| CMS Manual System | Department of Health & Human Services (DHHS) |
|---|---|
| Pub 100-04 Medicare Claims Processing | Centers for Medicare & Medicaid Services (CMS) |
| **Transmittal 1777** | **Date: JULY 24, 2009** |
| | **Change Request 6526** |

We are resending Transmittal 1777, sent on July 24, 2009, because the effective date just on the manual instruction was wrong. The correct date should be January 1, 2008. All other information in this instruction remains the same.

**SUBJECT: Payment of Bilateral Procedures in a Method II Critical Access Hospital (CAH)**

**I. SUMMARY OF CHANGES:** 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). Bilateral procedures are procedures performed on both sides of the body during the same operative session. Medicare makes payment for bilateral procedures based on the lesser of the actual charges or 150 percent of the Medicare Physician Fee Schedule (MPFS) amount when the procedure is authorized as a bilateral procedure. This Change Request implements the 150 percent payment adjustment for bilateral procedures.

**New / Revised Material**
**Effective Date: January 1, 2008**
**Implementation Date: January 4, 2010**

*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 | 4/90/Discontinuation of Value Code 05 Reporting |
| R | 4/250/250.2/Optional Method for Outpatient Services: Cost-Based Facility Services Plus 115 Percent Fee Schedule Payment for Professional Services |
| N | 4/250/250.11/Coding Bilateral Procedures Performed in a Method II CAH |
| N | 4/250/250.11.1/Use of Payment Policy Indicators for Determining Bilateral Procedures Eligible for 150 Percent Payment Adjustment |

| | |
|---|---|
| N | 4/250/250.11.2/Payment of Bilateral Procedures Rendered 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: 1777 | Date: July 24, 2009 | Change Request: 6526 |
|---|---|---|---|

We are resending Transmittal 1777, sent on July 24, 2009, because the effective date just on the manual instruction was wrong. The correct date should be January 1, 2008. All other information in this instruction remains the same.

**SUBJECT: Payment of Bilateral Procedures in a Method II Critical Access Hospital (CAH)**

**Effective Date**: January 1, 2008

**Implementation Date:** January 4, 2010

## 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).

Bilateral procedures are procedures performed on both sides of the body during the same operative session. Medicare makes payment for bilateral procedures based on the lesser of the actual charges or 150 percent of the Medicare Physician Fee Schedule (MPFS) amount when the procedure is authorized as a bilateral procedure. This Change Request implements the 150 percent payment adjustment for bilateral procedures.

**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.

As stated at 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 50 modifier (bilateral procedure).

Modifier 50 applies to bilateral procedures performed on both sides of the body during the same operative session. When a procedure is identified by the terminology as bilateral or unilateral, the 50 modifier is not reported.

If a procedure is authorized for the 150 percent payment adjustment for bilateral procedures (payment policy indicator 1), the procedure shall be reported on a single line item with the 50 modifier and one service unit. Whenever the 50 modifier is appended, the appropriate number of service units is one.

- Modifiers LT (left side) and RT (right side) shall not be reported when the 50 modifier applies. Claims with the LT and RT modifiers shall be returned to the provider (RTPd) when modifier 50 applies. See Pub. 100-04, Medicare Claims Processing Manual, Chapter 4, §20.6 for more information on the use of the 50, LT and RT modifiers.

If a procedure can be billed as bilateral, but is not authorized for the 150 percent payment adjustment for bilateral procedures (payment policy indicator 3), the procedure shall be reported on a single line item with the

50 modifier and one service unit. Payment is made based on the lesser of the actual charges or 100 percent of the MPFS amount for each side of the body.

The January 2010 Integrated Outpatient Code Editor (IOCE) specifications will include a change to edit 74 (units greater than one for bilateral procedures billed with modifier 50). Claims submitted on TOB 85X with RC 96X, 97X or 98X , a HCPCS/CPT code with a bilateral indicator of '1' or '3', modifier 50 and more than one service unit on the same line shall be RTPd with edit 74.

Medicare uses the bilateral surgery payment policy indicators on the MPFSDB to determine if the 150 percent payment adjustment is payable 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 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 standard system.

