DEPARTMENT OF HEALTH AND HUMAN SERVICES
DEPARTMENTAL APPEALS BOARD

DECISION OF MEDICARE APPEALS COUNCIL
Docket Number: M-10-1708

In the case of	**Claim for**
Med Health Services (Appellant)	Supplementary Medical Insurance Benefits (Part B)
**** (Beneficiary)	**** (HIC Number)
Highmark Medicare Services (Contractor)	**** (ALJ Appeal Number)

INTRODUCTION

The ALJ issued an unfavorable decision, dated July 14, 2010, which concerned Medicare reimbursement for doppler echocardiography services billed to Medicare under Current Procedural Terminology (CPT) codes 93320 and 93325 with transthoracic echocardiography (TTE) services billed under CPT code 93306. The ALJ found that CPT codes 93320 and 99325 were "add-on codes" included in CPT code 93306 and were not separately reimbursable. The appellant has asked the Medicare Appeals Council (Council) to review this action. The Council admits the appellant's request for review and enclosures and subsequent interim correspondence into the administrative record as Exhibits (Exhs.) MAC2-1 through MAC2-5.

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). As set forth below, the Council modifies the ALJ's decision to reflect additional bases for reimbursement denial and appellant responsibility for non-reimbursed charges.

BACKGROUND

This case comes to the Council following a wholly favorable decision by the ALJ, dated November 20, 2009; a subsequent referral for own motion review by the Centers for Medicare & Medicaid Services (CMS), dated January 11, 2010; an order of remand to the ALJ by the Council, dated April 12, 2010 (Order); and the ALJ's unfavorable decision, dated July 14, 2010, which is the subject of the appellant's request for review. The Council adopts and incorporates by reference the statement of procedural history, legal authorities, and issues as discussed in the Order.[1]

In the Order, the Council summarized the central issue as being "whether, on the dates of service at issue, the primary procedure code utilized by the appellant, 93306, encompassed the services described by codes 93320 and 93325." Order at 5.[2] The Council directed the ALJ to determine whether CPT codes 93320 and 93325 were "combined or bundled" into CPT code 93306; to consider the applicable National Correct Coding Initiative (NCCI) edits in place on the dates of service; and to determine whether the record supported the appellant's use of the -59 modifier with CPT codes 93320 and 93325. *Id.* at 5-8.[3] The Council also directed the ALJ to provide the parties and the CMS contractor the opportunity for another hearing and to issue a new decision addressing payment and coding issues. *Id.* at 9.

In the subsequent unfavorable decision, the ALJ found that the appellant had billed CPT codes 93320 and 93325 with CPT code 93306 for each beneficiary, following a physician referral for a TTE to examine the beneficiary's heart. Dec. at 2. The ALJ stated that her review of the record and Local Coverage Determination (LCD) for TTE (L27536) "leads to the conclusion that 93306 is inclusive of add-on codes 93320 and 93325." *Id.*

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[1] The ALJ's favorable decision, the Council's Order, the ALJ's unfavorable decision, and the recording of the ALJ's first hearing are in the ALJ Master File, which is also the claims file for lead beneficiary B.A. The agency referral, the appellant's exceptions, the Council's Order, and the recording of the ALJ's second hearing are in MAC Master File I. The appellant's request for review of the unfavorable decision is in MAC Master File II.

[2] As noted, the Order can be found as Exhibit 10 in the ALJ Master File and as an unexhibited document in MAC Master File I.

[3] CMS developed the Healthcare Common Procedure Coding System (HCPCS) to establish "uniform national definitions of services, codes to represent services, and payment modifiers to the codes." 42 C.F.R. § 414.40(a). Current Procedural Terminology (CPT) codes are 5-position numeric codes primarily representing physician services.

at 4.[4] The ALJ found it "clear from the definition of 93306 provided in the LCD that the echocardiography billed under 93306 includes spectral Doppler echocardiography and color flow Doppler echocardiography" billed under CPT codes 93320 and 93325 and that separate reimbursement could not be made. *Id.; see also id.* at 6 (Documentation did not meet requirements of section 1833(e) of the Social Security Act (Act) for reimbursement.).

