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

<table>
<thead>
<tr>
<th>Appellant at ALJ Level</th>
<th>ALJ Appeal Number</th>
<th>受益人（如果不是上诉人）</th>
<th>ALJ决定日期</th>
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<tr>
<th>Health Insurance Claim Number (HICN)*</th>
<th>Specific Item(s) OR Service(s)</th>
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<tbody>
<tr>
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<td>95920 (intraoperative nerve test, add-on), 95926 (somatosensory testing), 95861 (needle electromyography)</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>Michael A Bianco, M.D., P.C.</td>
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#### Basis for referral

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<th>Any Case</th>
<th>CMS as a Participant</th>
<th>Pre-BIPA</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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<td>☑ Broad policy or procedural issue of public interest</td>
<td>☐ Abuse of discretion</td>
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#### Rationale for Referral:

A physician billed Medicare for diagnostic tests furnished to a hospital inpatient. The physician billed the Part B Medicare contractor with CPT codes 95920, 95926 and 95861, indicating place of service “-21” (inpatient hospital). Payment was denied because the services were billed with the wrong place of service. The denial was upheld at the first two levels of appeal.

In his August 22, 2011 and August 24, 2011 fully favorable decisions, the ALJ allowed coverage of the diagnostic tests finding that, because the hospital is not capable of providing the diagnostic tests:

> The appellant has met the criteria for Medicare coverage under the applicable laws, regulations and policies for payment under Medicare Part B for the intraoperative neurophysiology testing, needle electromyography, and somatosensory testing provided to the Beneficiary....Therefore, the undersigned ALJ finds that the services provided were reasonable and necessary under § 1862(a)(1)(A) of the Act.

ALJ decisions at 5.

The ALJ erred in deciding that a physician should be paid for a technical component of diagnostic tests furnished to a hospital inpatient. Although the physician brought his own equipment into the hospital to perform the studies, “payments made under the [inpatient] prospective payment systems ... are payment in full for all inpatient hospital services.” 42 C.F.R. § 412.50(a). Medicare regulations and program guidance provide that payment for the technical component of diagnostic tests is included in the payment amount 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.” 42 C.F.R. § 412.1(a). Under the PPS, all items and nonphysician services furnished to inpatients must be furnished directly by the hospital or billed through the hospital under arrangements. 42 C.F.R. § 412.50(c). Payment may be made under Part B for the nonphysician (i.e. technical) portion of diagnostic tests furnished to an inpatient only if payment for these services cannot be made under Part A. Medicare Benefit Policy Manual (MBPM) (CMS Pub 100-2), Chapter 6, § 10.

Furthermore, contractor policy guidance, supported by comments to the final rule implementing the physician fee schedule, instructions in the 2010 physician fee schedule, and CMS manuals, state Part B Medicare does not pay for the technical component of the services at issue when furnished to hospital inpatients. National Government Services' “Local Coverage Article for Nerve Conduction Studies (NCS)/Electromyography (EMG) - Supplemental Instructions Article (A46185)” addresses services billed with CPT code 95861. Article A46185 provides, “The global service of [Nerve Conduction Studies] and [Electromyography] may be billed in office (11) or SNF (32) only for patients whose Part A benefits have been exhausted....” National Government Services' “Local Coverage Article for Somatosensory Testing – Supplemental Instructions Article (A48366)” provides similar instructions with regard to CPT codes 95920 and 95926. For these services, “The global service may be billed in the office (11), nursing facility (32 - for Medicare patient not in a Part A stay), and independent clinic (49).” See also 56 FR 59514, November 25, 1991 (“If [diagnostic testing] services are performed in a hospital setting, the physician bills only for the professional component); 74 FR 62015, November 25, 2009 (“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).

Background:

On March 25, 2010 and March 30, 2010, the Appellant in this case performed diagnostic tests on Medicare beneficiaries while they were inpatients at St. Vincent Medical Center and Brookdale Hospital, respectively. Exh 2 at 7.1 Tests included:

- 95920 – Intraoperative neurophysiology testing, per hour (list separately in addition to code for primary procedure)
- 95926 – Short-latency somatosensory evoked potential study, stimulation of any/all peripheral nerves or skin sites, recording from the central nervous system, in lower limbs
- 95861 – Needle electromyography, 2 extremities with or without related paraspinal areas

1 We cite exhibits in the administrative record for appeal 1-760156881. The issues, facts and reasons for denial are substantially similar in all three cases, except that in appeal 1-760157002, the Appellant performed the testing at Brookdale Hospital.
National Government Services, the Medicare Administrative Contractor (contractor), denied payment because “treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service.” Exh 1 at 1. In the September 17, 2010 request for redetermination, the Appellant’s representative argued, “While we understand the redetermination team at [the contractor] does not view this service payable for technical and professional components to the physician, this is the correct scenario under which Dr. Bianco should be paid. Dr. Bianco is a global provider and is entitled to be paid correctly for his services.” Exh 3 at 10. On October 26, 2010, the contractor upheld the initial denial because “the two digit place of service code was not appropriate for the reported procedure code(s).” The redetermination letter found the beneficiary is not responsible for the charge. Exh 3 at 13.