**Please note** that a revision to §90 in Pub. 100-04 is included in this Change Request. 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 | |
| 6526.1 | Contractors shall RTP bilateral procedures submitted on TOB 85X with RC 96X, 97X or 98X when the HCPCS/CPT code billed with the 50 modifier, has a payment policy indicator of '0', '2', or '9'.<br><br>Payment Policy Indicator 0 – 150 percent payment adjustment for bilateral procedures does **not** apply. The bilateral procedure is inappropriate for codes in this category because of physiology or anatomy or the code descriptor specifically states that it is a unilateral procedure and there is an existing code for the bilateral procedure.<br><br>Payment Policy Indicator 2 - 150 percent payment adjustment for bilateral procedures does **not** apply. The relative value units (RVUs) are based on a bilateral procedure because the code descriptor states that the procedure is bilateral, the codes descriptor states that the procedure may be performed either unilaterally or bilaterally, or the procedure is usually performed as a bilateral procedure.<br><br>Payment Policy Indicator 9 - concept does not apply | X | | X | | | X | | | | |
| 6526.2 | Contractors shall RTP bilateral procedures submitted on TOB 85X with RC 96X, 97X or 98X when the bilateral | 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 | |
| | procedure code is billed with the RT and LT modifiers and the payment policy indicator is '1' or '3'.<br><br>**NOTE:** This includes claims with a bilateral procedure and modifiers LT and RT on the same claim line or claims with the same bilateral procedure on two claim lines with the same line item date of service (LIDOS), one claim line with modifier RT and another claim line with modifier LT.<br><br>Payment Policy Indicator 1 – 150 percent payment adjustment for bilateral procedures applies. | | | | | | | | | | |
| 6526.3 | Contractors shall pay for bilateral procedures on TOB 85X with RC 96X, 97X or 98X, one service unit and modifier 50 when the HCPCS/CPT code has a payment policy indicator of '1' based on the lesser of the actual charges or the 150 percent payment adjustment for bilateral procedures as follows:<br><br>(facility specific MPFS amount times bilateral procedure adjustment (150%) minus (deductible and coinsurance)) times 115%<br><br>Payment Policy Indicator 1 - 150 percent payment adjustment for bilateral procedures applies. | | | | | | X | | | | |
| 6526.4 | Contractors shall pay for bilateral procedures on TOB 85X with RC 96X, 97X or 98X and modifier 50 and one service unit when the HCPCS/CPT code has a payment policy indicator of '3' based on the lesser of the actual charges or 200% of the MPFS amount as follows:<br><br>(facility specific MPFS amount times 200% (100% for each side) minus (deductible and coinsurance)) times 115%<br><br>Payment Policy Indicator 3 - 150% payment adjustment for bilateral procedures does **not** apply. Services in this category are generally radiology procedures or other diagnostic tests which are not subject to the special payment rules for other bilateral procedures.<br><br>**NOTE:** Although the 150% payment adjustment does not apply to payment policy indicator '3', modifier 50 may be billed with these procedures. When billed with the 50 modifier, payment is based on the lower of the | | | | | | 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 | |
| | actual charges or 200% of the fee schedule amount. | | | | | | | | | | |
| 6526.5 | Contractors shall calculate payment using all payment modifiers associated with the line item.<br><br>Example 1:<br>Modifiers 50, AS (physician assistant, nurse practitioner, or clinical nurse specialist services for assistant at surgery) and 80 (assistant surgeon) are submitted on the line. The line item HCPCS/CPT code is authorized for both bilateral surgery and assistant at surgery. Payment would be made based on the lesser of the actual charges or the following calculation:<br><br>(facility specific MPFS amount times bilateral procedure adjustment `(150%) times assistant at surgery reduction (16%) times non-physician practitioner adjustment (85%) minus (deductible and coinsurance)) times 115%<br><br>Example 2:<br>Modifiers 50 and 62 (two surgeons) are submitted on the line. The line item HCPCS/CPT code is authorized for both bilateral surgery and co-surgery. Payment would be made based on the lesser of the actual charges or the following calculation:<br><br>(facility specific MPFS amount times bilateral procedure adjustment (150%) times co-surgery reduction (62.5%) minus (deductible and coinsurance)) times 115% | | | | | | X | | | | |
| 6526.6 | Contractors shall be aware that claims with TOB 85X, RC 96X, 97X, 98X, a HCPCS/CPT code with a bilateral indicator of '1' or '3', modifier 50 and more than one service unit on the same line shall be RTPd with edit 74 upon implementation of the January 2010 IOCE. | X | | X | | | | | | | |
| 6526.7 | 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 | |
| 6526.8 | 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: 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:**

CR6013 – 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 or Yvonne Young at yvonne.young@cms.hhs.gov or 410-786-1886

**Post-Implementation Contact(s):** Appropriate Regional Office

## VI. FUNDING

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

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*(Rev. **1777, 07-24-09**)*

**Transmittals for Chapter 4**

Crosswalk to Old Manuals


*250.11 - Coding Bilateral Procedures Performed in a Method II CAH*

*250.11.1 - Use of Payment Policy Indicators for Determining Bilateral Procedures Eligible for 150 Percent Payment Adjustment*

*250.11.2 - Payment of Bilateral Procedures Rendered in a Method II CAH*

## 90 - Discontinuation of Value Code 05 Reporting

*(Rev. 1777; Issued: 07-24-09; Effective Date: 01-01-08; Implementation Date: 01-04-10)*

Value code 05, "Professional Component Included in Charges and Also Billed Separately to Carrier," was discontinued with the implementation of OPPS, *including* claims for *Critical Access Hospitals* and other hospitals not subject to OPPS.

