DEPARTMENT OF HEALTH AND HUMAN SERVICES
DEPARTMENTAL APPEALS BOARD

DECISION OF MEDICARE APPEALS COUNCIL
Docket Number: M-10-1181

In the case of	**Claim for**
Jacksonville Hearing & Balance Institute (Appellant)	Supplementary Medical Insurance Benefits (Part B)
**** (Beneficiaries)	**** (HIC Numbers)
First Coast Service Options (Contractor)	**** (ALJ Appeal Number)

The Medicare Appeals Council (Council) has decided, on its own motion, to review the Administrative Law Judge's (ALJ's) "fully favorable" decision dated March 17, 2010, because it contains an error of law material to the outcome of the claims. *See* 42 C.F.R. § 405.1110. This case arises from the appellant's claims for six units of sinusoidal vertical axis rotational testing, billed as HCPCS code 92546, which it furnished to each of 84 individual beneficiaries, each on a single date of service in either 2007 or 2008.[1,2] In each instance, the Qualified Independent Contractor (QIC) allowed payment for the first unit billed, but denied payment for the additional units at issue. ALJ Master File, Exh. 1. On appeal, the ALJ granted coverage for the second through sixth units of testing at issue.

[1] The Centers for Medicare & Medicaid Services (CMS) has 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). CMS also utilizes the American Medical Association (AMA)'s annual publication of Current Procedural Terminology (CPT) codes.

[2] To maintain privacy, the Council will refer to the beneficiaries by their initials. Their full names and HICNs, as well as the specific dates of service at issue, are listed in Attachment A to this decision.

In deciding whether to accept own motion review, the Council limits its review of the ALJ's decision "to those exceptions raised by CMS." 42 C.F.R. § 405.1110(c)(2). We have carefully considered the record that was before the ALJ, as well as the timely-filed memorandum from the Centers for Medicare & Medicaid Services (CMS) dated May 10, 2010, and the appellant's June 9, 2010, response. We enter the CMS memorandum into the administrative record as Exhibit (Exh.) MAC-1, and the appellant's response, including attachments, as Exhibit MAC-2.

As explained in further detail below, the Council hereby reverses the ALJ's decision. Specifically, we vacate the ALJ's determination that Medicare coverage is appropriate for the second through sixth units of testing for each beneficiary as billed by the appellant. We conclude that the appellant is not entitled to any additional payment beyond the one unit of testing per beneficiary, per date of service, already allowed by the QIC pursuant to the National Correct Coding Initiative (NCCI) and its Medically Unlikely Edit (MUE) concept. We also conclude the appellant may not bill the beneficiaries for these additional units of testing.

BACKGROUND AND PROCEDURAL HISTORY

The appellant billed Medicare for six units of sinusoidal vertical axis rotational testing, using HCPCS code 92546, which it furnished to 84 individual beneficiaries, each on a single date of service in either 2007 or 2008. As explained in the Medicare contractor's applicable local coverage determination (LCD):

> The vestibular system is the system of balance and equilibrium. The vestibuloocular reflex (VOR) forms the basis for many of the clinical tests used to evaluate balance function. The vestibular system controls reflexes that maintain stable vision and posture.
>
> Vestibular function tests are tests of function. The tests are used to determine potential causes of balance disturbances, and they [] help to determine if there is a problem with the vestibular portion of the brainstem and inner ear. The balance system depends on the inner ear, the eyes and the muscles and joints to send information related to the body's movement and

> orientation in space. When there are problems with the inner ear or other parts of the balance system, the patient may present with symptoms of vertigo, dizziness, imbalance or other symptoms.
>
> * * *
>
> [In HCPCS code] 92546 - Sinusoidal vertical axis rotational testing, [t]he patient is seated in a rotary chair with the head bent forward 30 degrees. ENG [electronystagmogram] electrodes are placed or VNG [videonystagmography] goggles are placed to measure nystagmus while the chair is rotated with the patients[’] eyes closed. A recording is made and studie[d] to determine an abnormal labyrinthine response on one side or the other. Auto Head Rotation Tests, sometimes referred to as Active-Head Rotation Tests, involve[] recording head and eye position while the patient actively turns his or her head side to side or up and down at progressively faster frequency, may be performed if the rotary chair is not available/used. These tests are not “head-shake” tests.

