Payment of Bilateral Procedures in a Method II Critical Access Hospital (CAH) – JA6526

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Key Words	MM6526, CR6526, R1777CP, Bilateral, Method II, CAH
Contractors Affected	• Part A/B Medicare Administrative Contractors (A/B MACs) • Fiscal Intermediaries (FIs)
Provider Types Affected	Method II CAH submitting claims to Medicare FIs and/or A/B MACs for bilateral procedure services provided to Medicare beneficiaries.

Change Request (CR) 6526 implements the 150 percent payment adjustment for bilateral procedures performed in Method II CAHs, in cases where the physician reassigns billing rights to the Method II CAH.

Provider Needs to Know…

Payment for Bilateral Procedures

- Bilateral procedures are procedures performed on both sides of the body during the same operative session.
- Medicare makes payment for bilateral procedures based on 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.
- 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 (TOB) 85X with revenue code (RC) 96X, 97X or 98X and the 50 modifier (bilateral procedure).

Modifiers 50

- 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 should 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) are not to be reported when the 50 modifier applies.
- Claims with the LT and RT modifiers will be returned to the provider (RTP) when modifier 50 applies
- Providers may view the *Medicare Claims Processing Manual*, Chapter 4, Section 20.6 at *http://www.cms.hhs.gov/manuals/downloads/clm104c04.pdf* on the Centers for Medicare & Medicaid Services (CMS) website for more information on the use of the 50, LT and RT modifiers.

Bilateral Procedure Not Authorized For 150 Percent Payment

- 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 is to 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% of the MPFS amount for each side of the body.
- Medicare uses the bilateral surgery payment policy indicators on the MPFS to determine if the 150 percent payment adjustment is payable for a specific Healthcare Common Procedure Coding System (HCPCS)/ Current Procedural Terminology (CPT) code.
- Providers may view the MPFS database is at *http://www.cms.hhs.gov/apps/ama/license.asp?file=/pfslookup/02_PFSsearch.asp* on the CMS website.
- Medicare contractors have access to the payment policy indicators via the Physician Fee Schedule Payment Policy Indicator File in their claims processing systems.

Note: The January 2010 Integrated Outpatient Code Editor specifications will include a change to edit 74 (units greater than one for bilateral procedures billed with modifier 50). At that time, claims submitted on TOB 85X with revenue code (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 will be RTP.

What A/B MACs and FIs Will DO

- FIs and A/B MACs will 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'.

- For payment policy indicator 0, the 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.
- For payment policy indicator 2, the 150 percent payment adjustment for bilateral procedures does not apply. The relative value units 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.
- For payment policy indicator 9, the concept does not apply.

- FIs and A/B MACs will RTP bilateral procedures submitted on TOB 85X with RC 96X, 97X or 98X when the bilateral procedure code is billed with the RT and LT modifiers and the payment policy indicator is '1' or '3'. 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, one claim line with modifier RT and another claim line with modifier LT.
  - For Payment Policy Indicator 1, the 150 percent payment adjustment for bilateral procedures does apply.
  - For Payment Policy Indicator 3, the 150 percent payment adjustment for bilateral procedures does not apply. Services in this category are generally radiology procedures or other diagnostic tests that are not subject to the special payment rules for other bilateral procedures.
- FIs and A/B MACs will 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: (facility specific MPFS amount times bilateral procedure adjustment (150 percent) minus (deductible and coinsurance)) times 115 percent.
- FIs and A/B MACs will 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 percent of the MPFS amount as follows: (facility specific MPFS amount times 200 percent (100 percent for each side) minus (deductible and coinsurance)) times 115 percent.

NOTE: Although the 150 percent 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 actual charges or 200 percent of the MPFS amount.

- FIs and A/B MACs will calculate payment using all payment modifiers associated with

the line item.

Example 1:

- 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: (facility specific MPFS amount **times** bilateral procedure adjustment (150 percent) **times** assistant at surgery reduction (16 percent) **times** non-physician practitioner adjustment (85 percent) **minus** (deductible and coinsurance)) times 115 percent.

Example 2:

- 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: (facility specific MPFS amount **times** bilateral procedure adjustment (150 percent) **times** co-surgery reduction (62.5 percent) **minus** (deductible and coinsurance)) **times** 115 percent.

Background	• The Social Security Act (Section 1834(g)(2)(B)) states that professional services included within outpatient CAH services, will 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. • Providers may view this section at *http://www.ssa.gov/OP_Home/ssact/title18/1834.htm* on the Internet. • 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). • Providers may view 42 Code of Federal Regulations 414.40 at *http://edocket.access.gpo.gov/cfr_2007/octqtr/pdf/42cfr414.42.pdf* on the Internet, • 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 the CAH. When the billing rights are reassigned to the Method II CAH, payment is made to the CAH for professional services (RCs 96X, 97X or 98X).
Operational Impact	Medicare contractors will not search for and adjust claims that have been paid prior to the implementation date of CR6526, but will adjust claims brought to their attention.

Reference Materials	The related MLN Matters® article can be found at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6526.pdf* on the CMS website. The official instruction (CR6526) issued regarding this change may be viewed at *http://www.cms.hhs.gov/Transmittals/downloads/R1777CP.pdf* on the CMS website. .