In the request for review, the appellant generally argues that the ALJ's decision "contradicts both of the Medicare policy standards as outlined in the Local Coverage Determinations and NCCI edits for Echocardiography." Exh. MAC2-1, at 1. More specifically, the appellant first contends that the ALJ failed to explain the basis for the unfavorable decision, which directly contrasts with her previous wholly favorable decision and the wholly favorable decisions issued by a different ALJ. *Id.* at 1-2. Second, the appellant argues that the ALJ erred in applying LCD L27536, which, in part, "instructs providers to list codes 93320 and 93325 'in addition' to" echocardiography services billed under CPT code 93306. *Id.* at 2-3. The appellant also argues that Medicare allows add-on codes 93320 and 93325 when performed with CPT code 93303 (Transthoracic Echocardiography for Congenital Cardiac Anomalies; Complete), which, the appellant maintains, follows the same protocol and has the same technology as the TTE billed under CPT code 93306. *Id.* at 2. Finally, the appellant argues that NCCI edits for CPT code 93306 (Modifier Indicator "1") specifically allows billing of the "add-on code 93325" and that Modifier Indicator "0" for CPT codes 93306 and 93320 is inconsistent with the LCD, which "clearly states to bill code 93320 'in addition to'" CPT code 93306. *Id.* at 3. Appellant also states that NCCI edits do not supersede the LCD which defines CPT codes 93320 and 93325 as being "in addition to" CPT code 93306. *Id.*

APPLICABLE LEGAL AUTHORITIES

CMS Final Rule - Calendar Year (CY) 2009 Payment Rates

CMS issued a final rule concerning calendar year (CY) 2009 Medicare payment rates, effective January 1, 2009, to implement

[4] Contractor LCDs and local policy articles can be found through the Medicare Coverage Database at http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx.

various statutory requirements and effect other program requirements. "Medicare Program: Hospital Outpatient Prospective Payment System and CY 2009 Payment Rates; Changes to the Ambulatory Surgical Center Payment System and CY 2009 Payment Rates, 68922-69830," Final rule with comment period; final rules, 73 Fed. Reg. 68501-69380 (Nov. 18, 2008). In pertinent part, CMS discussed the creation of new CPT code 93306 and its relationship to echocardiography services formerly billed under CPT codes 93307, 93320, and 93325, as follows:

> [T]he American Medical Association (AMA) revised several CPT codes in the 93000 series to more specifically describe particular services provided during echocardiography procedures. The CY 2009 descriptor for CPT code 93306 *essentially includes the services described in CY 2008 by CPT codes 93307; 93320 and 93325.* Therefore, in CY 2008, the service described in CY 2009 by new CPT code 93306 is reported with three CPT codes, specifically CPT codes 93307, 93320, and 93325. . . .
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> To determine the [costs] of CPT codes 93306 and 93307 . . . for purposes of CY 2009 ratesetting, we redefined . . . *the single claims for 93307 billed with packaged CPT codes 93320 and 93325 as single claims for CPT code 93306.*

73 Fed. Reg. at 68543 (emphasis supplied)(internal CPT code descriptors omitted).

LCD, Policy Article, and NCCI Edits

Medicare appeals regulations provide that ALJs and the Council are bound by "[a]ll laws and regulations pertaining to the [Medicare program]," including Title 18 of the Act and implementing regulations. 42 C.F.R. § 405.1063(a). With respect to administrative authority, "ALJs and the [Council] are not bound by LCDs, LMRPs [Local Medical Review Policies], or CMS program guidance, such as program memoranda and manual instructions, but will give substantial deference to these policies if they are applicable to a particular case." 42 C.F.R. § 405.1062(a). An ALJ or the Council must explain the reason for not applying an applicable policy. 42 C.F.R. § 405.1062(b).

In pertinent part, the applicable LCD in this case, LCD L27536, cross-references Policy Article A47806, Transthoracic Echocardiography (TTE) "for additional information." LCD L27536, "Additional Information." In turn, "Local Coverage Article for Transthoracic Echocardiography (TTE)(A47806)," effective July 11, 2008, provides as follows: "The HCPCS/CPT code(s) may be subject to Correct Coding Initiative (CCI) edits. This information does not take precedence over CCI edits. Please refer to CCI for correct coding guidelines and specific applicable code combinations prior to billing Medicare." Article A47806, "Coding Guidelines."

The National Correct Coding Policy Manual (NCCPM) provides CCI edits by CPT code. *See* NCCPM, CCI Edits by Code (Physician Version 15.0, effective January 1, 2009).[5] The CCI edit for CPT code 93306 (TTE w/ Doppler, Complete) states that CPT code 93306 (Column 1) includes the component CPT code 93320 (Column 2), with Modifier Indicator 1 and effective date January 1, 2009.[6] The CCI edit for CPT code 93320 (Doppler Echo Exam, Heart) states that CPT code 93320 (Column 1) includes the component code 93325 (Column 2), with Modifier Indicator 1 and effective date January 1, 2009. CCI edit instructions state that the designated code pairs "generally cannot be reported together. Use the Column 1 code." The instructions also provide that when Modifier Indicator 1 is indicated for a code pair, "there may be occasions where both codes are payable" and cross-references NCCPM Ch. 1, § E (Modifiers and Modifier Indicators).

