Rationale for Referral:

The Appellant, an optometrist, furnished developmental and cognitive testing to the Medicare beneficiary in this case. The Appellant billed Medicare with CPT codes 96111 (developmental testing) and 96116 (neurobehavioral status exam). The neurobehavioral status exam was billed with modifier “-59” indicating a distinct, separate procedure. The services initially denied because optometrists are not eligible to bill for these types of procedures. The denial was upheld at the first two levels of appeal.

In his March 28, 2011 request for Administrative Law Judge (ALJ) hearing, the Appellant’s representative characterized the services as “Developmental Visual Motor Testing” and “Cognitive Visual Non-Motor Testing” and requested that the ALJ revise Medicare’s local coverage determination (LCD) for Outpatient Psychiatry and Psychology Services to allow payment to be made to behavioral optometrists. The Appellant argued, “The State of Kentucky allows Optometrists to use any means to examine, diagnose, and treat the eye for visual efficiency and defects.” Exh 5 at 2 (emphasis in original).

In his August 24, 2011 decision letter, the ALJ agreed, finding:

Because Kentucky law allows for optometrists [to] evaluate, diagnose and treat “diseases, disorders, or conditions” of the eye and “to determine eye health, the visual efficiency of the human eye, or the powers or defects of vision in any authorized manner”, the services at issue are covered by Medicare. Accordingly, Medicare payment is authorized for the developmental visual motor testing and cognitive non-visual testing (CPT Codes 96111 and 96116-59) provided to the beneficiary by the appellant on October 13, 2010.

ALJ decision at 7. The ALJ’s decision is in error.
First, Current Procedural Terminology (CPT) code descriptions, coding guidance and contractor coverage policy consistently and unambiguously indicate that services billed with 96111 and 96116 are central nervous system assessments. CPT coding instructions state these “codes are used to report the services provided during testing of the cognitive function of the central nervous system.” 2010 Current Procedural Terminology (CPT), Professional Edition at 484. Section 1848(i)(1) of the Act prohibits review of “the establishment of the system for the coding of physicians' services” as well as CMS’s determination of “relative values and relative value units” for physician services. The ALJ erred in allowing payment for what the Appellant and ALJ characterize as essentially vision tests using codes meant to describe cognitive and neurobehavioral assessments.

Second, local coverage determination (LCD) L26895, Outpatient Psychiatry and Psychology Services, which governs Medicare coverage of the services at issue, restricts coverage to services furnished “by psychiatrists or other physicians trained in the treatment of mental illness (MDs/DOs), clinical psychologists, clinical social workers, clinical nurse specialists and other nurses” with specialized psychiatric or mental health training. The Appellant asserts that he is licensed and trained to treat disorders and diseases of the eye—not mental illness. Pursuant to L26895, the Appellant may not bill for the central nervous system assessments at issue. ALJs are not bound by contractor LCDs but must give substantial deference to these policies if they are applicable to a particular case. If an ALJ declines to follow a policy in a particular case, the ALJ or MAC decision must explain the reasons why the policy was not followed. 42 C.F.R. § 405.1062. The ALJ erred in not considering coverage criteria and limitations on coverage in the applicable LCD.

Third, Kentucky law cited by Appellant and the ALJ does not authorize optometrists to perform the psychological evaluations at issue in this case. Title XXVI, Chapter 320, § 210 of the Kentucky Revised Statutes defines the practice of optometry as:

(a) The evaluation, diagnosis, prevention, or surgical, nonsurgical, or related treatment of diseases, disorders, or conditions of the eye and its appendages and their impact on the human body provided by an optometrist within the scope of his or her education, training, and experience and in accordance with this chapter, the ethics of the profession, and applicable law. The practice of optometry include the examination, diagnosis, and treatment of the human eye and its appendages to correct and relive ocular abnormalities and to determine eye health, the visual efficiency of the human eye, or the powers or defects of vision in any authorized manner....