On December 17, 2010, Appellant’s representative wrote:

Dr. Bianco, though Neuro Data Inc., has been providing intraoperative monitoring since 1995, with rights to perform intraoperative monitoring in 35 hospitals in the tri-state area. Dr. Bianco is a board physician certified with credentials to perform intraoperative monitoring by the (AANEM) American Association of Neuromuscular and Electrodiagnostic Medicine. He owns the Cadwell intraoperative machines and maintains them according to the manufactures standards and provides the disposables. He also employs the technologists and is responsible for their workers compensation insurance, disability insurance and employee medical benefits. Our office bills globally for this service and deserves to be paid as such.

Exh 4 at 29-30. On March 3, 2011, the QIC issued an unfavorable reconsideration decision regarding payment for codes 95920, 95926 and 95861. The QIC determined the services at issue “will not be allowed when billed in an inpatient setting.” Exh 4 at 41. The QIC also found the provider was responsible for the denied charge. Id.

In the March 8, 2011 request for ALJ hearing, Appellant’s representative reiterated the arguments made at lower levels of appeal. Exh 5 at 57-58. The ALJ determined that this situation was unique because:

[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 service 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 rendered to an inpatient and be paid. Therefore, the ALJ finds that the services at issue here satisfy applicable Medicare coverage requirements.

ALJ decision at 5.

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2 More codes were appealed in 1-760157002, so we cite that QIC decision here.
Applicable Law, Regulation, and Medicare Policy:

I. **Hospital Inpatient Prospective Payment System; Hospital Inpatient Services**

42 C.F.R. § 412.1(a) implements § 1886(d) of the Act:

by establishing a prospective payment system for the operating costs of inpatient hospital services furnished to Medicare beneficiaries in cost reporting periods beginning on or after October 1, 1983 and a prospective payment system for the capital-related costs of inpatient hospital services furnished to Medicare beneficiaries in cost reporting periods beginning on or after October 1, 1991. Under these prospective payment systems, payment for the operating and capital-related costs of inpatient hospital services furnished by hospitals subject to the systems (generally, short-term, acute-care hospitals) is made on the basis of prospectively determined rates and applied on a per discharge basis. Payment for other costs related to inpatient hospital services (organ acquisition costs incurred by hospitals with approved organ transplantation centers, the costs of qualified nonphysician anesthetist's services, as described in § 412.113(c), and direct costs of approved nursing and allied health educational programs) is made on a reasonable cost basis. Payment for the direct costs of graduate medical education is made on a per resident amount basis in accordance with §§ 413.75–413.83 of this chapter. Additional payments are made for outlier cases, bad debts, indirect medical education costs, and for serving a disproportionate share of low-income patients. Under either prospective payment system, a hospital may keep the difference between its prospective payment rate and its operating or capital-related costs incurred in furnishing inpatient services, and the hospital is at risk for inpatient operating or inpatient capital-related costs that exceed its payment rate.

42 C.F.R. § 412.50 provides that the hospital must furnish all inpatient services, either directly or under arrangement, and payment under the PPS constitutes payment in full:

(a) The applicable payments made under the prospective payment systems, as described in subparts H and M of this part, are payment in full for all inpatient hospital services, as defined in § 409.10 of this chapter. Inpatient hospital services do not include the following types of services:

(1) Physician services that meet the requirements of § 415.102(a) of this chapter for payment on a fee schedule basis.

(2) Physician assistant services, as defined in section 1861(s)(2)(K)(i) of the Act.

(3) Nurse practitioner and clinical nurse specialist services, as defined in section 1861(s)(2)(K)(ii) of the Act.

(4) Certified nurse mid-wife services, as defined in section 1861(gg) of the Act.

(5) Qualified psychologist services, as defined in section 1861(ii) of the Act.

(6) Services of an anesthetist, as defined in §410.69 of this chapter.
(b) CMS does not pay any provider or supplier other than the hospital for services furnished to a beneficiary who is an inpatient, except for the services described in paragraphs (a)(1) through (a)(6) of this section.

(c) The hospital must furnish all necessary covered services to the beneficiary either directly or under arrangements (as defined in § 409.3 of this chapter).

Under the hospital inpatient prospective payment system (PPS):

hospitals are paid a predetermined rate per discharge for inpatient hospital services furnished to Medicare beneficiaries. Each type of Medicare discharge is classified according to a list of DRGs. These amounts are, with certain exceptions, payment in full to the hospital for inpatient operating costs.

Medicare Claims Processing Manual (MCPM) (CMS Pub 100-4), Chapter 3, § 20.A.

In general, inpatient hospital services include:

(1) Bed and board.

(2) Nursing services and other related services.

(3) Use of hospital or CAH facilities.

(4) Medical social services.

(5) Drugs, biologicals, supplies, appliances, and equipment.

(6) Certain other diagnostic or therapeutic services.

(7) Medical or surgical services provided by certain interns or residents-in-training.

(8) Transportation services, including transport by ambulance.

42. C.F.R. § 409.10(a).

Also included in payment for inpatient services (unless there is no Part A coverage) are:

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.....