## 250.2 - Optional Method for Outpatient Services: Cost-Based Facility Services Plus 115 percent Fee Schedule Payment for Professional Services

*(Rev. 1777; Issued: 07-24-09; Effective Date: 01-01-08; Implementation Date: 01-04-10)*

The BIPA legislation on payment for professional services at 115 percent of what would otherwise be paid under the fee schedule is effective for services furnished on or after July 1, 2001. A CAH may elect to be paid for outpatient services in any cost reporting period under this method by filing a written election with the intermediary on an annual basis at least 30 days before start of the Cost Reporting period to which the election applies. An election of this payment method, once made for a cost reporting period, remains in effect for all of that period for the CAH.

However, the Medicare Prescription Drugs, Improvement, and Modernization Act (MMA) of 2003, changes the requirement that each practitioner rendering a service at a CAH that has elected the optional method, reassign their billing rights to that CAH. This provision allows each practitioner to choose whether to reassign billing rights to the CAH or file claims for professional services through their carrier. The reassignment will remain in affect for that entire cost reporting period.

The individual practitioner must certify, using the Form CMS-855R, if he/she wishes to reassign their billing rights. The CAH must then forward a copy of the 855R to the intermediary and the appropriate carrier, must have the practitioner sign an attestation that clearly states that the practitioner will not bill the carrier for any services rendered at the CAH once the reassignment has been given to the CAH. This "attestation" will remain at the CAH.

For CAHs that elected the optional method before November 1, 2003, the provision is effective beginning on or after July 1, 2001. For CAHs electing the optional method on or after November 1, 2003, the provision is effective for cost reporting periods beginning on or after July 1, 2004. Under this election, a CAH will receive payment from their intermediary for professional services furnished in that CAH's outpatient department. Professional services are those furnished by all licensed professionals who otherwise would be entitled to bill the carrier under Part B.

Payment to the CAH for each outpatient visit (reassigned billing) will be the sum of the following:

- For facility services, not including physician or other practitioner services, payment will be based on 101 percent of the reasonable costs of the services. On the ANSI X12N 837 I, list the facility service(s) rendered to outpatients using the appropriate revenue code. The FI will pay the amount equal to the lesser of 80 percent of 101 percent of the reasonable costs of its outpatient services, or the 101 percent of the outpatient services less applicable Part B deductible and coinsurance amounts, plus:

- On a separate line, list the professional services, along with the appropriate HCPCS code (physician or other practitioner) in one of the following revenue codes - 096X, 097X, or 098X.

    - The FI uses the Medicare Physician Fee Schedule (MPFS) supplementary file, established for use by the CORF, and the CORF Abstract File, to pay for all the physician/professional services rendered in a CAH that elected the all-inclusive method. The data in the supplemental file are in the same format as the abstract file. The FI will pay 115 percent of whatever Medicare would pay of the physician fee schedule. (The fee schedule amount, after applicable deductions, will be multiplied by 1.15 percent.) Payment for non physician practitioners will be 115 percent of 85 percent of the allowable amount under the physician fee schedule; and

      For a non-participating physician service, a CAH must place modifier AK on the claim. The intermediary should pay 95 percent of the payment amount for non-participating physician services. Calculating 95 percent of 115 percent of an amount is equivalent to multiplying the amount by a factor of 1.0925. To calculate the Medicare limiting charge for a physician service for a locality, multiply the fee schedule amount by a factor of 1.0925.

      Payment for non-physician practitioners will be 115 percent of the allowable amount under the physician fee schedule.

      If a non-physician practitioner renders a service, one of the following modifiers must be on the applicable line:

      GF - Services rendered in a CAH by a nurse practitioner (NP), clinical nurse specialist (CNS), certified registered nurse (CRN) or physician assistant (PA). (The “GF” modifier is not to be used for CRNA services. If a claim is received and it has the “GF” modifier for CRNA services, the claim is returned to the provider.)

      SB - Services rendered in a CAH by a nurse midwife.
      AH - Services rendered in a CAH by a clinical psychologist.

