DEPARTMENT OF HEALTH AND HUMAN SERVICES
DEPARTMENTAL APPEALS BOARD

DECISION OF MEDICARE APPEALS COUNCIL
Docket Number: M-12-647

In the case of	**Claim for**
Steven B. Cagen, M.D., P.C. (Appellant)	Supplementary Medical Insurance Benefits (Part B)
**** (Beneficiary)	**** (HIC Number)
National Government Services (Contractor)	**** (ALJ Appeal Numbers)

The Medicare Appeals Council has decided, on its own motion, to review the Administrative Law Judge's (ALJ's) decision dated December 20, 2011, because there is an error of law material to the outcome of the claims. *See* 42 C.F.R. § 405.1110. The decision concerned Medicare Part B coverage for intraoperative testing services billed by a physician using billing codes 95920, 95926, and 95861 furnished to a hospital inpatient on June 10, 2010 and November 4, 2010.[1]

By a February 8, 2012 memorandum of referral, the Centers for Medicare & Medicaid Services (CMS) asks the Council to exercise own-motion review of the ALJ's decision based on error of law material to the outcome of each claim. The Council limits its review of the ALJ's actions to those exceptions raised by CMS in the referral memorandum. The CMS memorandum is admitted into the record as Exhibit (Exh.) MAC-1. The appellant's response to

[1] The appellant billed codes 95920 and 95926 for services furnished on June 10, 2010, and codes 95920, 95926, and 95861 for services furnished on November 4, 2010. The appellant also billed codes 95928 and 95929 for June 10, 2010 which the contractor also found non-covered. While it appears that these codes were appealed and addressed in the redetermination, the reconsideration and ALJ decisions addressed only codes 95920, 95926, and 95861. Neither CMS, in its agency referral memorandum, nor the appellant, in its response to the memorandum, has raised specific arguments with regard to codes 95928 and 95929 and thus they will not be covered by this decision. The Council's decision here is limited to addressing codes 95920, 95926, and 95861.

the referral, dated February 13, 2012 and received by the Council on February 21, 2012, is entered into the record as Exh. MAC-2.

For the reasons and bases set forth below, the Council reverses the ALJ's decision. Medicare Part B payment is not available for the global services billed by the appellant under codes 95920, 95926, and 95861 as furnished to the beneficiary on the date of service at issue.

BACKGROUND

On June 10, 2010, the appellant furnished the inpatient beneficiary, and billed the Medicare Part B contractor for, surgical-related intraoperative testing services under codes 95920 (intraoperative neurophysiology testing, per hour, list separately in addition to code for primary procedure); and 95926 (short latency somatosensory evoked potential study, stimulation of any/all peripheral nerves or skin sites, recording from the central nervous system, in lower limits). On November 4, 2010, the appellant furnished the inpatient beneficiary, and billed the Medicare Part B contractor for, surgical-related intraoperative testing services furnished under billing codes 95920 and 95926, as well as under 95861 (needle electromyography, two extremities with or without related paraspinal nerves). The claims were denied in their entirety through the reconsideration level of review on the basis that the services cannot be paid when submitted using place of service code, "-21" (inpatient hospital).[2] The appellant physician's practice, and not the beneficiary, was assigned financial liability for the denied charges.

On further review, the ALJ reversed the denials. The ALJ noted that in each case, the services were furnished for intraoperative neurophysiological monitoring and to protect the patient against neural damage or injury during surgery. The ALJ further noted the appellant's assertions that he owned the machines used to perform the procedures, and that the hospitals where the surgeries were furnished did not have this type of equipment. Dec. at 4-5. The ALJ found coverage, reasoning –

[2] *See* Medicare Claims Processing Manual (MCPM), CMS Pub. 100-04, Ch. 26, §§ 10.5 (Place of Service Codes (POS) and Definitions); 10.6 (Carrier Instructions for Place of Service (POS) Codes).

> The Court finds that the services at issue are covered and payable under Medicare. The QIC found that [Medicare contractors] may not pay for the technical component of services furnished to hospital [in]patients. However, this case presents a unique set of circumstances in that the hospital is not capable of providing the services at issue to its patients and must call upon the appellant to render those services. Accordingly, the hospital bundling rules cannot apply because the hospital did not provide the service or equipment. The hospital that uses the appellant's services is unable to submit a bill to Medicare for the technical component of these services because it did not provide the services. As such, the Appellant stands in the hospital's shoes. Therefore, the Appellant should be able to submit a claim for services he rendered to an inpatient and be paid under Medicare Part B as a global provider.