Code definitions and coverage policies indicate that the services billed do not describe “evaluation, diagnosis, … or related treatment of diseases, disorders, or conditions of the eye and its appendages and their impact on the human body.” The ALJ erred in relying on Title XXVI of the Kentucky Revised Statutes as a basis for finding that the central nervous system assessments billed in this case are covered.
Fourth, even if the Appellant were authorized to furnish the services at issue, an NCCI edit precludes payment for 96111 when billed with 96116 under the circumstances presented in this case. Code 96116 is listed in the “Column One/Column Two Correct Coding Edits” table as a “Column One” code. Code 96111 is listed as a “Column Two” code when billed with code 96116. The modifier indicator for this pair of codes is a “1,” signaling that the two services may be paid separately only if documented clinical circumstances justify the use of modifier “-59” and separate billing. According to National Correct Coding Initiative instructions, this means the services can only be paid separately if the services were performed at separate anatomical locations or separate patient encounters. CMS' NCCI program was created under the statutory authority of § 1848(c)(4) as an ancillary policy to implement the nationwide physician fee schedule effectively. Section 1848(i)(1) 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 paid under the fee schedule. The NCCI is an example of an ancillary policy created under the statutory authority of section 1848(c)(4) of the Act to determine “relative values and relative value units” and implement the nationwide physician fee schedule effectively. The ALJ erred in failing to consider the applicable NCCI edit to determine whether the 96111 is separately reimbursable when billed with 96116 under the present circumstances.

Background:

The Appellant billed Medicare for central nervous system assessments/tests administered to the beneficiary on October 13, 2010. The claim included the following CPT codes:

96111 – Developmental testing, extended (includes assessment of motor, language, social, adaptive, and/or cognitive functioning by standardized developmental instruments) with interpretation and report

96116 – Neurobehavioral status exam (clinical assessment of thinking, reasoning and judgment, eg, acquired knowledge, attention, language, memory, planning and problem solving, and visual spatial abilities), per hour of the psychologist’s or physician’s time, both face-to-face time with the patient and time interpreting test results and preparing the report

CPT 96116 was billed with modifier “-59,” indicating a separate, distinct procedure. Exh 1 at 6. The claim initial denied because “this provider was not certified, eligible to be paid for this procedure/service on this date of services.” Id. at 7. In his November 19, 2010 and January 7, 2011 requests for appeal, the Appellant’s representative argued that “these services do fall within the full scope of my legal license as determined by the Attorney General of the State of Kentucky, and Optometrists are reimbursed the same as Medical Doctors. The Neuro Visual Rehabilitation Center has the same NPI number and tax i.d. number as Leadingham Eye Care Center.” Exh 1 at 2 and Exh 3 at 1.
In the January 3, 2011 decision letter, National Government Services, the Medicare contractor, issued an unfavorable decision, determining that the Appellant is “not set up with the correct provider type for [96111 and 96116-59]. Therefore, payment cannot be made.” Exh 2 at 3. The Appellant was deemed liable for services.

Likewise, in the March 21, 2011 reconsideration decision, the Qualified Independent Contractor (QIC) explained that the billing provider must be approved to bill for the tests in question, stating the Appellant was “not set up with the correct provider type for the procedures at issue. Therefore, payment cannot be made.” Exh 4 at 4. The QIC found the Appellant liable for the tests. Id.

In his March 28, 2011 letter to the Office of Medicare Hearings and Appeal, the Appellant’s representative reiterated that he’s a fully licensed behavioral optometrist and “the services do fall within the full scope of my legal license as determined by the Attorney General of the State of Kentucky, and Behavioral Optometrists are reimbursed the same as Physicians.” Exh 5 at 2. He also provided an excerpt of the Kentucky statute he felt supported his argument. Id.

On August 24, 2011, the ALJ issued a fully favorable decision, determining:

The developmental visual motor testing and cognitive non-visual motor testing were provided to treat an eye disorder caused by a stroke. Under the MBPM, an optometrist is considered a physician with respect to all services the optometrist is authorized to perform under State law or regulation. Under Kentucky law, optometrists are authorized to provide examinations and developmental visual motor testing and cognitive non-visual motor testing. Therefore, the service at issue are payable under Part B of the Medicare program.

ALJ decision at 8.

Applicable Law, Regulation, and Medicare Policy:

Correct Coding Policies

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. Section 1848(c)(5) of the Act authorizes the Secretary to establish a uniform procedure coding system for all physician’s services. Section 1848(c)(4) of the Act also authorizes the Secretary to establish “ancillary policies (with respect to the use of modifiers, local codes, and other matters) as may be necessary to implement” the fee schedule. Section 1848(i)(1) states that “there shall be no administrative or judicial review under section 1869” of “the determination relative values and relative value units under subsection (c)” or of “the establishment of the system for the coding of physicians’ services under this section.”

