### CMS Referral for Own Motion Review by DAB/MAC

<table>
<thead>
<tr>
<th>Appellant at ALJ Level</th>
<th>ALJ Appeal Number</th>
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<tbody>
<tr>
<td>M. E. Umlas, M.D.</td>
<td>1-765778336, 1-765770306, 1-765770448</td>
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<tr>
<th>Beneficiary (if not the Appellant)</th>
<th>List attached</th>
<th>ALJ Decision Date</th>
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<tbody>
<tr>
<td>Multiple</td>
<td></td>
<td>August 15, 2011</td>
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<thead>
<tr>
<th>Health Insurance Claim Number (HICN)*</th>
<th>Specific Item(s) OR Service(s)</th>
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<tbody>
<tr>
<td>Multiple</td>
<td>73565 (x-ray exam of knees)</td>
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<tr>
<th>Provider, Practitioner OR Supplier</th>
<th>Part A</th>
<th>Part B</th>
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<td>M. E. Umlas, M.D.</td>
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#### Basis for referral

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<th><strong>Any Case</strong></th>
<th><strong>CMS as a Participant</strong></th>
<th><strong>Pre-BIPA</strong></th>
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<tr>
<td>☑ Error of law material to the outcome of the claim</td>
<td>☑ Decision not supported by the preponderance of evidence</td>
<td>☑ Decision not supported by substantial evidence</td>
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<tr>
<td>☑ Broad policy or procedural issue of public interest</td>
<td>☑ Abuse of discretion</td>
<td>☑ Abuse of discretion</td>
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#### Rationale for Referral:

A physician billed Medicare for x-ray of knees performed on three Medicare beneficiaries using CPT codes 73564 (x-ray exam knee 4 or more) and 73565 (x-ray exam of knees) with modifier “-59” (distinct procedural service). Payment for code 73565 denied because a National Correct Coding Initiative (NCCI) edit precludes separate payment for 73565 when billed with 73564. The denials were upheld at the first two levels of appeal.

Following the May 24, 2011 telephone hearing¹, the Administrative Law Judge (ALJ) rendered favorable decisions, finding that, “the x-ray of the knees standing, anteroposterior (73565 59) is separate and identifiable procedure from the x-rays of the knees, four or more views (73564). Payment of the x-rays of the knees standing anteroposterior (73565 59) is allowed under Title XVIII of the Social Security Act.” ALJ decision at 8.²

The x-rays at issue in this case are paid under the physician fee schedule, which establishes uniform national definitions of services and payment amounts for each defined service, based on relative value units for physicians’ work, practice expense, and malpractice insurance. 42 C.F.R. § 414.22 and § 414.40. NCCI policies are part of the physician fee schedule billing and reimbursement policies defining physician services and establishing uniform payment amounts for each defined service. The NCCI is an example of an ancillary policy created under the statutory authority of § 1848(c)(4) of the Social Security Act (the Act) to determine “relative values and relative value units” and implement the nationwide physician fee schedule effectively. In this case, the NCCI “Column One/Column Two Correct Coding Edits” table does not allow use of a modifier

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¹ The hearing CD is located in the folder for appeal 1-765770306 and includes testimony relevant to appeal 1-765777862 which was sent to the DAB on September 27, 2011.

² Exhibits are taken from the purple folder with black lining for Appeal 1-765778336, unless otherwise noted.
and separate payment for 73565 when billed with 73564. The edit is consistent with CPT code descriptions and guidelines that explain code 73564 represents a complete radiological knee exam with four or more views, regardless of whether the patient is standing or lying down.

Section 1848(i)(1) of the Act prohibits review of “the establishment of the system for the coding of physicians' services under this section” as well as CMS’s determination of “relative values and relative value units” for physician services.” The NCCI edit table reflects CMS’ determination that payment for 73564 includes payment for the time and work involved in 73565. Accordingly, the ALJ erred in determining that 73565 is separately reimbursable when billed with 73564.