ALJ Dec. at 5.

This case is before the Council on CMS's memorandum of referral requesting that we review, on our own motion, the ALJ's decision based on material legal error. CMS argues that the ALJ erred in concluding that a physician may be paid for a technical component of diagnostic testing services furnished to a hospital inpatient, as the payment for the technical component of diagnostic tests is included in the Medicare reimbursement for inpatient hospital services paid under the hospital prospective payment system (PPS) on the basis of prospectively determined rates and applied on a per discharge basis. Exh. MAC-1.

AUTHORITIES

Section 1848 of the Social Security Act (Act) is the statutory authority for Medicare Part B reimbursement of physicians' services. In part, section 1848 establishes fee schedules and instructions for determining the relative values for physicians' services. Section 1848(c)(5) of the Act authorizes the Secretary to establish a uniform procedure coding system for all physician services. Section 1848(c)(4) authorizes the Secretary to establish "ancillary policies (with respect to use of modifiers, local codes, and other matters) as may be necessary to implement" the fee schedule. Section 1848(i)(1) of the Act prohibits administrative and judicial review of "the

establishment of the system for the coding of physicians' services under this section" and CMS's determination of "relative values and relative value units" for physician services paid in accordance with the fee schedule.

The implementing regulations provide that payment is computed based on the relative value units (RVUs), geographic adjustment factor, and conversion factor for each service. CMS establishes uniform definitions of services, codes to represent the services, and payment modifiers to the codes, as well as uniform ancillary policies necessary to implement the fee schedule. 42 C.F.R. § 414.40. CMS created the Healthcare Common Procedure Coding System (HCPCS) to develop uniform national definitions of physician services, codes for those services and payment modifiers, to process, screen, identify, and pay Medicare claims. *See* 42 C.F.R. §§ 414.2 and 414.40. The Current Procedure Terminology (CPT) is an American Medical Association publication of billing codes for medical services. The HCPCS incorporates the CPT coding system and includes additional coding references.

Under the PPS for hospital inpatient services, hospitals are paid "on the basis of prospectively determined rates and applied on a per discharge basis." *See* Act, § 1886(d); 42 C.F.R. § 412.1(a). The types of discharges are classified according to a list of Diagnosis Related Groups (DRGs). Generally, the payment amount for a given DRG constitutes payment in full to the hospital for the inpatient operating costs. *See generally* Medicare Claim Processing Manual (MCPM), CMS Pub. 100-04, Ch. 3, § 20.

All items and non-physician services furnished to inpatients must be furnished directly by the hospital or billed through the hospital under arrangements. This provision applies to all hospitals, regardless of whether the hospitals are subject to PPS. MCPM, Ch. 3, § 10.4. The MCPM provides that certain services furnished to inpatients are covered under Part A and, consequently, are covered by the PPS rate or reimbursed as reasonable costs under Part A to hospitals excluded from PPS. Those services include diagnostic laboratory and radiology services. *See* MCPM, Ch. 3, § 10.4.A.

The MCPM, Ch. 3, § 40.3.B provides, in part: "Diagnostic services (including clinical diagnostic laboratory tests) provided to a beneficiary by the admitting hospital, or by an entity wholly owned or wholly operated by the admitting hospital

(or by another entity under arrangements with the admitting hospital), within 3 days prior to and including the date of the beneficiary's admission are deemed to be inpatient services and included in the inpatient payment, unless there is no Part A coverage."

The final rule implementing the physician fee schedule (PFS) discusses services that include both a professional and technical component:

> There are three types of physicians' services that have both professional and technical components. One group is diagnostic and therapeutic radiology services; the second is certain diagnostic tests that involve a physician's interpretation; and the third is made up of physician pathology services. If services are performed in a hospital setting, the physician bills only for the professional component. If a physician pathology service is performed in an independent laboratory, a global billing for both components is submitted.