AE - Services rendered in a CAH by a nutrition professional/registered dietitian.

- Outpatient services, including ASC type services, rendered in an all-inclusive rate provider should be billed using the 85X type of bill (TOB). Non-patient laboratory specimens are billed on TOB 14X.

  The (MPFS) supplemental file is used for payment of all physician/professional services rendered in a CAH that has elected the optional method. If a HCPCS has a facility rate and a non-facility rate, pay the facility rate.

## SUPPLEMENTAL FEE SCHEDULE
## CRITICAL ACCESS HOSPTIAL FEE SCHEDULE

**DATA SET NAMES: MU00.@BF12390.MPFS.CY05.SUPL.V1122.FI**

This is the final physician fee schedule supplemental file.

**RECORD LENGTH:** 60

**RECORD FORMAT:** FB

**BLOCK SIZE:** 6000

**CHARACTER CODE:** EBCDIC

**SORT SEQUENCE:** Carrier, Locality HCPCS Code, Modifier

| Data Element Name | Location | Picture | Value |
|---|---|---|---|
| 1 - HCPCS | 1-5 | X(05) | |
| 2 - Modifier | 6-7 | X(02) | |
| 3 - Filler | 8-9 | X(02) | |
| 4 - Non-Facility Fee | 10-16 | 9(05)V99 | |
| 5 - Filler | 17-17 | X(01) | |
| 6 - PCTC Indicator | 18-18 | X(01) | This field is only applicable when pricing Critical Access Hospitals (CAHs) that have elected the optional method (Method 2) of payment. |
| 7 - Filler | 19 | X(1) | |
| 8 - Facility Fee | 20-26 | 9(05)V99 | |
| 9 - Filler | 27-30 | X(4) | |
| 10 - Carrier Number | 31-35 | X(05) | |
| 11 - Locality | 36-37 | X(02) | |
| 12 - Filler | 38-40 | X(03) | |
| 13 - Fee Indicator | 41-41 | X(1) | Field not populated— filled with spaces. |

| | | | |
|---|---|---|---|
| 14 - Outpatient Hospital | 42-42 | X(1) | Field not populated—Filled with spaces. |
| 15 - Status Code | 43-43 | X(1) | Separate instructions will be issued for the use of this field at a later date. This field indicates whether the code is in the physician fee schedule and whether it's separately payable if the service is covered. |
| 16 - Filler | 44-60 | X(17) | |

**Physician Fee Schedule Payment Policy Indicator File Record Layout**

The information on the Physician Fee Schedule Payment Policy Indicator file record layout is used to identify endoscopic base codes, payment policy indicators, global surgery indicators or the preoperative, intraoperative and postoperative percentages that are needed to determine if payment adjustment rules apply to a specific CPT code and the associated pricing modifier(s). See Chapter 12 of Pub. 100-04 for more information on payment policy indicators and payment adjustment rules.

| FIELD NAME & DESCRIPTION | LENGTH & PIC | Position |
|---|---|---|
| **File Year**<br><br>This field displays the effective year of the file. | 4 Pic x(4) | 1-4 |
| **HCPCS Code**<br><br>This field represents the procedure code. Each Current Procedural Terminology (CPT) code and alpha-numeric HCPCS codes A, C, T, and some R codes that are currently returned on the MPFS supplemental file will be included. The standard sort for this field is blanks, alpha, and numeric in ascending order. | 5 Pic x(5) | 5-9 |
| **Modifier**<br><br>For diagnostic tests, a blank in this field denotes the global service and the following modifiers identify the components:<br>26 = Professional component; and<br>TC = Technical component.<br><br>For services other than those with a professional and/or technical component, a blank will appear in this field with one exception: the presence of CPT | 2 Pic x(2) | 10-11 |

| FIELD NAME & DESCRIPTION | LENGTH & PIC | Position |
|---|---|---|
| modifier -53 which indicates that separate Relative Value Units (RVUs) and a fee schedule amount have been established for procedures which the physician terminated before completion. This modifier is used only with colonoscopy code 45378 and screening colonoscopy codes G0105 and G0121. Any other codes billed with modifier -53 are subject to medical review and priced by individual consideration.<br>Modifier-53 = Discontinued Procedure - Under certain circumstances, the physician may elect to terminate a surgical or diagnostic procedure. Due to extenuating circumstances, or those that threaten the well being of the patient, it may be necessary to indicate that a surgical or diagnostic procedure was started but discontinued. | | |
| **Code Status**<br><br>This 1 position field provides the status of each code under the full fee schedule. Each status code is explained in Pub. 100-04, Chapter 23, §30.2.2. | 1 Pic x(1) | 12 |
| **Global Surgery**<br><br>This field provides the postoperative time frames that apply to payment for each surgical procedure or another indicator that describes the applicability of the global concept to the service.<br><br>000 = Endoscopic or minor procedure with related preoperative and postoperative relative values on the day of the procedure only included in the fee schedule payment amount; evaluation and management services on the day of the procedure generally not payable.<br><br>010 = Minor procedure with preoperative relative values on the day of the procedure and postoperative relative values during a 10-day postoperative period included in the fee schedule amount; evaluation and management services on the day of the procedure and during this 10-day postoperative period generally not payable. | 3 Pic x(3) | 13-15 |