Background:

On August 25, 2010, August 30, 2010 and September 13, 2010, the Appellant provided x-rays of knees to three Medicare beneficiaries. Relevant to this case, the appellant billed Medicare for services using CPT codes:

- 73564 – radiologic examination, knee; complete, 4 or more views
- 73565 – radiologic examination, both knees, standing, anteroposterior

In appeal 1-765778336, the Appellant billed 73564 with the “-LT” modifier for the left knee. Exh 1 at 33. In appeals 1-765770448 and 1-765770306, the Appellant billed 73564 with the “-RT” modifier for the right knee. Exh 1 at 35 (both files). In all three cases, the Appellant billed 73565 with modifier “-59.” Exh 1 at 33 in Appeal 1-765778336 and, Exh 1 at 35 in appeals 1-765770448 and 1-765770306. The 73565-59 initially denied. The Appellant requested a redetermination, arguing, “code 73565-59 is used for standing weight bearing view of both knees when form and structure is examined.” Exh 1 at 22. The November 15, 2010 redetermination letter upheld the initial denial, explaining:

This service was denied because this service is not paid separately. We cannot pay for this when performed during the same session as another approved procedure for this beneficiary.

Effective on or after March 31, 1997, Medicare guidelines do not allow payment for 73565-59 when performed on the same day as 73564-LT. This guideline applies even if a procedural modifier is submitted which indicates that the services were performed separately.

Exh 1 at 19. The provider was found liable for the service. Id.

The Appellant requested a reconsideration on the basis that “CPT 73565-59 is used for a standing weight bearing view of both knees when form and structure is examined. This examination is performed typically on pts with osteoarthritis and for presurgical

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3 ALJ decision for Appeal 1-765770448 indicates the date of services was September 30, 2010.
planning.” *Id.* at 14. On January 21, 2011, the QIC issued an unfavorable decision on the basis that National Correct Coding Initiative will not allow separate payment for the service in question. The QIC determined:

the service represented by 73565-59 is a component of code 73564 (knee x-ray). The reports included in the request show that the X-rays were performed in the same area of the knee. There are some comprehensive/components (correct coding) and mutually exclusive code edits, which CMS does not think would ever warrant the use of any of the modifiers associated with CCI. These code pairs are assigned a correct coding modifier indicator of “0”, which means that the modifiers associated with the CCI are not allowed. There is no situation in which the providers could justify the payment for both procedures based on separate patient encounters or different anatomic sites. This is the case with code 73564 and 73565. Code 73565 has a “0” indicator when billed with code 73564 and therefore, payment cannot be made for this coding pair.

*Id.* at 7. The QIC also found the beneficiary was not liable for the charges. *Id.* at 8.

In the request for an ALJ hearing, the Appellant reiterated that the “code 73565-59 is used for a standing weight bearing view of both knees when form and structure is examined.” *Id.* at 1. In his August 15, 2011 hearing decision, the ALJ agreed with the Appellant, finding “the x-rays of the knees standing anteroposterior (73565 59) is separate and identifiable procedure from the x-rays of the knees, four or more views (73564).” ALJ decision at 8.

**Applicable Law, Regulation, and Medicare Policy:**

Section 1848 of the Act governs payment for physicians’ services under Medicare Part B, including establishment of fee schedules and instructions for determining relative values for physicians’ services. Sections 1848(c)(4) and (5) of the Act authorize the Secretary to establish a uniform procedure coding system for all physician’s services as well as “ancillary policies (with respect to the use of modifiers, local codes, and other matters) as may be necessary to implement” the fee schedule.

45 C.F.R. 162.1002(a)(5) identifies CPT-4 as the standard medical data code set physician services that CMS has adopted. The American Medical Association (AMA) publishes annual guidance for CPT coding, including code descriptions, use of modifiers, and coding instructions. CMS also provides instructions regarding correct coding policy in Chapters 12 and 23 of the Medicare Claims Processing Manual (CMS Pub 100-4) (MCPM) and the National Correct Coding Initiative Policy Manual (NCCIPM) for Medicare Services. [Http://www.cms.hhs.gov/NationalCorrectCodInitEd/](http://www.cms.hhs.gov/NationalCorrectCodInitEd/) CMS developed the NCCI:

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4 The acronyms “CCI” and “NCCI” are used interchangeably. The MCPM refers to the “CCI,” whereas the CMS Web site and the NCCIPM generally refers to the “NCCI.”
to promote national correct coding methodologies and to control improper coding that leads to inappropriate payment of Part B claims. The coding policies are based on coding conventions defined in the American Medical Association's Current Procedural Terminology (CPT) Manual, national and local Medicare policies and edits, coding guidelines developed by national societies, standard medical and surgical practice, and/or current coding practice.