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1 MBPM stands for Medicare Benefits Policy Manual.
45 CFR 162.1002(a)(5) identifies CPT-4 as the standard medical data code set for 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 has also provided instructions regarding correct coding policy in Chapters 12 and 23 of the Medicare Claims Processing Manual (MCPM) (CMS Pub 100-4) and the National Correct Coding Initiative Policy Manual (NCCIPM) for Medicare Services. Http://www.cms.hhs.gov/NationalCorrectCodInitEd/. CMS explains that it:

developed the National Correct Coding Initiative (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.)

**NCCI Coding Edits**

As part of the NCCI system, CMS also publishes tables of “edits” that identify pairs of codes that should not be reported together. The CMS Web site 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 Coding Policy Manual

Http://www.cms.hhs.gov/NationalCorrectCodInitEd/.

Chapter 23, § 20.9.1 of the MCPM, provides Correct Coding Modifier Indicators and HCPCs Codes Modifiers. The Correct Coding File Formats continue to include a Correct Coding Modifier (CCM) indicator (carrier only) for both the Comprehensive/Component Table and the Mutually Exclusive Table. This indicator determines whether a CCM causes the code pair to bypass the edit. This indicator will be either a “0”, “1”, or a “9”. The definitions of each is:

0 = A CCM is not allowed and will not bypass the edits.

1 = A CCM is allowed and will bypass the edits.

9 = The use of modifiers is not specified. This indicator is used for all code pairs that have a deletion date that is the same as the effective date. This indicator was created so that no blank spaces would be in the indicator field.

**Modifier -59**
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.” 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”).

In addition to publishing CPT codes and descriptions, the AMA has created several two-character modifiers that may be appended to a CPT code to indicate that a procedure has been modified by some circumstance but is still described by the code definition. One of these modifiers is modifier -59: distinct procedural service. The CPT 2007 Professional Edition discusses use of modifier -59:

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. However, when another already established modifier is appropriate it should be used rather than modifier 59. Only if no more descriptive modifier is available, and the use of modifier 59 best explains the circumstances, should modifier 59 be used.

According to the NCCIPM, “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.” NCCIPM, Chapter 1, § E.1.d. The manual cautions:

One of the common misuses of modifier 59 is related to the portion of the definition of modifier 59 allowing its use to describe "different procedure or surgery". The code descriptors of the two codes of a code pair edit consisting of two surgical procedures or two diagnostic procedures usually represent different procedures or surgeries. The edit indicates that the two procedures/surgeries cannot be reported together if performed at the same anatomic site and same patient encounter. The provider cannot use modifier 59 for such an edit based on the two codes being different procedures/surgeries. However, if the two procedures/surgeries are performed at separate anatomic sites or at separate patient encounters on the same date of service, modifier 59 may be appended to indicate that they are different procedures/surgeries on that date of service.

Id. The MCPM explains that modifier 59 “indicates that the procedure represents a distinct procedure or service from others billed on the same date of service.” This includes a:

- different session
- different surgery
• different anatomical site or organ system
• separate incision/excision
• different lesion, or
• different injury or area of injury. [Chapter 23, § 20.9.1.1.B.]

Medicare Coverage of Optometry Services

Section 1861(r)(4) of the Act defines physician to include “a doctor of optometry, but only for purposes of subsection (p)(1) with respect to the provision of items or services described in subsection (s) which he is legally authorized to perform as a doctor of optometry by the State in which he performs them....”

Title XXVI, Chapter 320 § 210 of the Kentucky Revised Statutes\(^2\) defines the practice of optometry as:

(a) The evaluation, diagnosis, prevention, or surgical nonsurgical, or related treatment of diseases, disorders, or conditions of the eye and its appendages and their impact on the human body provided by an optometrist within the scope of his or her education, training, and experience and in accordance with this chapter, the ethics of the profession, and applicable law. The practice of optometry include the examination, diagnosis, and treatment of the human eye and its appendages to correct and relieve ocular abnormalities and to determine eye health, the visual efficiency of the human eye, or the powers or defects of vision in any authorized manner including but not limited to:

1. Prescribing and adapting lenses, contact lenses, spectacles, eyeglasses, prisms, ocular devices, and all routes of administration of pharmaceutical agents, except controlled substances classified in Schedules I and II, as authorized by KRS 320.240; or

2. Employing vision therapy or orthoptics, low vision rehabilitation, and laser surgery procedures, excluding retina, LASIK, and PRK.