56 Fed. Reg. 59514 (Nov. 25, 1991). CMS has indicated that there is no Medicare Part B reimbursement for the technical component of physician services when those services are furnished to hospital inpatients. CMS stated –

> If [diagnostic testing] services are performed in a hospital setting, the physician bills only for the professional component.

Id.

CMS also explained:

> Services that have an "NA" in the "Facility PE RVUs" column of Addendum B are typically not paid using the PFS when provided in a facility setting. These services (which include . . . the technical portion of

> diagnostic tests) are generally . . . bundled into the hospital inpatient prospective payment system payment).

74 Fed. Reg. 62015 (Nov. 25, 2009).

Also instructive is Local Coverage Article for Nerve Conduction Studies (NCS)/Electromyography (EMG) – Supplemental Instructions Article (A546185). It states, in pertinent part:

> The global service of [nerve conduction studies] and [EMG] may be billed in office (11) or SNF (32) only for patients whose Part A benefits have been exhausted . . .
>
> Use modifier TC when reporting the technical component of these services. The technical component is payable in office (11) or SNF (32) only for patients whose Part A benefits have been exhausted . . .
>
> Use modifier 26 when reporting the professional component of the services. The professional component is payable in office (11), in-patient hospital (21), out-patient hospital (22), emergency room (23), skilled nursing facility (32) only for patients whose Part A benefits have been exhausted . . .

As CMS notes, the Article expressly applies to services billed under code 95861. However, similar provisions addressing code 95926 are found in Article A48366.

DISCUSSION

In the referral memorandum, CMS argues that the ALJ erred in determining that the appellant may be reimbursed for the technical component of the tests because he furnished his own testing equipment, which was otherwise unavailable in the hospital. Exh. MAC-1. CMS argues that payments made under the inpatient prospective payment system are payment for *all* covered inpatient hospital services, which the hospital must cover either directly or under arrangements with outside providers and/or suppliers. In such circumstances, an outside provider or supplier must make financial arrangements with the hospital for reimbursement for the technical component of furnishing the

procedure rather than billing the technical component directly to the Medicare Administrative Contractor. *Id.*

The Council has reviewed the complete record in this case as well as the contentions of the appellant. The Council agrees with CMS. The issue in this case is not whether the services were medically necessary. Rather, the issue is whether separate payment may be made for the technical component of the services at issue under Part B, or whether the cost of the technical component are subsumed into, and therefore should be reimbursed from, the hospital's Part A reimbursement under the prospective payment system.

The appellant billed for the services in question using codes 95920, 95926, and 95861. The appellant billed the services without using modifiers, such as "TC," to designate a technical component, or "-26," to designate a professional component. Exh. 1 at 1; *see also* Exh. 2. By not using modifier(s), the appellant billed for both the technical and professional components, indicating that the appellant is requesting global reimbursement for both components. Addendum A to the 2010 PFS explains, in relevant part:

> A modifier is shown if there is a technical component (modifier TC) and a professional component (PC) (modifier -26) for the service. If there is a PC and a TC for the service, Addendum B contains three entries for the code. A code for: the global values (both professional and technical); modifier -26 (PC); and, modifier TC. The global service is not designated by a modifier, and physicians must bill using the code without a modifier if the physician furnished both the PC and the TC of the service.

74 Fed. Reg. 62015 (Nov. 25, 2009). For each of the codes – 95920, 95926, and 95861 – Addendum B to the 2010 PFS separately lists the codes when billed globally, with a TC modifier, and with a -26 modifier. For each code, there is an "NA" in the column for Facility [Practice Expense] RVUs" when billed globally or with a TC modifier. When billed with a -26 modifier, each service includes a "Facility PE RVUs" value. *Id.* at 62133, 62134.

Addendum A to the 2010 PFS further provides –

> Services that have an "NA" in the "Facility PE RVUs" column of Addendum B are typically not paid using the PFS when provided in a facility setting. These services (which include "incident to" services and the technical portion of diagnostic tests) are generally paid under either the outpatient hospital [PPS] or bundled into the hospital inpatient [PPS] payment.

Id. at 62015.