NCCIPM, Introduction. CMS developed the correct coding policies and NCCI edits “for application to Medicare services billed by a single provider for a single patient on the same date of service.” *Id.* The NCCIPM includes an introduction and narrative chapters that address general coding policy as well as instructions specific to certain codes or groups of codes. As part of the NCCI system, CMS also publishes tables of edits that identify pairs of codes that should not be reported together. CMS explains:

The purpose of the NCCI edits is to prevent improper payment when incorrect code combinations are reported. The NCCI contains two tables of edits. The Column One/Column Two Correct Coding Edits table and the Mutually Exclusive Edits table include code pairs that should not be reported together for a number of reasons explained in the [NCCIPM].


For the “Column One/Column Two Correct Coding Edits” table, codes listed in “Column One” represent procedures that may include multiple services that, when performed together, should generally be billed only under that code. Codes in “Column Two” identify procedures that can be billed separately when performed individually, but when performed with a comprehensive procedure cannot be separately paid unless the edit permits the use of a modifier associated with the NCCI. If a provider reports the two codes of an edit pair, the column two code is denied, and the column one code is eligible for payment. NCCIPM, Chapter 1, § A – Introduction; § O. - Misuse of Column Two Code with Column One Code.

Chapter 1, § E of the NCCPM explains that modifiers “are attached to the end of a HCPCS/CPT code and give the physician a mechanism to indicate that a service or procedure has been modified by some circumstance but is still described by the code definition.” Each 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 can be used to bypass an edit under appropriate circumstances.” *Id.*  See also MCPM, chapter 23, § 20.9.1.

Pertinent to this case, code 73564 is listed in the “Column One/Column Two Correct Coding Edits” table as a “Column One” code. Code 73565 is listed as a “Column Two” code when billed with 73564. The modifier indicator for this pair of codes is a “0,” signaling that use of a modifier is not allowed since code 73565 is never paid separately when billed with code 73564. The effective date for this edit is January 1, 1996.

Section 1848(i)(1) of the Act precludes administrative or judicial review of “the establishment of the system for the coding of physicians’ services under this section” as
well as “the determination of relative values and relative value units” for physicians’ services. Regulations governing Part A and B fee-for-service appeals reiterate that “Any issue regarding the computation of the payment amount of program reimbursement of general applicability for which CMS or a carrier has sole responsibility under Part B such as the establishment of a fee schedule set forth in part 414 of this chapter,” is not reviewable. 42 C.F.R. § 405.926(c).

Discussion:
The appellant billed codes 73564 and 73565-59 for both the radiologic examination, knee; complete, 4 or more views and the radiologic examination, knee, both knees, standing, anteroposterior. Medicare paid for 73564 and denied payment for 73565. The ALJ found that 73565-59 is separately reimbursable because the services were separate from 73564. ALJ decision at 8.

Codes 73564 and 73565 are the subject of an NCCI edit that precludes use of a modifier and separate payment for 73565 when billed with 73564. In this case, the NCCI “Column One/Column Two Correct Coding Edits” table shows that 73565 is “Column 2” code when billed with code 73564. According to NCCI policy, this means that payment for code 73565 will be denied because payment for 73564 constitutes payment in full, unless an NCCI modifier is appropriate. For this pair of codes, the modifier indicator is “0,” denoting that a modifier is not allowed; hence the services are never paid separately. This edit has been in effect since January 1, 1996; CMS Web site at http://www.cms.hhs.gov/NationalCorrectCodInitEd/NCCIEP/list.asp#TopOfPage.

The MCPM, Chapter 23, § 20.9.1.1, provides that modifier -59 may be used to bypass coding edits “if the two procedures are performed at separate anatomic sites.” This modifier, however, is not appropriate when the modifier indicator in the NCCI table is “0,” which means “a correct coding modifier is not allowed and will not bypass the edits.” When an indicator is “0,” there can be no separate Medicare payment made for the component code. See also NCCIPM, Chapter 1, Section O – Misuse of Column Two Code with Column One Code (“If these edits allow use of NCCI-associated modifiers (modifier indicator of “1”), there are limited circumstances when the column two code may be reported on the same date of service as the column one code”).

