Medicare Learning Network
MLN Matters®
CMS
Information for Medicare Fee-For-Service Health Care Professionals

News Flash – The revised *Critical Access Hospital Fact Sheet* (April 2009), which provides information about eligible Critical Access Hospital (CAH) providers; CAH designation; CAH payments; reasonable cost payment principles that do not apply to CAHs; election of Standard Payment Method or Optional (Elective) Payment Method; Medicare Rural Pass-Through funding for certain anesthesia services; Health Professional Shortage Area Incentive payments; Physician Scarcity Area Bonus payments; Medicare Prescription Drug, Improvement, and Modernization Act of 2003 provisions that impact Critical Access Hospitals; and grants to states under the Medicare Rural Hospital Flexibility Program, can be accessed at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/CritAccessHospfctsht.pdf on the Centers for Medicare & Medicaid Services website.

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Related Change Request (CR) #: 6526
Related CR Release Date: July 24, 2009
Effective Date: January 1, 2008
Related CR Transmittal #: R1777CP
Implementation Date: January 4, 2010

Note: This article was updated on December 28, 2012, to reflect current Web addresses. All other information remains unchanged.

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

Provider Types Affected

Method II Critical Access Hospitals (CAH) submitting claims to Medicare contractors (Fiscal Intermediaries (FIs) and/or A/B Medicare Administrative Contractors (A/B MACs)) for bilateral procedure services provided to Medicare beneficiaries

Provider Action Needed

STOP – Impact to You

This article is based on Change Request (CR) 6526 which implements payment for bilateral procedures performed in Method II Critical Access Hospitals (CAHs), in cases where the physician reassigns billing rights to the Method II CAH.

CAUTION – What You Need to Know

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. Modifier 50 is used for bilateral procedures and this article provides information on claims submission for these procedures. CR 6526 implements the 150 percent payment adjustment for bilateral procedures.

GO – What You Need to Do

See the Background and Additional Information Sections of this article for further details regarding these changes.

Background

The Social Security Act (Section 1834(g)(2)(B); see http://www.ssa.gov/OP_Home/ssact/title18/1834.htm on the Internet) states that professional services included within outpatient Critical Access Hospital (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. The Centers for Medicare & Medicaid Services (CMS) establishes uniform national definitions of services, codes to represent services, and payment modifiers to the codes. See 42 CFR 414.40 at http://edocket.access.gpo.gov/cfr_2007/octqtr/pdf/42cfr414.42.pdf on the Internet, This includes the use of the 50 modifier (bilateral procedure).

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).

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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 TOB 85X with revenue code (RC) 96X, 97X or 98X and 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 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. See the *Medicare Claims Processing Manual*, Chapter 4, section 20.6 at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c04.pdf on the CMS website 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 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.

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). At that time, claims submitted on TOB 85X with revenue code (RC) 96X, 97X or 98X , a Healthcare Common Procedure Coding System/Current Procedural Terminology (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 returned to the provider.

Medicare uses the bilateral surgery payment policy indicators on the MPFS to determine if the 150 percent payment adjustment is payable for a specific HCPCS/CPT code. The MPFS database is located at http://www.cms.gov/apps/physician-fee-schedule/ 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.

In summary, Medicare contractors will:

- Return to Provider (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'.
  - 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.
  - 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.
  - Payment Policy Indicator 9 - concept does not apply.
- 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 (LIDOS), one claim line with modifier RT and another claim line with modifier LT.
  - Payment Policy Indicator 1 – 150 percent payment adjustment for bilateral procedures does apply.
  - Payment Policy Indicator 3 - 150 percent 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.
- 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.

- 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.

- 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.

Note: Medicare contractors will not search for and adjust claims that have been paid prior to the implementation date of CR 6526, but will adjust claims brought to their attention.

Additional Information

The official instruction, CR 6526, issued to your FI and A/B MAC regarding this change may be viewed at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R1777CP.pdf on the CMS website.

If you have any questions, please contact your FI or A/B MAC at their toll-free number, which may be found at http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html on the CMS website.