LCD for Vestibular Function Tests (L24039).[3]

For each beneficiary on each date of service, in addition to other diagnostic testing codes not at issue here, the appellant billed six units of 92546 with the -59 modifier, indicating it had performed a distinct procedural service. *See, e.g.,* M.A. Claim File, Exh. 1 at 17; *see also* American Medical Assn. HCPCS and CPT CodeBook 2008. During prior stages of the appeals process, the appellant maintained that such billing was appropriate because it tested each beneficiary in a rotary chair at six separate frequencies, and thus, each “unit” billed represented a different frequency and a distinct procedure. *See, e.g.,* M.A. Claim File, Exh. 1 at 1 (request for hearing), 15 (request for reconsideration), 16 (request for redetermination).

[3] LCD L24039 is available online at http://www.cms.gov/mcd/viewlcd.asp?lcd_id=24039&lcd_version=6&show=all (last visited July 21, 2010).

The Medicare contractor processed the appellant's claims in a variety of ways.[4] Initially, the contractor either denied payment for all of the units billed, or allowed payment for one of the units billed. *See, e.g.,* M.A. Claim File, Exh. 1 at 17 (no units allowed); F.L. Claim File, Exh. 1 at 16 (one unit allowed).

Upon redetermination, in most instances, the contractor allowed one unit of testing and denied reimbursement for the additional five units at issue. *See, e.g.,* V.Mc. Claim File, Exh. 1 at 12-14. In other instances, the contractor's redetermination only addressed and denied reimbursement for five units of testing. *See, e.g.,* M.A. Claim File, Exh. 1 at 12-14.

Upon reconsideration, the QIC generally allowed the first unit billed for each beneficiary, but denied payment for the second through sixth units at issue.[5] *See, e.g.,* ALJ Master File, Exh. 1 at 66-69. In some instances, the QIC only addressed and denied reimbursement for the five additional units of testing at issue. *Id.* at 1-4. The QIC explained that CMS implemented its MUE program to reduce the rate of Part B claims that are paid improperly and that "[q]uantities billed in excess of the number of units covered are considered 'medically unlikely,' and are automatically denied." *Id.* at 2. The QIC also explained that "[t]he MUE concept does not permit physicians or suppliers to bill the beneficiary for excess charges due to units of service greater than the MUE." *Id.*

On appeal, and after conducting a hearing with the appellant's counsel and witnesses, the ALJ issued a "fully favorable" decision, granting Medicare coverage for the second through sixth units of testing at issue, relying upon LCD L24039. Dec. at 2, 6-11.

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[4] The CMS referral does not accurately recount the procedural history of this case. For example, the referral states: "At first, all claims were paid." In support of this statement, it cites to the "ALJ Master File 2, Exh. 7 at 59, *et seq*." Exh. MAC-1 at 3. However, the documents referenced consist of claims data for beneficiaries whose claims are not part of the instant appeal.

[5] There is one notable exception to this statement. In the case of Ju.C., the QIC determined that the documentation submitted supported the number of units billed (six) and allowed five units of testing. ALJ Master File, Exh. 1 at 71-73. The QIC reasoned it could not reimburse the appellant for the sixth unit because the carrier had already done so below. *Id.*

CMS referred the ALJ's decision for Council review. 42 C.F.R. § 405.1110(b). Exh. MAC-1. Before the Council, CMS maintains that the ALJ erred in granting coverage for the units of sinusoidal vertical axis rotational testing in excess of one per beneficiary encounter because they are not covered pursuant to the carrier's applicable LCD or payable pursuant to the NCCI's MUE concept. *Id.* CMS further asserts that the medical necessity of the testing and its payment for the initial unit of testing for each beneficiary is not at issue. *Id.* CMS also contends that the ALJ erred in reviewing the MUE value for code 92546 and finding it did not limit the appellant's claims. *Id.*

In response to the CMS memorandum, the appellant asserts that the Council should dismiss CMS' referral because neither CMS nor its contractors participated below as parties to the ALJ hearing, and therefore, CMS lacks standing to appeal the ALJ's decision. Exh. MAC-2. The appellant does not raise any substantive exceptions to the referral memorandum. *Id.*

DISCUSSION

A. Procedural Considerations

As a preliminary matter, the appellant requests that the Council dismiss CMS' referral because neither CMS nor its contractors participated below as parties to the ALJ hearing, and therefore, it lacks standing to appeal the ALJ's decision. Exh. MAC-2. In support of its position, the appellant references and includes a highlighted copy of the regulations at 42 C.F.R. sections 405.1100 and 405.1102, which address the filing of requests for review. These sections do not apply to agency referrals for the Council's own motion review which are made in accordance with 42 C.F.R. section 405.1110. *Id.*

The governing regulation at 42 C.F.R. section 405.1110(a) provides that the Council "may decide on its own motion to review a decision or dismissal issued by an ALJ. CMS or any of its contractors may refer a case to the [Council] for it to consider reviewing under this authority anytime within 60 days after the date of an ALJ's decision or dismissal."[6] 42 C.F.R. § 405.1110(a). The regulation also sets forth specific requirements for the referral of cases to the Council. *Id.* at

[6] The appellant also included a copy of this regulation with its submission to the Council. *See* Exh. MAC-2, tab 3 at 3. However, the appellant apparently did not consider its application to the instant case.

