DEPARTMENT OF HEALTH AND HUMAN SERVICES
DEPARTMENTAL APPEALS BOARD

DECISION OF MEDICARE APPEALS COUNCIL
Docket Number: M-13-1442

In the case of	**Claim for**
Marc E. Umlas, M.D. (Appellant)	Supplementary Medical Insurance Benefits (Part B)
**** (Beneficiaries)	**** (HIC Number)
First Coast Services Options (Contractor)	**** (ALJ Appeal Number)

The Medicare Appeals Council has decided, on its own motion, to review the Administrative Law Judge's (ALJ's) two decisions dated January 23, 2013, because there is an error of law material to the outcome of the claim. *See* 42 C.F.R. § 405.1110. The decisions concerned Medicare payment for a series of knee X-rays furnished to each of the beneficiaries on July 21, 2011. The ALJ decided that Medicare would make separate payment for X-ray services billed under CPT code 73565-59 notwithstanding the fact that Medicare had paid for X-ray services billed under CPT code 73564 for the same date of service.[1]

By memorandum dated March 14, 2013, Q2 Administrators, the Administrative Qualified Independent Contractor acting on behalf of the Centers for Medicare and Medicaid (CMS), asked the Council to review the ALJ's decision on its own motion pursuant to 42 C.F.R. § 405.1110(b). A copy of the CMS referral memorandum was previously furnished to the appellant physician,

[1] CPT (Current Procedural Terminology) codes were designed by the American Medical Association to describe medical and surgical services performed by physicians. The CPT code system has been incorporated into the Healthcare Common Procedure Coding System (HCPCS) developed by the Centers for Medicare & Medicaid Services (CMS) for processing, screening, identifying, and paying Medicare claims. 42 C.F.R. §§ 414.2, 414.40.

who has not filed a response. The Council admits the referral memorandum into the record as Exhibit (Exh.) MAC-1.

The Council has carefully considered the record that was before the ALJ, as well as the CMS memorandum. For the reasons set forth below, the Council reverses the ALJ's decision. The Council denies separate Medicare reimbursement for CPT code 73565 for the claims at issue. The appellant may not bill the beneficiaries for these services.

BACKGROUND AND PROCEDURAL HISTORY

The appellant physician sought Medicare reimbursement for X-ray examinations furnished to two beneficiaries on July 21, 2011. The X-ray services were billed under CPT code 73565-59 (Radiologic Examination, Knee; Both Knees, Standing, Antero-posterior). The appellant separately billed Medicare for X-ray examinations coded as 73564 (Radiologic Examination, Knee; Complete, 4 or more Views) furnished to each beneficiary for the same date of service. The contractor reimbursed the appellant for services billed under CPT code 73564, but denied payment for code 73565. *See, e.g.,* Claim File for Beneficiary W.G. (W.G. File), Exh. 1, at 18.

On redetermination and reconsideration, the contractor and the Qualified Independent Contractor (QIC) determined that the appellant could not receive additional payment under code 73565, a component code, because the appellant received payment for services billed under comprehensive code 73564 for the same date of service. *See* W.G. File, Exh. 1, at 2-7, 11-14; S.S. File, Exh. 1, at 3-8, 14-17. In each case, the appellant requested a hearing before an ALJ. The ALJ conducted a telephonic hearing on January 8, 2013.

The appellant's office manager, R.U., participated in the hearing on his behalf. Dec. at 1; CD Recording of ALJ Hearing, January 8, 2013. After consideration of the appellant's arguments and evidence, the ALJ determined that Medicare would cover CPT code 73565 for the beneficiaries and dates of service at issue.[2] The decision includes the following analysis:

[2] The amount billed for each service is less than $130 amount in controversy required for the ALJ to have jurisdiction over a request for hearing. We presume that the ALJ implicitly aggregated these claims to meet the amount in controversy, as permitted by 42 C.F.R. § 405.1006.