| FIELD NAME & DESCRIPTION | LENGTH & PIC | Position |
| --- | --- | --- |
| 090 = Major surgery with a 1-day preoperative period and 90-day postoperative period included in the fee schedule payment amount.<br><br>MMM = Maternity codes; usual global period does not apply.<br><br>XXX = Global concept does not apply.<br><br>YYY = Fiscal intermediary (FI) determines whether global concept applies and establishes postoperative period, if appropriate, at time of pricing.<br><br>ZZZ = Code related to another service and is always included in the global period of the other service. (**NOTE**: Physician work is associated with intra-service time and in some instances the post service time.) | | |
| **Preoperative Percentage (Modifier 56)**<br><br>This field contains the percentage (shown in decimal format) for the preoperative portion of the global package. For example, 10 percent will be shown as 010000. The total of the preoperative percentage, intraoperative percentage, and the postoperative percentage fields will usually equal one. Any variance is slight and results from rounding. | 6 Pic 9v9(5) | 16-21 |
| **Intraoperative Percentage (Modifier 54)**<br><br>This field contains the percentage (shown in decimal format) for the intraoperative portion of the global package including postoperative work in the hospital. For example, 63 percent will be shown as 063000. The total of the preoperative percentage, intraoperative percentage, and the postoperative percentage fields will usually equal one. Any variance is slight and results from rounding. | 6 Pic 9v9(5) | 22-27 |
| **Postoperative Percentage (Modifier 55)**<br><br>This field contains the percentage (shown in decimal format) for the postoperative portion of the global | 6 Pic 9v9(5) | 28-33 |

| FIELD NAME & DESCRIPTION | LENGTH & PIC | Position |
|---|---|---|
| package that is provided in the office after discharge from the hospital. For example, 17 percent will be shown as 017000. The total of the preoperative percentage, intraoperative percentage, and the postoperative percentage fields will usually equal one. Any variance is slight and results from rounding. | | |
| **Professional Component (PC)/Technical Component (TC) Indicator**<br><br>0 = Physician service codes: This indicator identifies codes that describe physician services. Examples include visits, consultations, and surgical procedures. The concept of PC/TC does not apply since physician services cannot be split into professional and technical components. Modifiers 26 & TC cannot be used with these codes. The total Relative Value Units (RVUs) include values for physician work, practice expense and malpractice expense. There are some codes with no work RVUs.<br><br>1 = Diagnostic tests or radiology services: This indicator identifies codes that describe diagnostic tests, e.g., pulmonary function tests, or therapeutic radiology procedures, e.g., radiation therapy. These codes generally have both a professional and technical component. Modifiers 26 and TC can be used with these codes.<br><br>The total RVUs for codes reported with a 26 modifier include values for physician work, practice expense, and malpractice expense.<br><br>The total RVUs for codes reported with a TC modifier include values for practice expense and malpractice expense only. The total RVUs for codes reported without a modifier equals the sum of RVUs for both the professional and technical component.<br><br>2 = Professional component only codes: This indicator identifies stand alone codes that describe the physician work portion of selected diagnostic | 1 Pic x(1) | 34 |

| FIELD NAME & DESCRIPTION | LENGTH & PIC | Position |
|---|---|---|
| tests for which there is an associated code that describes the technical component of the diagnostic test only and another associated code that describes the global test.<br><br>An example of a professional component only code is 93010, Electrocardiogram; interpretation and report. Modifiers 26 and TC cannot be used with these codes. The total RVUs for professional component only codes include values for physician work, practice expense, and malpractice expense.<br><br>3 = Technical component only codes: This indicator identifies stand alone codes that describe the technical component (i.e., staff and equipment costs) of selected diagnostic tests for which there is an associated code that describes the professional component of the diagnostic tests only.<br><br>An example of a technical component code is 93005, Electrocardiogram, tracing only, without interpretation and report. It also identifies codes that are covered only as diagnostic tests and therefore do not have a related professional code. Modifiers 26 and TC cannot be used with these codes.<br><br>The total RVUs for technical component only codes include values for practice expense and malpractice expense only.<br><br>4 = Global test only codes: This indicator identifies stand alone codes for which there are associated codes that describe: a) the professional component of the test only and b) the technical component of the test only. Modifiers 26 and TC cannot be used with these codes. The total RVUs for global procedure only codes include values for physician work, practice expense, and malpractice expense. The total RVUs for global procedure only codes equals the sum of the total RVUs for the professional and technical components only codes combined.<br><br>5 = Incident to Codes: This indicator identifies codes | | |