The practice of optometry includes the correction and relief of ocular abnormalities by surgical procedures not excluded in paragraph (b) of this subsection;

(b) The following procedures are excluded from the scope of practice of optometry, except for the preoperative and postoperative care of these procedures:

1. Retina laser procedures, LASIK, and PRK;

2. Nonlaser surgery related to removal of the eye from a living human being;

3. Nonlaser surgery requiring full thickness incision or excision of the cornea or sclera other than paracentesis in an emergency situation requiring immediate reduction of the pressure inside the eye;

4. Penetrating keratoplasty (corneal transplant), or lamellar keratoplasty;

\(^2\) The Kentucky Statute for optometrists is located at [http://www.lrc.ky.gov/KRS/320-00/CHAPTER.HTM](http://www.lrc.ky.gov/KRS/320-00/CHAPTER.HTM).
5. Nonlaser surgery requiring incision of the iris and ciliary body, including iris diathermy or cryotherapy;
6. Nonlaser surgery requiring incision of the vitreous;
7. Nonlaser surgery requiring incision of the retina;
8. Nonlaser surgical extraction of the crystalline lens;
9. Nonlaser surgical intraocular implants;
10. Incisional or excisional nonlaser surgery of the extraocular
11. Nonlaser surgery of the eyelid for eyelid malignancies or for incisional cosmetic or mechanical repair of blepharochalasis, ptosis, and tarsorrhaphy;
12. Nonlaser surgery of the bony orbit, including orbital implants;
13. Incisional or excisional nonlaser surgery of the lacrimal system other than lacrimal probing or related procedures;
14. Nonlaser surgery requiring full thickness conjunctivoplasty with graft or flap;
15. Any nonlaser surgical procedure that does not provide for the correction and relief of ocular abnormalities;
16. Laser or nonlaser injection into the posterior chamber of the eye to treat any macular or retinal disease; and
17. The administration of general anesthesia;
(c) Any person shall be regarded as practicing optometry if he or she:
1. Performs or advertises to perform optometric operations of any kind, including diagnosing or treating diseases of the eye or visual system or deficiencies of the eye and its appendages, or attempts to correct the vision thereof;
2. Prescribes, provides, furnishes, adapts, uses, or employs lenses, prisms, contact lenses, visual therapy, orthoptics, ocular exercise, autorefraction, or any other means or device for the aid, relief, or correction of the human eye and its appendages, except upon the written prescription of a licensed optometrist; or
3. Uses the words "optometrist," "doctor of optometry," the letters "O.D.," or other letters or title in connection with his or her name, which in any way represents him or her as being engaged in the practice of optometry; and
(d) Low vision rehabilitation.

Psychiatry and Psychology Services

Psychological and neuropsychological tests are covered under Part B pursuant to Section 1861(s)(3) of the Social Security Act.

National Government Services (NGS), the Medicare contractor in the Appellant’s jurisdiction, has issued LCD L26895, Outpatient Psychiatry and Psychology Services,
which “outlines the medical necessity requirements for Part A and Part B services in the fields of psychiatry, psychology, clinical social work, and psychiatric nursing for the diagnosis and treatment of various mental disorders and/or diseases.” L26895 governs services billed with CPT 96111 and 96116. L26895 limits coverage of the psychiatric and psychological services to those furnished by:

a. Psychiatrists (MD/DO)
b. Clinical Psychologists
c. Clinical Social Workers
d. Nurse Practitioners
e. Clinical Nurse Specialists
f. Physician Assistants
g. Other providers of mental health services licensed or otherwise authorized by the state in which they practice (e.g., licensed clinical professional counselors, licensed marriage and family therapists). These other providers may not bill Medicare directly for their services, but may provider mental health treatment services to Medicare beneficiaries under the “incident to” provision.