Prior to 1999, the CPT code description for 73564 read, “73564 Knee, complete including oblique(s), and/or tunnel, and/or patellar and/or standing views.” Emphasis added. See 63 FR 47814, September 8, 1998. In 1999, the AMA revised the description to read, “radiologic examination, knee; complete, 4 or more views.” A 1998 article published by the AMA explains, “Codes 73560 – 73564 have been editorially revised to remove all reference to specific types of views of the knee, anteroposterior, lateral and oblique. The numbers of views have been added to codes 73560 and 73564 to allow greater flexibility and accuracy in coding.” CPT Assistant, “Review of the 1999 CPT Coding Changes,” November 1998.
In his request for ALJ hearing, the Appellant argued, “The CPT code 73565-59 is used for a standing weight bearing view of both knees when form and structure is examined. This is performed typically on patients with osteoarthritis and for presurgical planning.” Exh 1 at 1. This language appears almost verbatim in a Fall 2006 article in “Clinical Examples in Radiology.” The article is cited for reference with codes 73565 and 73564 in The CPT 2009 Professional Edition. The relevant portion of that article reads:

Code 73565 is used for a standing view of both knees when morphology (form and structure) is examined. This examination is performed typically on patients with osteoarthritis and for presurgical planning. This code should be reported when the anteroposterior (AP) standing view is the only view taken. This code should not be used for studies involving two or three views of each knee even if one of the views happens to be upright (see codes 73560, Radiological examination, knee; one or two views; 73562, Radiological examination, knee; three views; and 73564, Radiological examination, knee; complete four or more views, to report radiological examination of the knee).

Emphasis added. When read in its entirety, this passage expressly instructs coders not to bill 73565 with 73564, as 73564 represents the complete radiologic knee exam, including an upright view.5

Physicians who accept assignment on Medicare claims agree to accept the Medicare allowed amount as payment in full for the services they furnish and agree to charge the beneficiary no more than the deductible and coinsurance for the covered service. 42 C.F.R. § 424.55(b). The Introduction to the NCCIPM provides:

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….

In the present case, the Appellant has been paid for the procedure billed with code 73564. The Appellant may not bill the beneficiary for more than the deductible and copayment of the allowed amount for 73564.

Conclusion:

To determine the correct amount to be paid under the physician fee schedule, § 1848(c) of the Act authorizes the Secretary to “establish a uniform procedure coding system for

5 Publicly available guidance from other professional coding and radiology associations also support this position. See, e.g., http://www.aapc.com/memberarea/forums/showthread.php?t=19059 (citing the Clinical Examples in Radiology article); http://www.supercoder.com/articles/articles-alerts/rca/resolve-five-perplexing-x-ray-studies/ (“Coding experts note that when obtained during the same session as other views, the standing views would not be reported as a separate service”); http://www.wisconsinmedicalsoociety.org/education/seminar_follow-up/radiology_imaging_feb_07.
the coding of all physicians' services" as well as “ancillary policies (with respect to the use of modifiers, local codes, and other matters) as may be necessary to implement” the fee schedule. CMS' NCCI program was created under the statutory authority of § 1848(c)(4) as an ancillary policy to determine “relative values and relative value units” and implement the nationwide physician fee schedule effectively. Accordingly, NCCI policies represent Medicare's uniform national billing and reimbursement policy. According to AMA coding descriptions and NCCI edits, the payment amount for CPT code for 73564 represents the complete x-ray exam of the knees and constitutes payment in full for the procedures. Allowing separate payment for CPT code 73565 contradicts the NCCI policy and circumvents CMS’s determination of payment amounts for physician services the “relative values and relative value units” CMS has assigned to those services. Pursuant to § 1848(i)(1), CMS’s determination of payment amounts for physician services under the fee schedule is not subject to review. Because the judge erred in allowing separate reimbursement for CPT code 73565, we refer this case to the Appeals Council for review on its own motion.