| FIELD NAME & DESCRIPTION | LENGTH & PIC | Position |
|---|---|---|
| that describe services covered incident to a physicians service when they are provided by auxiliary personnel employed by the physician and working under his or her direct supervision.<br><br>Payment may not be made by carriers for these services when they are provided to hospital inpatients or patients in a hospital outpatient department. Modifiers 26 and TC cannot be used with these codes.<br><br>6 = Laboratory physician interpretation codes: This indicator identifies clinical laboratory codes for which separate payment for interpretations by laboratory physicians may be made. Actual performance of the tests is paid for under the lab fee schedule. Modifier TC cannot be used with these codes. The total RVUs for laboratory physician interpretation codes include values for physician work, practice expense and malpractice expense.<br><br>7 = Physical therapy service: Payment may not be made if the service is provided to either a hospital outpatient or inpatient by an independently practicing physical or occupational therapist.<br><br>8 = Physician interpretation codes: This indicator identifies the professional component of clinical laboratory codes for which separate payment may be made only if the physician interprets an abnormal smear for hospital inpatient. This applies only to code 85060. No TC billing is recognized because payment for the underlying clinical laboratory test is made to the hospital, generally through the PPS rate.<br><br>No payment is recognized for code 85060 furnished to hospital outpatients or non-hospital patients. The physician interpretation is paid through the clinical laboratory fee schedule payment for the clinical laboratory test.<br><br>9 = Concept of a professional/technical component does not apply | | |

| FIELD NAME & DESCRIPTION | LENGTH & PIC | Position |
|---|---|---|
| **Multiple Procedure (Modifier 51)**<br>Indicator indicates which payment adjustment rule for multiple procedures applies to the service.<br><br>0 = No payment adjustment rules for multiple procedures apply. If the procedure is reported on the same day as another procedure, base payment on the lower of: (a) the actual charge or (b) the fee schedule amount for the procedure.<br><br>1 = Standard payment adjustment rules in effect before January 1, 1996, for multiple procedures apply. In the 1996 MPFSDB, this indicator only applies to codes with procedure status of "D." If a procedure is reported on the same day as another procedure with an indicator of 1,2, or 3, rank the procedures by fee schedule amount and apply the appropriate reduction to this code (100 percent, 50 percent, 25 percent, 25 percent, 25 percent, and by report). Base payment on the lower of: (a) the actual charge or (b) the fee schedule amount reduced by the appropriate percentage.<br><br>2 = Standard payment adjustment rules for multiple procedures apply. If the procedure is reported on the same day as another procedure with an indicator of 1, 2, or 3, rank the procedures by fee schedule amount and apply the appropriate reduction to this code (100 percent, 50 percent, 50 percent, 50 percent, 50 percent, and by report). Base payment on the lower of: (a) the actual charge or (b) the fee schedule amount reduced by the appropriate percentage.<br><br>3 = Special rules for multiple endoscopic procedures apply if procedure is billed with another endoscopy in the same family (i.e., another endoscopy that has the same base procedure). The base procedure for each code with this indicator is identified in the endoscopic base code field.<br><br>Apply the multiple endoscopy rules to a family before ranking the family with other procedures | 1 Pic (x)1 | 35 |