The LCD further specifies:

Unless otherwise indicated the above codes may be used by psychiatrists or other physicians trained in the treatment of mental illness (MDs/DOs), clinical psychologists, clinical social workers, clinical nurse specialists and other nurses with special training and/or experience in psychiatric nursing beyond the standard curriculum required for a registered nurse (e.g., Masters of Science in psychiatric nursing, or its equivalent [Advanced Registered Nurse Practitioner with a Master's degree in Mental Health, or equivalent to a Master's prepared, certified Clinical Nurse Specialist]).

Indications, D.

Consistent with CPT coding guidelines, the LCD categorizes CPT codes 96111 and 96116 as “Central Nervous System Assessments/Tests.” L26895 indicates that these codes are defined by their CPT narratives. Section VI.B. The 2010 Current Procedural Terminology (CPT), Professional Edition provides the following code descriptions:

96111 – developmental testing, extended (includes assessment of motor, language, social, adaptive and/or cognitive functioning by standardized developmental instruments) with interpretation and report

96116 – Neurobehavioral status exam (clinical assessment of thinking, reasoning and judgment, eg, acquired knowledge, attention, language, memory, planning and problem solving, and visual spatial abilities), per hour of the psychologist’s or physician’s time, both face-to-face time with the patient and time interpreting test results and preparing the report.
Discussion:

In the present case, the tests denied because the Appellant is not eligible to receive payment. This denial was upheld at both appeal levels. The ALJ, however, disagreed, finding instead that the Appellant should be paid for the tests in question. He opined that “under Kentucky law, optometrists are authorized to provide examinations and developmental visual motor testing and cognitive non-visual motor testing.” ALJ decision at 8.

The ALJ’s decision contains multiple errors. First, the CPT code descriptions for the tests at issue do not describe vision tests. Throughout the appeals process, the Appellant has characterized the procedure billed with 96111 as “Developmental Visual Motor Testing” and 96116 as “Cognitive Visual Non-Motor Testing.” See, e.g., Exh 5 at 1. The ALJ used similar language to describe the tests. ALJ at 8. The Appellant also described the testing instruments employed as “the Developmental Test of Visual-Motor Integration” and “the Test of Visual Perceptual Skills.” Exh 5 at 2. However, in authoritative CPT coding guidance, the American Medical Association categorizes codes 96101 – 96125 as “Central Nervous System Assessments/Tests” and states these “codes are used to report the services provided during testing of the cognitive function of the central nervous system.” 2010 Current Procedural Terminology (CPT), Professional Edition at 484. The code description for 96111 (developmental testing) does not mention vision or visual testing, but “includes assessment of motor, language, social, adaptive, and/or cognitive functioning by standardized developmental instruments…. The procedure described by CPT code 96116 (neurobehavioral status exam) includes “clinical assessment of thinking, reasoning and judgment, eg, acquired knowledge, attention, language, memory, planning and problem solving, and visual spatial abilities…."

Neither the Appellant nor the ALJ have authority to redefine the codes or place a different meaning on the codes when billing Medicare for services. See § 1848(i)(1) of the Act, which prohibits review of “the establishment of the system for the coding of physicians' services” as well as CMS’s determination of “relative values and relative value units” for physician services. The ALJ erred in allowing payment for what the Appellant describes as essentially vision tests using codes meant to assess cognitive and neurobehavioral infirmities.

Second, the Medicare contractor’s LCD, L26895 – Outpatient Psychiatry and Psychology Services, which sets forth coverage requirements for the developmental and neurobehavioral tests at issue, does not allow payment under the circumstances presented in this case. Consistent with AMA coding instructions, the LCD describes CPT codes 96101 – 96120 as “Central Nervous System Assessments/Tests.” For all services governed by L26895, coverage is limited to services furnished “by psychiatrists or other physicians trained in the treatment of mental illness (MDs/DOs), clinical psychologists, clinical social workers, clinical nurse specialists and other nurses” with specialized psychiatric or mental health training. The LCD does not list optometrists or
behavioral optometrists as approved entities that may furnish and bill for these services. The Appellant’s representative asserts that he is licensed and trained to treat disorders and diseases of the eye—not mental illness. Conversely, the LCD addresses only psychiatric and psychological testing and does not mention vision testing or other optometric services.

