

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services



News Flash – Time is running out: Test Your Medicare Claims Now using HIPAA Version 5010!
CMS is approaching the final milestone of January 1, 2012, requiring all trading partners to be ready to submit claims electronically using the Accredited Standards Committee (ASC) X12 Version 5010 and National Council for Prescription Drug Programs (NCPDP) Version D.0 standards. Failure to transition to HIPAA Version 5010 may risk disrupting cash flow from Medicare Fee-for-Service claim processing. As a reminder, CMS offers free billing software that is Version 5010 compliant. Please contact your MAC, FI, or Carrier to obtain the latest Version of PC-Ace Pro32. CMS also provides the Medicare Remit Easy Print (MREP) software to view and print compliant HIPAA 5010 835 remittance advices at http://www.cms.gov/AccessstoDataApplication/02_MedicareRemitEasyPrint.asp on the CMS website. For more information on 5010, please visit <https://www.cms.gov/Versions5010andD0> on the CMS website.

MLN Matters® Number: MM7587

Related Change Request (CR) #: CR 7587

Related CR Release Date: October 28, 2011

Effective Date: April 1, 2012

Related CR Transmittal #: R2333CP

Implementation Date: April 2, 2012

Payment for Multiple Surgeries in a Method II Critical Access Hospital (CAH)

Provider Types Affected

Physicians, providers, and Method II Critical Access Hospitals (CAHs) submitting claims to Medicare contractors (Fiscal Intermediaries (FIs) and/or A/B Medicare Administrative Contractors (A/B MACs)) for services provided to Medicare beneficiaries are affected.

Provider Action Needed

This article is based on Change Request (CR) 7587 which implements the multiple procedure payment reduction policy for CAH Method II providers. CR 7587 updates the "Medicare Claims Processing Manual" (Chapter 4, Section 250). CR7587 is for clarification purposes only and does not introduce any policy changes.

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Background

Medicare uses the payment policy indicators on the Medicare Physician Fee Schedule (MPFS) to determine if a multiple procedure is authorized for a specific Healthcare Common Procedure Coding System/Current Procedural Terminology (HCPCS/CPT) code.

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 code 96X, 97X, or 98X) based on the MPFS supplemental file.

Multiple surgeries are separate procedures performed by a single physician or physicians in the same group practice on the same patient at the same operative session or on the same day for which separate payment may be allowed. Co-surgeons, surgical teams, or assistants-at-surgery may participate in performing multiple surgeries on the same patient on the same day.

Medicare pays for multiple surgeries by ranking from the highest MPFS amount to the lowest MPFS amount. When the same physician performs more than one surgical service at the same session, the allowed amount is 100 percent for the surgical code with the highest MPFS amount. The allowed amount for the subsequent surgical codes is based on 50 percent of the MPFS amount. In addition, special endoscopic pricing rules are applied prior to the multiple surgery rules, if applicable. Claims lines containing Modifier 22 are excluded from the multiple surgery payment methodology.

When the multiple surgery and/or special endoscopic payment methodologies are applied, the remittance advice notice will contain:

- Claim adjustment reason code 59 – “Processed based on the multiple or concurrent procedure rules” and
- Group code “CO” contractual obligation.

Endoscopies

If multiple endoscopies are billed, special rules for multiple endoscopic procedures apply. Medicare contractors will perform the following actions when multiple HCPCS/CPT codes with a payment policy indicator of ‘3’ (Special rules for multiple endoscopic procedures), with the same date of service, are present:

1. Identify if the billed codes share the same Endoscopic Base Code (using the Physician Fee Schedule Payment Policy Indicator File).
2. Pay the full value of the highest valued endoscopy (if the same base is shared), plus the difference between the next highest and the base endoscopy.

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Example: In the course of performing a fiber optic colonoscopy (CPT code 45378), a physician performs a biopsy on a lesion (code 45380) and removes a polyp (code 45385) from a different part of the colon. The physician bills for codes 45380 and 45385. The value of codes 45380 and 45385 have the value of the diagnostic colonoscopy (45378) built in. Rather than paying 100 for the highest valued procedure (45385) and 50 for the next (45380), pay the full value of the higher valued endoscopy (45385), plus the difference between the next highest endoscopy (45380) and the base endoscopy (45378).

Medicare contractors:

- Assume the following fee schedule amounts for these codes: 45378 - \$255.40; 45380 - \$285.98; 45385 - \$374.56; and
- Pay the full value of 45385 (\$374.56), plus the difference between 45380 and 45378 (\$30.58), for a total of \$405.14.

NOTE: If an endoscopic procedure with an indicator of '3' (Special rules for multiple endoscopic procedures) is billed with other procedures that are **not** endoscopies (procedures with an indicator of '2' (Standard payment adjustment rules for multiple procedures)), the standard multiple surgery rules apply.

3. Apply the following rules where multiple endoscopies are performed on the same day as unrelated endoscopies or other surgical procedures (indicator of '2' (Standard payment adjustment rules for multiple procedures)):

Procedure Performed	Rules Applied
Two unrelated endoscopies (e.g., 46606 and 43217)	Apply the usual multiple surgery rules.
Two sets of unrelated endoscopies (e.g., 43202 and 43217; 46606 and 46608)	1. Apply the special endoscopy rules to each series, then 2. Apply the multiple surgery rules. (Consider the total payment for each set of endoscopies as one service)
Two unrelated endoscopies and a third, unrelated procedure	Apply the multiple surgery rules.
Two related endoscopies and a third, unrelated procedure	1. Apply the special endoscopic rules to the related endoscopies, then 2. Apply the multiple surgery rules. (Consider the total payment for the related endoscopies as one service and the unrelated endoscopy as another service.)

You can review the multiple surgery and special endoscopic pricing rules in the Medicare Claims Processing Manual (Chapter 12 (Physicians/Nonphysician

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Practitioners), Section 40.6 (Claims for Multiple Surgeries)); see <https://www.cms.gov/manuals/downloads/clm104c12.pdf> on the CMS website). In addition, Chapter 12, Section 40.6.D addresses rare situations where the above payment rules may be bypassed using modifier 22 (Increased Procedural Services). Providers should be aware that CAH claims billed with Modifier 22 may be subject to medical review.

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

Additional Information

The official instruction, CR7587, issued to your FIs and A/B MACs regarding this change may be viewed at <http://www.cms.gov/Transmittals/downloads/R2333CP.pdf> on the CMS website.

If you have any questions, please contact your FIs or A/B MACs at their toll-free number, which may be found at <http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip> on the CMS website.

News Flash – Vaccinate Early to Protect Against the Flu /2011-2012 Influenza Vaccine Prices Are Now Available. CDC recommends a yearly flu vaccination as the most important step in protecting against flu viruses. Remind your patients that annual vaccination is recommended for optimal protection. Under Medicare Part B, Medicare pays for the flu vaccine and its administration for seniors and other Medicare beneficiaries with no co-pay or deductible. Take advantage of each office visit and start protecting your patients as soon as your 2011-2012 seasonal flu vaccine arrives. And don't forget to immunize yourself and your staff. Get the Flu Vaccination – Not the Flu. CMS has posted the 2011-2012 seasonal influenza vaccine payment limits at: http://www.CMS.gov/McrPartBDrugAvgSalesPrice/10_VaccinesPricing.asp on the CMS website. Influenza vaccine is NOT a Part D-covered drug. For information about Medicare's coverage of the influenza vaccine, its administration, and educational resources for healthcare professionals and their staff, visit http://www.CMS.gov/MLNProducts/35_PreventiveServices.asp on the CMS website

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