As CMS noted in its referral, the appellant billed component codes 93320 and 93325 (Column 2) with CPT code 93306 (Column 1) for services provided to the beneficiaries, using the -59 modifier. MAC Master File I, Exh. MAC-1, at 2. In pertinent part, the NCCPM generally discusses modifiers as follows:

> The AMA CPT Manual and CMS define modifiers that may be appended to HCPCS/CPT codes to provide additional information about the services rendered. Modifiers consist of two alphanumeric characters.

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[5] The updated NCCPM can be found on the NCCI webpage at http://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html?redirect=/NationalCorrectCodInitEd/ (June 5, 2012).

[6] The NCCPM explains that "[e]ach NCCI edit has an assigned modifier indicator. A modifier indicator of '0' indicates that NCCI-associated modifiers cannot be used to bypass the edit. A modifier indicator of '1' indicates that NCCI-associated modifiers may be used to bypass an edit under appropriate circumstances." NCCPM (NCCI 14.3), Ch. 1, § E.3.

> Modifiers may be appended to HCPCS/CPT codes only if the clinical circumstances justify the use of the modifier. A modifier should not be appended to a HCPCS/CPT code solely to bypass an NCCI edit if the clinical circumstances do not justify its use. If the Medicare program imposes restrictions on the use of a modifier, the modifier may only be used to bypass an NCCI edit if the Medicare restrictions are fulfilled.
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> Modifiers that may be used under appropriate clinical circumstances to bypass an NCCI edit include: [anatomic modifiers and global surgery modifiers and] Other modifiers: -27, -59, -91.
>
> It is very important that NCCI-associated modifiers only be used when appropriate. In general, these circumstances relate to *separate patient encounters, separate anatomic sites or separate specimens. . . .*
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> The appropriate use of most of these modifiers is straightforward. However, further explanation is provided about modifiers-25, -58, and -59. . . .

NCCPM (NCCI 14.3), Ch. 1, § E.1 (emphasis supplied).

With respect to modifier -59, the NCCPM states, in part, as follows:

> Modifier -59 is an important NCCI-associated modifier that is often used incorrectly. For the NCCI, *its primary purpose is to indicate that two or more procedures are performed at different anatomic sites or different patient encounters.* It should only be used if no other modifier more appropriately describes the relationships of the two or more procedure codes. The CPT Manual defines modifier -59 as follows: Modifier -59: Distinct Procedural Service: Under certain circumstances, the physician may need to indicate that a procedure or service was distinct or independent from other services performed on the same day. Modifier -59 is used to identify procedures/ services that are not normally reported together, but are appropriate under the circumstances. This may represent a different session or patient encounter,

> different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same physician. . . . Only if no more descriptive modifier is available, and the use of modifier -59 best explains the circumstances, should modifier -59 be used.
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> NCCI edits define when two procedure HCPCS/CPT codes may not be reported together except under special circumstances. If an edit allows use of NCCI-associated modifiers, the two procedure codes may be reported together *if the two procedures are performed at different anatomic sites or different patient encounters.* Carrier processing systems utilize NCCI-associated modifiers to allow payment of both codes of an edit. Modifier -59 and other NCCI-associated modifiers should NOT be used to bypass an NCCI edit, unless the proper criteria for use of the modifier is met. Documentation in the medical record must satisfy the criteria required by any NCCI-associated modifier used.
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> * * * * *
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> The HCPCS/CPT codes remain bundled unless the procedures/surgeries are performed at different anatomic sites.
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> From an NCCI perspective, the definition of different anatomic sites includes different organs or different lesions in the same organ. . . .

NCCPM (NCCI 14.3), Ch. 1, § E.1.d (emphasis supplied).

DISCUSSION

Claims for CPT Codes 99320 and 99325 Are Not Separately Reimbursable from CPT Code 93306

As the Council noted in the Order, the central issue in this case is whether, on the dates of service, "the primary procedure code used by the appellant, 93306, encompassed the services described by codes 93320 and 93325." Order, at 5. After

reviewing the record, applicable authority, and the appellant's contentions, the Council finds that CPT codes 93320 and 93325 were component codes of 93306 during the dates of service and agrees with the ALJ that they are not separately reimbursable.