(b)-(c). In this case, the CMS referral comports with these regulatory requirements. There is no basis for the Council to dismiss the CMS referral.

B. Coverage Determination

As noted above, the Council limits its review of the ALJ's decision "to those exceptions raised by CMS." 42 C.F.R. § 405.1110(c)(2). The issue in this case, as framed by CMS in its referral memorandum, "is not whether vestibular testing is reasonable and necessary, but whether the [a]ppellant may bill for six units of 92546 for each patient encounter." Exh. MAC-1 at 8. CMS also maintains that "payment for one unit of CPT code 92546 constitutes Medicare's full payment for each procedure performed." *Id.* at 13.

In its Medicare Claims Processing Manual (MCPM), CMS explains the correct coding initiative edits as follows:

> Medicare does not make separate payment for procedures that are part of a more comprehensive group of services, nor does it make payment for services that cannot be performed at the same time. **These are not medical necessity denials.** Instead, payment for the comprehensive procedure includes any separately identified component parts of the procedure. **The limitation on liability protections in § 1879 of the Act are not a consideration nor are the physician refund protections in § 1842(l) of the Act a consideration.** The maximum a provider may bill a Medicare beneficiary is whatever the limiting charge is for the comprehensive (Column I) service. This policy has been in effect since January 1, 1991.

MCPM, Pub. 100-04, Ch. 23 at § 20.9.2 ("Limiting Charge and CCI Edits") (emphasis added).[7] In this case, the additional units of service billed during single sessions were denied as a result of NCCI edits, not medical necessity. As noted, there is no dispute that the test itself was medically necessary. Nor is the applicability of LCD L24039 to this case, or that this LCD contemplates coverage, though seldom, of additional unit(s) billed during one session, but only if requisite medical documentation requirements are met. *See* LCD L24039; Exh. MAC-1

[7] CMS Manuals are available online at http://www.cms.gov/Manuals (last visited July 21, 2010).

at 2, 7-8. As CMS notes, in Exh. MAC-1 at 2 and 8-9, the appellant does not assert that it performed six distinct procedures; rather, six units were billed for each session. But the ALJ, in essence, relied upon the LCD to find that five additional units per patient encounter were covered as medically reasonable and necessary. Dec. at 11.

The Council agrees with CMS that the ALJ's reliance on the LCD in this instance, to allow coverage of five additional units of 92546 in each beneficiary claim, was misplaced, as we will explain below. The contractor's LCD provides policy guidance on Medicare coverage of the underlying services at issue; it does not provide *billing or payment* guidance, a matter distinct and separate from medical necessity and coverage. This case turns on billing and payment issues. Therefore, consistent with CMS' referral and the MCPM, the Council will address below those issues as applicable to this case. We will not consider the medical necessity of the test for each beneficiary in this case.

C. The National Correct Coding Initiative

The MCPM states, in relevant part:

> The Correct Coding Initiative was developed to promote national correct coding methodologies and to control improper coding leading to inappropriate payment in Part B claims.
>
> * * *
>
> The principles for the correct coding policy are:
>
> > The service represents the standard of care in accomplishing the overall procedure;
> >
> > The service is necessary to successfully accomplish the comprehensive procedure. Failure to perform the service may compromise the success of the procedure; and
> >
> > The service does not represent a separately identifiable procedure unrelated to the comprehensive procedure planned.
>
> * * *

> All services integral to accomplishing a procedure are considered bundled into that procedure and, therefore, are considered a component part of the comprehensive code.
>
> * * *
>
> The narrative for many CPT codes includes a parenthetical statement that the procedure represents a "separate procedure."

MCPM, Ch. 12 at § 30. CMS has also explained that it "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." CMS website at http://www.cms.gov/NationalCorrectCodInitEd/01_overview.asp#TopOfPage ("National Correct Coding Initiative") (last visited July 21, 2010).