> Here, the record, through procedure notes and the MRI evaluation result, clearly reflects the delivery of two separate x-ray service types. The HCPCS billed codes are not on the CCI mutually exclusive list, per the Centers for Medicare and Medicaid Services database. Additionally, the CMS Physician Fee Schedule allows for separate payments for HCPCS codes 73564 and 73565.
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> From an overall view, the evidence and the uncontroverted testimony under oath of the appellant’s witness, the x-ray services HCPCS code 73565-59 were provided to the beneficiary on July 21, 2011, as well as the Medicare reimbursed services HCPCS code 73564. As such, the conditions necessary to sufficiently document the services and allow Medicare coverage are present. The x-ray services HCPCS codes 73565-59 in question were medically reasonable and necessary for the treatment of the beneficiary’s condition as provided in Section 1862(a)(1) of the Act and are separately covered under the provisions of Title XVIII of the Social Security Act.

Dec. at 5.

CMS referred the ALJ’s decision for Council review. 42 C.F.R. § 405.1110(b); Exh. MAC-1. Before the Council, CMS asserts that the ALJ erred in allowing separate payment for CPT code 73565 because Medicare paid for CPT code 73564 on the same date of service, and the National Correct Coding Initiative (NCCI) “Column One/Column Two Correct Coding Edits” table does not allow the use of a modifier and separate payment for 73565 when billed with 73564. Exh. MAC-1, at 5-7.

DISCUSSION

The ALJ concluded that separate payment may be made for 73565 and 73564 because the x-rays were medically reasonable and necessary and not included in the list of mutually exclusive code pairs. However, the ALJ did not consider whether the codes were included in the list of Column I/Column II codes, which identify comprehensive procedures into which payment for a component procedure is bundled. The ALJ erred in disregarding this binding CMS authority regarding payment for the knee X-rays at issue under the physician fee schedule. Even if these X-rays are medically reasonable and necessary, and we do not question that they were, no separate payment may be made under the fee schedule. Payment for code 73565 has already been bundled into

the payment for the more comprehensive code 73564 which, by definition, encompasses multiple views of the knee, including views taken while the patient is lying down and standing.

CMS has the authority under the physician fee schedule to establish "uniform national definitions of services, codes to represent services, and payment modifiers to the codes." 42 C.F.R. § 414.40(a). CMS also establishes uniform "national ancillary policies necessary to implement the fee schedule for physician services." *Id.* at (b). The NCCI is an example of a national ancillary policy. The physician fee schedule establishes uniform national payment amounts for each defined service, based on relative value units (RVUs) for physician's work, practice expense and malpractice insurance. 42 C.F.R. § 414.22. Any adjustments in the fee schedule payment amounts must be budget neutral. Neither the ALJ nor the Council has the authority to redefine the definition of a code or modifier, increase the RVUs or fee schedule payment amount, or ignore the NCCI for any HCPCS code.

The Medicare Claims Processing Manual (MCPM), in relevant part, states as follows:

> The CMS developed the Correct Coding Initiative (CCI)[3] to promote national correct coding methodologies and to control improper coding leading to inappropriate payment in Part B claims. The CMS developed its coding policies based on coding conventions defined in the American Medical Association's CPT manual, national and local policies and edits, coding guidelines developed by national societies, analysis of standard medical and surgical practices, and a review of current coding practices. An overview of the CCI can be found on CMS Web site, Medlearn Page at http://cms.hhs.gov/medlearn/ncci.asp. The CMS will e-mail an updated version of the CCI Coding Policy Manual to the ROs [Regional Offices] for distribution to the carriers. The Coding Policy Manual should be utilized by carriers as a general reference tool that explains the rationale for CCI edits.

[3] As CMS notes in the referral memorandum, the terms "NCCI" and "CCI" are used interchangeably. *See* Exh. MAC-1, at 4 n.2.

> Carriers implemented CCI edits within their claim processing systems for dates of service on or after January 1, 1996.
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> *****
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> The purpose of the CCI edits is to ensure the most comprehensive groups of codes are billed rather than the component parts. Additionally, CCI edits check for mutually exclusive code pairs. These edits were implemented to ensure that only appropriate codes are grouped and priced.

Pub. 100-04, MCPM, Ch. 23, § 20.9 (October 1, 2003).[4,5] A "Correct Coding Modifier (CCM) indicator . . . determines whether a CCM causes the code pair to bypass the [CCI] edit. This indicator will be either [sic] a '0,' '1,' or '9.'" *Id.* at § 20.9.1. A "0" generally indicates that a CCM will not bypass CCI edits for a code pair and, thus, that the specified code combination is not separately payable.