The ALJ's decision in the present case was erroneous inasmuch as the comments to the final rule for the PFS, the 2010 PFS, and program guidance materials, read together, provide that Medicare Part B payment may not be made for the technical component of the services in question when the services are furnished to hospital inpatients. Medicare reimbursement for the technical component is included in the PPS DRG payment made for the hospital inpatient stay. The payment amount for a particular DRG constitutes payment in full to the hospital for all inpatient operating costs. This includes payment for the non-physician-service portion of testing services, i.e., the technical component, furnished to hospital inpatient beneficiaries. Medicare Part B will only pay for the non-physician portion of diagnostic tests if payment is not available under Part A. When the services at issue are furnished to an inpatient, the physician may not bill Medicare for the technical component and may only be paid directly by the Medicare Part B contractor for the professional component of the tests. It is irrelevant that the hospital cannot separately bill Medicare for additional payment for the technical component; the hospital is already reimbursed for the technical component in its PPS DRG payment.

The appellant argues that the Medicare provisions pertaining to the billing of diagnostic services are inapplicable here because the services furnished consisted of "intraoperative monitoring procedures" rather than "diagnostic testing services," within the common dictionary meaning of the word "diagnostic." However, the commonplace use of this term is not determinative. Under the Medicare regulations, "inpatient hospital services" (i.e., those for which the hospital is reimbursed under the prospective payment system) include "drugs, biologicals, supplies, appliances *and equipment,"* as well as "certain other diagnostic *or therapeutic* services" (*italics added.)* 42 C.F.R. § 409.10(a)(5),(6). Thus, payment under inpatient prospective payment (for which separate billing to the contractor is

prohibited under 42 C.F.R. § 412.50(c)) is not limited only to diagnostic services. Moreover, the appellant billed using codes defined as "study" and "testing" codes. The contractor has specified, through local coverage articles, that for the codes at issue, the technical component of the services identified by these codes may not be billed to the contractor when furnished in an inpatient hospital setting. The Council gives substantial deference to agency policy and finds no compelling reason to depart from that policy here. 42 C.F.R. § 405.1062(a).

The appellant again contends that the hospital in which the beneficiary was an inpatient does not possess the specific equipment or staff required to provide the intraoperative monitoring as requested by the surgeon. Exh. MAC-2. Therefore, according to the appellant, matters of "impropriety and fraud" would arise if the hospital included the technical component in its billing. *Id.* This argument demonstrates a misunderstanding of the principles of Medicare Part A PPS reimbursement to hospitals. As noted above, a hospital's Medicare payment under PPS is not based on the individual items and services provided to each inpatient; rather it is a single global payment based on each inpatient's diagnosis. Further, as CMS correctly argues, the applicable regulations provide that a hospital reimbursed under PPS must furnish "all necessary covered services either directly or under arrangements." Exh. MAC-1, at 10 (quoting 42 C.F.R. § 412.50(c)). This includes all necessary equipment. As CMS observes, "under arrangements" means that if the hospital does not own or maintain the equipment necessary to provide certain inpatient services, it must make financial arrangements with the owner of the equipment to fulfill the hospital's responsibility to provide all necessary non-physician services to its inpatients. *See id.*

Thus, in the present case, the fact that the hospital in question does not own or otherwise have the necessary testing equipment available, or that the appellant purchased expensive testing equipment used to furnish the services, is not a basis for ordering Medicare to make Part B payment for the technical component of such services. The hospital bears the responsibility to furnish the technical component as non-physician services provided to the hospital's inpatients. If the hospital does not furnish these components directly, the hospital and the appellant, a physician practice offering these services, may make appropriate arrangements for reimbursement from the hospital's PPS payments of the practice's expenses as owner of the testing equipment.

The issue of whether the appellant in this instance may pursue the hospital in question for the recovery of any portion of the cost of the services at issue is not within the scope of this decision. We do note, however, that the contractor informed the appellant that the denial of the claim in its entirety was a technical billing denial for which the appellant must bear the expenses. Exh. 6, at 28-29 ("The service in question . . . is denied as provider liable. The provider cannot bill the beneficiary for any amounts denied under this contractual obligation. The beneficiary has no financial obligation to this claim.

The Council reverses the ALJ's decision.

MEDICARE APPEALS COUNCIL

/s/ Gilde Morrisson
Administrative Appeals Judge

/s/ Stanley I. Osborne, Jr.
Administrative Appeals Judge

Date: April 12, 2012