As one part of the NCCI, CMS "developed Medically Unlikely Edits (MUEs) to reduce the paid claims error rate for Part B claims. An MUE for a HCPCS/CPT code is the maximum units of service that a provider would report under most circumstances for a single beneficiary on a single date of service." CMS website at, http://www.cms.gov/NationalCorrectCodInitEd/08_MUE.asp#TopOfPage ("Medically Unlikely Edits") (last visited July 21, 2010). The MUE concept "was implemented January 1, 2007 and is utilized to adjudicate claims at Carriers, Fiscal Intermediaries, and DME MACs." *Id.*

The claims at issue arose from services furnished on September 7, 2007, through September 3, 2008. *See* Attachment A. Thus, the ALJ should have more fully considered the specific NCCI coding edits in effect during the period of service at issue, including the applicable MUE edits. As noted by CMS in its referral memorandum, code 92546 has an MUE edit for all units of service exceeding one during the period of service at issue. Exh. MAC-1 at 6. Before the Council, the appellant has not raised any contentions regarding the MUE edit, nor has it produced any evidence to support its original claims for six units of testing for each beneficiary, including its use of the -59 modifier to indicate the performance of a distinct procedure. Exh. MAC-2. A review of the evidence of record leads the Council to the opposite conclusion: the appellant

routinely performed the same testing, including six frequencies, and billed Medicare for six units of the testing, regardless of the individual characteristics of any one beneficiary's medical condition. Thus, we find that the record does not support the appellant's use of the -59 modifier to bypass the MUE in effect during the period of service at issue. Accordingly, we find that the appellant is not entitled to reimbursement for the second through sixth units of 92546 testing at issue.

D. Appellant's Contentions

Before the ALJ, the appellant asserted, among other things, that the code at issue is outdated, that Medicare's MUE value for the code has not kept pace with technological advancements, and that it is not financially feasible for it to continue performing the tests at issue if it can only be reimbursed for one unit of service. Dec. at 7-9. The ALJ agreed that "Medicare's MUE value for 92546 has not kept up with the new technology and multiple testing performed by the computerized rotational chair." Dec. at 10. These contentions do not provide a basis for the ALJ or the Council to grant additional payment beyond the one unit allowed under the NCCI and MUE policies.

The 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). The CMS also establishes uniform "national ancillary policies necessary to implement the fee schedule for physician services." *Id.* at (b). The NCCI and MUE are examples of these necessary policies. The physician fee schedule establishes uniform national payment amounts for each defined service, based on relative value units 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.

Inherent in the definition of code 92546 and the assignment of RVUs is the concept that one unit may be billed for each patient encounter. The MUE limitation is a necessary tool to enforce that definition, as is the definition of modifier 59. The calculation of the RVUs for payment already takes into account the practice expenses associated with that code. See, e.g. 73 Fed. Reg. 69725, 69731 (Nov. 19, 2008).

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 adjust the MUE for this or any other HCPCS code. Yet this is the precise effect of the ALJ's reasoning that the code and MUE have not kept up with changes over time, so additional payment should be made for five extra units of code 92546 in each patient encounter. If the appellant would like to challenge the number of units considered medically unlikely for this HCPCS code, it should "submit a request for reconsideration of an MUE value" and follow "the procedure described in the MUE Frequently Asked Questions (FAQ)" page of the CMS website.[8] According to the CMS website, such requests should be addressed to National Correct Coding Initiative, Correct Coding Solutions, LLC, P.O. Box 907, Carmel, IN 46082-0907. Or it may seek an increase in the RVUs as part of the annual physician fee schedule rulemaking.

The appellant also seems to take issue with the utilization guidelines set forth in the applicable LCD. Similarly, the Council has no authority to review the validity of any LCD. The regulations at 42 C.F.R. part 426 provide a process for reviewing the validity of LCDs. The review of an LCD is distinct from the claims appeal process in 42 C.F.R. part 405, subpart I, under which the present case arose. 42 C.F.R. § 426.310(a). If the appellant wishes to challenge the validity of an LCD, it must do so before an ALJ in the Civil Remedies Division of the Departmental Appeals Board, not before the Medicare Appeals Council. *See* Act at § 1869(f)(2)(A); 42 C.F.R. Part 426, Subparts C and D.

[8] Available online at http://www.cms.gov/NationalCorrectCodInitEd/08_MUE.asp#TopOfPage (last visited July 21, 2010).

DECISION

It is the decision of the Medicare Appeals Council that the appellant is not entitled to separate or additional payment for units two through six of the 92546 testing billed. The appellant may not bill the beneficiaries for these non-covered services.

MEDICARE APPEALS COUNCIL

/s/ Susan S. Yim
Administrative Appeals Judge

/s/ Clausen J. Krzywicki
Administrative Appeals Judge

Date: August 2, 2010