DEPARTMENT OF HEALTH AND HUMAN SERVICES
DEPARTMENTAL APPEALS BOARD

**DECISION OF MEDICARE APPEALS COUNCIL**
**Docket Number: M-12-1236**

| **In the case of** | **Claim for** |
|---|---|
| Radiation Oncology Healthcare, P.A. (Appellant) | Supplementary Medical Insurance Benefits (Part B) |
| **** (Beneficiary) | **** (HIC Number) |
| Highmark Medicare Services (Contractor) | **** (ALJ Appeal Number) |

The Administrative Law Judge (ALJ) issued a decision dated January 26, 2012, which concerned radiation services furnished to two beneficiaries, beneficiary C.D. on December 6, 2010, and beneficiary N.L. on January 7, 2011.[1] Specifically, the ALJ's decision involved whether separate payment could be made for services billed under CPT code 77315 when billed on the same date of service as CPT code 77295, for each of the beneficiaries listed in Attachment A of this decision.[2] The ALJ determined, for each beneficiary, that code 77315 is not a separately identifiable service unrelated to comprehensive code 77295, and thus the two codes were not separately payable under Medicare guidelines. The appellant has asked the Medicare Appeals Council to review this action.

[1] A list with the full name and HICN of each beneficiary, as well as the dates of service at issue is attached to this decision as Attachment A. Each beneficiary is identified by her initials.

[2] 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.

The Council reviews the ALJ's decision *de novo*. 42 C.F.R. § 405.1108(a). The Council will limit its review of the ALJ's action to the exceptions raised by the party in the request for review, unless the appellant is an unrepresented beneficiary. 42 C.F.R. § 405.1112(c). The appellant's request for review is hereby entered into the record as Exh. MAC-1. As set forth below, the Council adopts the ALJ's decision.

## BACKGROUND

The appellant sought Medicare reimbursement for radiology services furnished to each of the beneficiaries in this case. The radiology services were billed under CPT code 77295-26 (Therapeutic Radiology Simulation-Aided Field Setting; 3-Dimensional) and, for the same dates of service for each beneficiary, CPT code 77315-26-59 (Teletherapy Isodose Plan Complete).[3] Highmark Medicare Services (the contractor) reimbursed the appellant for the services billed under CPT code 77295, for each beneficiary, but denied separate coverage for code 77315. *See, e.g.,* C.D. claim file, Exh. 1, at 1. The contractor and the Qualified Independent Contractor (QIC) both determined that the appellant could not receive additional payment under the component code 77315 because the appellant received payment for services billed under the comprehensive code 77295. *See id.,* Exhs. 3, at 2; 5, at 2-3.

The ALJ conducted a telephonic hearing on December 7, 2011. In his decision, the ALJ noted that for each beneficiary's services, "[the National Correct Coding Initiative (NCCI)] code pair indicator indicates that the code pair for CPT codes 77295 and 77315 generally cannot be reported together." Dec. at 8. The ALJ also noted that Local Coverage Determination (LCD) L27515, *Radiation Therapy Services*, states that:

> Procedure code 77295 should be used only when true 3-D treatment planning computers are used. When this equipment is used, it is appropriate to bundle CPT code 77295 with CPT code 77315 because the entire procedure is performed on one computer. The radiation oncologist and the physicist do the procedure together. It would not be appropriate to bill for CPT code 77315 because there is not a separately billable

[3] Modifier "-26" is used to indicate that a provider performed only the professional component of a service or procedure. Modifier "-59" is used to indicate that a provider performed a distinct procedure or service for a beneficiary on the same date of service as another procedure or service.

> procedure. The entire process is appropriately billed as one code, namely CPT code 77295.

Dec. at 8 (quoting LCD L27515). In his decision, the ALJ determined that, for each beneficiary, Medicare would not provide additional payment for code 77315 after paying the appellant for code 77295.