Furthermore, the Appellant identifies the patient’s diagnoses to include 378.83 (convergence insufficiency), 368.32 (visual perception without fusion), 379.58 (Deficiencies of smooth pursuit movements), 379.57 (Deficiencies of saccadic eye movements) and 368.10 (Subjective visual disturbance). None of these are deemed psychiatric diagnoses for which 96111 and 96116 may be covered, according to L26895.

We note that the Appellant requested that the ALJ revise LCD L26895 to allow behavioral optometrists to provide the testing at issue. This request must go to National Government Services, the contractor that issued L26895. Neither the ALJ nor other adjudicator in the appeals process has authority to change or review the validity of an LCD. In the event the Appellant wishes to challenge the LCD, the review process is distinct and governed by regulations at 42 C.F.R. part 426. ALJs are not bound by contractor LCDs but must give substantial deference to these policies if they are applicable to a particular case. If an ALJ declines to follow a policy in a particular case, the ALJ or MAC decision must explain the reasons why the policy was not followed. 42 C.F.R. § 405.1062. The ALJ erred in not considering coverage criteria and limitations on coverage in the applicable LCD.

Third, Title XXVI of the Kentucky Revised Statutes cited by Appellant does not authorize optometrists to perform the psychological evaluations at issue in this case. Title XXVI, Chapter 320, § 320.210 of the statute limits optometry services to “evaluation, diagnosis, prevention, or surgical nonsurgical, or related treatment of diseases, disorders, or conditions of the eye and its appendages and their impact on the human body.” The statute further restricts the practice of optometry to such services “provided by an optometrist within the scope of his or her education, training, and experience and in accordance with this chapter, the ethics of the profession, and applicable law.” Contrary to the Appellant’s assertion, the statute does not allow optometrists “to use any means to examine, diagnose, and treat the eye.” Exh 5 at 2. Moreover, the Kentucky statute does not authorize optometrists to perform psychological or psychiatric assessments, nor does it authorize optometrists to assess “motor, language, social, adaptive, and/or cognitive functioning” as described by CPT code 96111 or “clinical assessment of thinking, reasoning and judgment, eg, acquired knowledge, attention, language, memory, planning and problem solving, and visual spatial abilities” as described by CPT code 96116. Accordingly, the ALJ’s reliance on Title XXVI, Chapter 320, § 320.210 of the Kentucky Revised Statutes is misplaced.

Fourth, even if the Appellant’s representative were authorized to furnish the services at issue and the services otherwise met coverage requirements, an active NCCI edit
precludes payment under the circumstances presented in this case. Code 96116 is listed in the “Column One/Column Two Correct Coding Edits” table as a “Column One” code. Code 96111 is listed as a “Column Two” code when billed with code 96116. The modifier indicator for this pair of codes is a “1,” signaling that clinical circumstances must justify the use of the modifier and documentation must justify the billing. The effective date for this edit is January 2, 2006.

The provider billed 96116 with the modifier “-59,” signifying a distinct procedural service. 

NCCI instructions state:

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.

NCCIPM, Chapter I, § E. The manual explains that the NCCI “edit indicates that the two procedures/surgeries cannot be reported together if performed at the same anatomic site and same patient encounter. The provider cannot use modifier 59 for such an edit based on the two codes being different procedures/surgeries.” Id. at § E.1.d. Only if the two procedures “are performed at separate anatomic sites or at separate patient encounters on the same date of service” may the -59 modifier be used to indicate the physician performed separate procedures on that date of service. Id. In this case, code 96111 is a component code of 96116 and generally cannot be reported with 96116. By definition, the central nervous system assessments at issue could not have been performed on separate anatomical sites. Unless performed at a separate patient encounter, 96111 cannot be considered separate and distinct from 96116. Having determined the underlying services were covered, the ALJ erred in failing to consider the applicable NCCI edit to determine whether the 96111 is separately reimbursable when billed with 96116 under the present circumstances.

Conclusion:

Because we believe the ALJ erred in allowing payment for the testing in question, we refer this case to the Medicare Appeals Council for review on its own motion.

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3 The Appellant appended the modifier “-59” to the comprehensive code instead of the component code, as required by CMS coding instructions.