| FIELD NAME & DESCRIPTION | LENGTH & PIC | Position |
|---|---|---|
| performed on the same day (for example, if multiple endoscopies in the same family are reported on the same day as endoscopies in another family or on the same day as a non-endoscopic procedure).<br><br>If an endoscopic procedure is reported with only its base procedure, do not pay separately for the base procedure. Payment for the base procedure is included in the payment for the other endoscopy.<br><br>4 = Subject to 25% reduction of the TC diagnostic imaging (effective for services January 1, 2006 and after). Note: The 4 will be changed to a 9 because the 4 does not apply to Method II CAH claims for professional services processed by the fiscal intermediary.<br><br>9 = Concept does not apply. | | |
| **Bilateral Surgery Indicator (Modifier 50)**<br>This field provides an indicator for services subject to a payment adjustment.<br><br>0 = 150 percent payment adjustment for bilateral procedures does not apply.<br><br>The bilateral adjustment is inappropriate for codes in this category because of: (a) physiology or anatomy, or (b) because the code descriptor specifically states that it is a unilateral procedure and there is an existing code for the bilateral procedure.<br><br>1 = 150 percent payment adjustment for bilateral procedures applies. If code is billed with the bilateral modifier base payment for these codes when reported as bilateral procedures on the lower of: (a) the total actual charge for both sides or (b) 150 percent of the fee schedule amount for a single code.<br><br>If code is reported as a bilateral procedure and is reported with other procedure codes on the same day, apply the bilateral adjustment before applying | 1 Pic (x)1 | 36 |

| FIELD NAME & DESCRIPTION | LENGTH & PIC | Position |
|---|---|---|
| any applicable multiple procedure rules.<br><br>2 = 150 percent payment adjustment for bilateral procedure does not apply. RVUs are already based on the procedure being performed as a bilateral procedure.<br><br>The RVUs are based on a bilateral procedure because: (a) the code descriptor specifically states that the procedure is bilateral; (b) the code descriptor states that the procedure may be performed either unilaterally or bilaterally; or (c) the procedure is usually performed as a bilateral procedure.<br><br>3 = The usual payment adjustment for bilateral procedures does not apply.<br><br>Services in this category are generally radiology procedures or other diagnostic tests which are not subject to the special payment rules for other bilateral procedures. *If a procedure is billed with the 50 modifier, base payment on the lesser of the total actual charges for **each** side or 100% of the fee schedule amount for **each** side.*<br><br>9 = Concept does not apply. | | |
| **Assistant at Surgery (Modifiers AS, 80, 81 and 82)**<br><br>This field provides an indicator for services where an assistant at surgery may be paid:<br><br>0 = Payment restriction for assistants at surgery applies to this procedure unless supporting documentation is submitted to establish medical necessity.<br><br>1 = Statutory payment restriction for assistants at surgery applies to this procedure. Assistant at surgery may not be paid.<br><br>2 = Payment restriction for assistants at surgery does not apply to this procedure. Assistant at surgery | 1 Pic (x)1 | 37 |

| FIELD NAME & DESCRIPTION | LENGTH & PIC | Position |
|---|---|---|
| may be paid.<br><br>9 = Concept does not apply. | | |
| **Co-Surgeons (Modifier 62)**<br><br>This field provides an indicator for services for which two surgeons, each in a different specialty, may be paid.<br><br>0 = Co-surgeons not permitted for this procedure.<br><br>1 = Co-surgeons could be paid; supporting documentation required to establish medical necessity of two surgeons for the procedure.<br><br>2 = Co-surgeons permitted; no documentation required if two specialty requirements are met.<br><br>9 = Concept does not apply. | 1 Pic (x)1 | 38 |
| **Team Surgeons (Modifier 66**)<br><br>This field provides an indicator for services for which team surgeons may be paid.<br><br>0 = Team surgeons not permitted for this procedure.<br><br>1 = Team surgeons could be paid; supporting documentation required to establish medical necessity of a team; pay by report.<br><br>2 = Team surgeons permitted; pay by report.<br>9 = Concept does not apply. | 1 Pic (x)1 | 39 |
| **Endoscopic Base Codes**<br><br>This field identifies an endoscopic base code for each code with a multiple surgery indicator of 3. | 5 Pic x(5) | 40-44 |
| **Performance Payment Indicator**<br>(For future use) | 1 Pic x (1) | 45 |
| **Filler** | 30 Pic x(30) | 46-75 |

**Health Professional Shortage Area (HPSA) Incentive Payments for Physicians**

Section 1833 (m) of the Social Security Act, provides incentive payments for physicians who furnish services in areas designated as HPSAs under section 332(a)(1)(A) of the Public Health Service (PHS) Act. This statute recognizes geographic-based, primary medical care and mental health HPSAs, are areas for receiving a 10 percent bonus payment. The Health Resources and Services Administration (HRSA), within the Department of Health & Human Services, is responsible for designating shortage areas.

Physicians, including psychiatrists, who provide covered professional services in a primary medical care HPSA, are entitled to an incentive payment. In addition, psychiatrists furnishing services in mental health HPSAs are eligible to receive bonus payments. The bonus is payable for psychiatric services furnished in either a primary care HPSA, or a mental health HPSA. Dental HPSAs remain ineligible for the bonus payment.