**DISCUSSION**

Before the Council, the appellant states that it disagrees that it has failed to demonstrate two separately identifiable services for the beneficiaries at issue. *See* Exh. MAC-1. The appellant contends that "the treatment sites of the supraclavicular and axillary lymph nodes and the breast are two separate and distinct anatomical areas." Exh. MAC-1. The appellant further asserts that "the treatment techniques used to treat these two separate areas are completely different as well, requiring two unrelated treatment planning procedures." *Id.*

The Centers for Medicare & Medicaid Services (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 physicians' 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) 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.
>
> 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.

MCPM (CMS IOM Pub. 100-04), Ch. 23, § 20.9 (October 1, 2003).[4,5]

The National Correct Coding Initiative Coding Policy Manual for Medicare Services (Coding Policy Manual) 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

[4] Manuals issued by CMS can be found at http://www.cms.hhs.gov/manuals (Last visited June 4, 2012).

[5] An overview of the CCI can now be found at http://www.cms.gov/NationalCorrectCodInitEd (Last visited June 4, 2012).

> beneficiary with or without a "notice of exclusions from Medicare Benefits" (NEMB) form.
>
> Since the NCCI is a CMS program, its policies and edits represent CMS national policy.

Coding Policy Manual, at Intro – 4-5.

As the ALJ indicated in his decision, CPT codes 77295 and 77315 appear on the Column One/Column Two Correct Coding Edits Table as mutually exclusive of each other. Moreover, the code pairing for CPT codes 77295 and 77315 indicate that code 77295 is the comprehensive code and 77315 is the component code. NCCI Edits – Column One/Column Two Correct Coding Edits Table. Thus, the two codes cannot be billed together unless the code pair is permitted to bypass the CCI edit.

In the case of the two beneficiaries at issue, the appellant used modifier -59 to indicate that it was providing a separate procedure or service for the same beneficiaries on the same dates of service. In order to determine whether a modifier can be used to allow separate payment for services that generally cannot be billed separately, 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.'" MCPM 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 code pair of CPT codes 77295 and 77315 contains a "modifier indicator" of "0," defined as "not allowed." *Id*. Thus, the NCCI edits in effect for the dates of service at issue clearly indicate that use of a modifier is not appropriate to override the payment restriction. *See* Coding Policy Manual.

Additionally, we agree with the ALJ that LCD L27515 instructs that CPT code 77315 should be bundled into code 77295.[6] LCD L27515 describes code 77295 as a procedure that "involves three dimensional computer-generated reconstruction of tumor volume and surrounding critical normal tissue structures from direct CT scan and/or MRI data in preparation for non-coplanar or coplanar therapy." LCD L27515. The LCD goes on to explain that "CPT

[6] While the Council is not bound by a contractor's LCD, the Council gives substantial deference to one where applicable. 42 C.F.R. § 405.1062(a). If the Council declines to follow an LCD in a particular case, the rationale for not following that policy must be explained. *Id.* at (b). The Council has found no reason to depart from LCD L5017 in this case.

code 77295 also includes the work done for a teletherapy isodose plan (codes 77305-77315)." *Id.* The LCD indicates that the entire procedure coded as 77295 is performed on one computer, and thus, there is not a separately billable procedure for 77315. *See* LCD L27515. Therefore, neither the appellant's assertion that the treatment sites for the beneficiaries were performed on two separate and distinct anatomical areas nor the assertion that separate treatment techniques had to be used on the two distinct areas has a bearing on whether the services defined by codes 77295 and 77315 are separately billable. Consequently, we find no reason to depart from the LCD's provision that CPT codes 77295 and 77315 should be billed as one comprehensive service under code 77295, particularly as this is consistent with NCCI policy.

## DECISION

It is the decision of the Medicare Appeals Council that the appellant's claims for CPT code 77315 are not payable by Medicare for the dates of service at issue. The appellant may not bill the beneficiaries for these services. Accordingly, we adopt the ALJ's decision.

MEDICARE APPEALS COUNCIL

/s/ Gilde Morrisson
Administrative Appeals Judge

Date: June 11, 2012