The NCCI Policy Manual (NCCIPM) provides, with respect to X-ray services, that "[f]or a given radiographic series, the procedure code that most accurately describes what was performed should be reported." NCCIPM at IX-5. The Manual cautions that "[b]ecause the number of views necessary to obtain medically useful information may vary, a complete review of CPT coding options for a given radiographic session is important to assure accurate coding *with the most comprehensive code describing the services performed rather than billing multiple codes* to describe the service." *Id.* (emphasis supplied).

CMS has published the NCCI Edits – Column One/Column Two Correct Coding Edits table. The table lists CPT code 73564 as the comprehensive code and CPT code 73565 as a component code.[6] This code pairing also contains a "modifier indicator" of "0," defined as "*not allowed.*" Thus, the NCCI edits in effect for the date of service at issue clearly denote that 73564 and 73565

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[4] Manuals issued by CMS can be found at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs.html (last accessed May 14, 2013).
[5] An overview of the correct coding initiative can be found at http://www.cms.gov/NationalCorrectCodInitEd (last accessed May 14, 2013). The NCCI Policy Manual may also be accessed from this webpage.
[6] The table of physician CCI edits may be accessed at http://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/NCCI-Coding-Edits.html (last accessed May 14, 2013).

are not separately billable and indicate that use of a modifier is not appropriate to override the payment restriction. *See* NCCIPM.

Despite the appellant's contentions before the ALJ, there is nothing in the administrative authority which states that CPT code 73564 is limited to X-rays taken *only* when a patient is non-weight-bearing. Instead, the code encompasses a full set of knee X-rays, where four *or more* views are taken. HCPCS and CPT Codebook, Radiology Services, 73564 (X-Ray Exam, Knee, 4 or More) (emphasis added). The CCI clearly states that CPT code 73565 is a component code of the comprehensive code 73564 and the two codes may not be billed concurrently. Thus, CPT codes 73564 and 73565 may not be paid for the same beneficiary and same date of service, even if the modifier "59" is added to the component code. As explained above, neither modifier 59 nor any other modifier may be used to permit CPT code 73565 to be billed for the same date of service as CPT code 73564. For these reasons, the ALJ erred by concluding that "the CMS Physician Fee Schedule allows for separate payments for HCPCS codes 73564 and 73565." *See* Dec. at 5.

Medicare previously paid for the X-ray services the appellant furnished the beneficiaries under CPT code 73564. No additional payment may be made for CPT code 73565. Physicians who accept assignment of Medicare claims agree to accept the Medicare allowed amount as payment in full for the services they furnish and agree to charge beneficiaries no more than the deductible and coinsurance for the covered service. 42 C.F.R. § 424.55(b). Further, the NCCIPM provides that beneficiaries may not be billed for services denied payment due to NCCI edits:

> CPT codes representing services denied based on NCCI edits may not be billed to Medicare beneficiaries. Since these denials are based on incorrect coding rather than medical necessity, the provider cannot utilize an "Advanced Beneficiary Notice" (ABN) form to seek payment from a Medicare beneficiary. Furthermore, since the denials are based on incorrect coding rather than a legislated Medicare benefit exclusion, the provider cannot seek payment from the beneficiary with or without a "notice of exclusions from Medicare Benefits" (NEMB) form.
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> Since the NCCI is a CMS program, its policies and edits represent CMS national policy.

Manual, at Intro – 4-5. Therefore, the appellant may not bill the beneficiaries for the cost of the services billed under CPT code 74565.

DECISION

It is the decision of the Medicare Appeals Council that separate payment for the appellant's claims for CPT code 73565-59 is not due for the beneficiaries and dates of service at issue, as payment was already included in the Medicare fee schedule allowance for code 73564. The appellant may not bill the beneficiaries for this service. The ALJ's decision is reversed accordingly.

MEDICARE APPEALS COUNCIL

\s\ Clausen J. Krzywicki
Administrative Appeals Judge

\s\Constance B. Tobias, Chair
Departmental Appeals Board

Date: May 17, 2013