First, the NCCI edits, effective January 1, 2009, provide that CPT code 93325 is a component code of CPT code 93320 and that CPT code 93320 is a component code of CPT code 93306. NCCPM, CCI Edits by Code, Codes beginning with '9,' Codes 93306, 93320, and 93325.[7] Contrary to the appellant's contentions, the CPT code descriptors in the LCD do not supersede NCCI correct coding policies. Indeed, the LCD references a related policy article which provides that the LCD and article "do not take precedence over CCI edits. Please refer to CCI for correct coding guidelines and specific applicable code combinations prior to billing Medicare." Article A47806, Coding Guidelines. The NCCPM also provides that "[s]ince the NCCI is a CMS program, its policies and edits represent *CMS national policy*. However, NCCI policies and edits do not supersede any other CMS national coding, coverage, or payment policies." NCCPM, Introduction, at ix (emphasis supplied). The correct coding guidelines clearly provide that CPT code 93306 encompasses services billed under CPT code 93320, which, in turn, encompasses services billed under CPT code 93325. The code descriptors in local coverage policies and article do not undercut the unambiguous NCCI edits. The "add-on" CPT codes 93320 and 93325 may not be reported separately and reimbursed in addition to CPT code 93306.

Second, in its final rule for CY 2009 payment rates, CMS stated that, effective January 1, 2009, the newly created CPT code 93306 would include all echocardiography services formerly billed under CPT codes 93307, 93320, and 93325. It is clear that CMS intended that CPT codes 93320 and 99325 be subsumed under CPT code 93306 as of January 1, 2009. The dates of service at issue in this case are from January 2, 2009, through

January 30, 2009. For calendar year 2009, CMS payment policy provides that CPT code 93306 includes CPT codes 93320 and 93325 as component codes, absent limited exceptions not present here. The appellant is not entitled to separate reimbursement for CPT codes 93320 and 93325 billed with CPT code 93306.

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[7] CMS also implemented an NCCI code edit in the next quarterly update, effective April 1, 2009, which reflects that CPT code 93325 is a component code of CPT code 93306. MAC Master File I, Exh. MAC-1, at 8, n2.

Finally, appellant nowhere argues that the record supports that echocardiography services provided to the beneficiaries and billed to Medicare under CPT codes 93320 and 93325 qualify for separate reimbursement through use of modifier -59, pursuant to NCCI Modifier Indicator "1."[8] As CMS advises, modifier -59 may not be used to bypass NCCI edits, but is only appropriate when the services "relate to separate patient encounters [or] separate anatomic sites." NCCPM (NCCI 14.3), Ch. 1, § E.1. As the ALJ found, each beneficiary was referred by a physician for echocardiography services related to the beneficiary's heart, and the appellant billed for three separate echocardiography services provided to each beneficiary. The appellant does not contend, and the record does not indicate, that the services were provided in separate patient encounters or were related to separate anatomic sites. The services billed to Medicare under component codes 93320 and 93325 do not meet the requirements for separate reimbursement pursuant to use of modifier -59.

For the above reasons, the Council agrees with the ALJ that the documentation does not support that CPT codes 99320 and 99325 are separately reimbursable in addition to reimbursement for the primary procedure code, CPT code 93306. The Council modifies the ALJ's decision consistent with the above analysis.

The Appellant is Responsible for Reimbursement Denials

The NCCPM provides as follows concerning responsibility or liability for denials based on 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.

[8] The Council notes that NCCI Code Pair Checking for CPT codes 93306 and 93320 for period 10/01/09 - 12/31/09 reflect that the Modifier Indicator was changed from "1" to "0," effective January 1, 2009. Because the Council finds that the component codes are not separately reimbursable using modifier -59, it need not and does not reach the issue of whether Modifier Indicator "0" applies to CPT code pairs 93306 and 93320 effective January 1, 2009.

NCCPM, Introduction, at ix. The Council therefore finds that the appellant is responsible for the reimbursement denials for CPT codes 93320 and 93325 billed to Medicare in conjunction with CPT code 93306. The beneficiaries may not be billed for these services.

DECISION

It is the decision of the Medicare Appeals Council that the services provided to the beneficiaries and billed under CPT codes 93320 and 93325 are not reimbursable by Medicare. The appellant is responsible for the non-reimbursed amounts. The ALJ decision is modified consistent with the above analysis.

MEDICARE APPEALS COUNCIL

/s/ Gilde Morrisson
Administrative Appeals Judge

/s/ Leslie A. Sussan,
Deputy Chair
Departmental Appeals Board

Date: June 14, 2012