Services Medicare Summary Notice (MSN) and Remittance Advice (RA) Messages*

***(Rev. 1781, Issued: 07-29-09; Effective: 01-01-08; Implementation: 07-06-09)***

*Contractors shall use the following MSN and RA messages when denying co-surgeon services for HCPCS/CPT codes with a payment policy indicator of '0'.*

***MSN Messages:***

*15.12 – Medicare does not pay for two surgeons for this procedure.*

*Spanish version:*

*15.12 - Medicare no paga por dos cirujanos para este procedimiento.*

***RA Remark Code***
*N431 – Service is not covered with this procedure.*

***RA Group Code***
*PR – Patient Responsibility*

***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 medically unnecessary co-surgeon services for HCPCS/CPT codes with a payment policy indicator of '1' 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 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.*

***RA Group Code***
*PR – Patient Responsibility*

***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 medically unnecessary co-surgeon services for HCPCS/CPT codes with a payment policy indicator of '1' when an Advance Beneficiary Notice (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 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 co-surgeon services for HCPCS/CPT codes with a payment policy indicator of '2' when the co-surgeons each have the same specialty.*

***MSN Message***

*21.21 – This service was denied because Medicare only covers this service under certain circumstances.*

*Spanish version:*
*21.21 - Este servicio fue denegado porque Medicare solamente lo cubre bajo ciertas circunstancias.*

***RA Remark Code***
*N95 – The provider type/provider specialty may not bill this service.*

***RA Group Code***
*PR – Patient Responsibility*

***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 line items for co-surgeon services without the 62 modifier on claims with the same surgical procedure code and line item date of service on more than one line when only one line has the 62 modifier.*

***MSN Message***

*16.10 – Medicare does not pay for this item or service.*

*Spanish version:*

*Medicare no paga por este artículo o servicio.*

***RA Remark Code***
*N180 – This item or service does not meet the criteria for the category under which it was billed.*

***RA Group Code***
*CO – Contractual Obligation*

***RA Claim Adjustment Reason Code***
*4 – The procedure code is inconsistent with the modifier used or a required modifier is missing.*

## *250.10.4 – Review of Supporting Documentation for Co-surgeon Services in a Method II CAH*

***(Rev. 1781, Issued: 07-29-09; Effective: 01-01-08; Implementation: 07-06-09)***

*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 FIs and A/B MACs shall also determine if a clinician or non-clinician medical reviewer shall review co-surgeon services.*