Physicians providing services in either rural or urban HPSAs are eligible for a 10percent incentive payment. It is not enough for the physician merely to have his/her office or primary service location in a HPSA, nor must the beneficiary reside in a HPSA, although, frequently, this will be the case. The key to eligibility is where the service is actually provided (place of service). For example, a physician providing a service in his/her office, the patient's home, or in a hospital, qualifies for the incentive payment as long as the specific location of the service provision is within an area designed as a HPSA. On the other hand, a physician may have an office in a HPSA, but go outside the office (and the designated HPSA area) to provide the service. In this case, the physician would not be eligible for the incentive payment.

If the CAH electing the Optional Method (Method II) is located within a primary medical care HPSA, and/or mental health HPSA, the physicians providing (outpatient) professional services in the CAH are eligible for HPSA physician incentive payments. Therefore, payments to such a CAH for professional services of physicians in the outpatient department will be 115 percent **times** the amount payable under fee schedule **times** 110 percent. An approved Optional Method CAH that is located in a HPSA County should notify you of its HPSA designation **in writing**. Once you receive the information, place an indicator on the provider file showing the effective date of the CAH's HPSA status. The CMS will furnish quarterly lists of mental health HPSAs to intermediaries.

The HPSA incentive payment is 10 percent of the amount actually paid, not the approved amount. Do not include the incentive payment in each claim. Create a utility file so that you can run your paid claims file for a quarterly log. From this log you will send a quarterly report to the CAHs for each physician payment, one month following the end of each quarter. The sum of the "10% of line Reimbursement" column should equal the payment sent along with the report to the CAH. If any of the claims included on the report are adjusted, be sure the adjustment also goes to the report If an adjustment request is received after the end of the quarter, any related adjustment by the FI will be

included on next quarter's report. The CAHs must be sure to keep adequate records to permit distribution of the HPSA bonus payment when received. If an area is designated as both a mental health HPSA and a primary medical care HPSA, only one 10 percent bonus payment shall be made for a single service.

## *250.11 – Coding Bilateral Procedures Performed in a Method II CAH*

*(Rev. 1777; Issued: 07-24-09; Effective Date: 01-01-08; Implementation Date: 01-04-10)*

*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 bilateral procedures.*

*Bilateral procedures rendered by a physician that has reassigned their billing rights to a Method II CAH are payable by Medicare when the procedure is authorized as a bilateral procedure and is billed on type of bill 85X with revenue code (RC) 96X, 97X or 98X and the 50 modifier (bilateral procedure).*

*Modifier 50 applies to a bilateral procedure performed on both sides of the body during the same operative session. When a procedure is identified by the terminology as bilateral or unilateral, the 50 modifier is not reported.*

*If a procedure is authorized for the 150 percent payment adjustment for bilateral procedures (payment policy indicator 1), the procedure shall be reported on a single line item with the 50 modifier and one service unit. Modifiers LT (left side) and RT (right side) shall not be reported when the 50 modifier applies. See §20.6 in this chapter for more information on the use of the 50, LT and RT modifiers. See the Physician Fee Schedule Payment Policy Record Layout in §250.2 for a description of the bilateral procedure payment policy indicators.*

*If a procedure can be billed as bilateral, but is not authorized for the 150 percent bilateral adjustment (payment policy indicator 3), the procedure shall be reported on a single line item with the 50 modifier and one service unit.*

## *250.11.1 – Use of Payment Policy Indicators for Determining Bilateral Procedures Eligible for 150 Percent Payment Adjustment*

*(Rev. 1777; Issued: 07-24-09; Effective Date: 01-01-08; Implementation Date: 01-04-10)*

*Medicare uses the payment policy indicators on the Medicare Physician Fee Schedule Database (MPFSDB) to determine if a bilateral procedure is authorized 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 fiscal intermediary standard system.*

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

## *250.11.2 – Payment of Bilateral Procedures Rendered in a Method II CAH*

*(Rev. 1777; Issued: 07-24-09; Effective Date: 01-01-08; Implementation Date: 01-04-10)*

*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 bilateral procedures with a payment policy indicator of '1' and the 50 modifier is based on the lesser of the actual charges or the 150 percent payment adjustment for bilateral procedures and is calculated as follows:*

> *(facility specific MPFS amount times payment adjustment for bilateral procedures (150%) minus (deductible and coinsurance)) times 115%*

*Payment for bilateral procedures with the 50 modifier and a payment policy indicator of '3' is based on the lesser of the actual charges or 100% of the MPFS for* ***each*** *side of the body (200%) and is calculated as follows:*

> *(facility specific MPFS amount times 200% minus (deductible and coinsurance)) times 115%*