Id. at § 40.3.B.

“All items and nonphysician services furnished to inpatients must be furnished directly by the hospital or billed through the hospital under arrangements.” MCPM, Chapter 3, § 10.

Chapter 15, § 250 of the Medicare Benefit Policy Manual (MBPM) (CMS Pub 100-2) identifies medical and other health services furnished to inpatients of hospitals and skilled nursing facilities “covered under Part B, even though the patient has Part A coverage for the hospital or SNF stay.” The only diagnostic testing service listed in § 250 is bone mass measurements.
Chapter 6, § 10 of the MBPM identifies nonphysician medical and other health services furnished to a hospital inpatient that may be paid under Part B “but only if payment for these services cannot be made under Part A” (e.g., the patient had exhausted benefit days before admission or otherwise no eligible for or entitled to Part A coverage). Services listed as payable under Part B only when payment is unavailable under Part A include “diagnostic x-ray tests, diagnostic laboratory tests, and other diagnostic tests.”

II. Payment Under the Physician Fee Schedule

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. Payment is computed based on the relative value units (RVUs), geographic adjustment factor and conversion factor for each service. 42 C.F.R. § 414.20. To implement the physician fee schedule, CMS establishes uniform national definitions of services, codes to represent services, and payment modifiers to the codes, as well as uniform national ancillary policies necessary to implement the fee schedule. 42 C.F.R. §414.40. 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’ determination of “relative values and relative value units” for services paid under the fee schedule.

RVUs for practice expenses of a particular service vary depending on whether the service was furnished to patients in a facility (e.g., a hospital or SNF) or performed in a non-facility location (e.g. a physician’s office). 42 C.F.R. § 414.22(b)(5)(i)(A-B). In commentary to the final rule for the 2009 physician fee schedule, CMS explained, “The difference between the facility and nonfacility RVUs reflects the fact that a facility typically receives separate payment from Medicare for its costs of providing the service, apart from payment under the PFS.” 73 FR 69730, November 19, 2008.

The final rule implementing the physician fee schedule 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.


National Government Services has issued two coverage policy articles that specify, the services at issue, the physician may only bill for the global service when furnished in an office (place of service 11) or a nursing facility (place of service 32) for patients whose Part A benefits have been exhausted, and independent clinic (place of service 49). When furnished to hospital inpatients, a physician may bill only for the professional component of the service. See National Government Services’ “Local Coverage Article
Discussion:

In his request for ALJ hearing, the Appellant contended that payment was warranted because Dr. Bianco owns the equipment, employees the staff that furnish the tests, and “provides this service at the request of the surgeons for patients in hospitals that do not have the ability to provide this service in house.” Exh 5 at 57. The ALJ agreed, finding “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.” The ALJ thus determined, “the services at issue here satisfy applicable Medicare coverage requirements.” ALJ decision at 5.

The ALJ erred in allowing global reimbursement to the physician for the diagnostic tests furnished to a hospital inpatient. CMS and contractor instruction regarding the physician fee schedule provide that 95920, 95926 and 95861 are not paid globally when furnished to hospital inpatients. Similarly, regulations and guidelines regarding hospital inpatient services indicate diagnostic tests furnished to hospital inpatients are considered inpatient services and payable under the inpatient PPS.

*Services Paid Under the Physician Fee Schedule*

Medicare pays for physician services based on a fee schedule. Section 1848(a) of the Act. The 1991 final rule implementing the physician fee schedule explains that diagnostic tests are one type of physicians’ service that have both professional and technical components. The final rule states, “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 FR 59514, November 25, 1991.

National Government Services’ “Local Coverage Article for Nerve Conduction Studies (NCS)/Electromyography (EMG) - Supplemental Instructions Article (A46185)” instructs physicians to:

Report these procedure codes without a modifier if the global service is being performed. *The global service of NCS and EMG may be billed in office (11) or SNF (32) only for patients whose Part A benefits have been exhausted, and independent clinic (49).*

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, independent clinic (49), federally qualified health center (50) and rural health clinic (72).
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, *independent clinic* (49), *comprehensive inpatient rehabilitation facility* (61), *comprehensive outpatient rehabilitation facility* (62), and *ESRD treatment facility* (65).

Http://www.cms.gov/medicare-coverage-database/ (emphasis added). The article expressly applies to services billed with CPT code 95861.

National Government Services’ “Local Coverage Article for Somatosensory Testing – Supplemental Instructions Article (A48366)” provides similar instructions with regard to CPT codes 95920 and 95926:

*For claims submitted to the carrier or Part B MAC:*

All services/procedures performed on the same day for the same beneficiary by the physician/provider should be billed on the same day.

When reporting the technical component of these services use modifier TC. *The technical component is payable in the office* (11), *nursing facility* (32 - for Medicare patient not in a Part A stay), *independent clinic* (49), *federally qualified health centers* (50) and *rural health clinics* (72).

When reporting the professional component of the services use modifier 26. The professional component is payable in the office (11), *in-patient hospital* (21), *out-patient hospital* (22), emergency room (23), skilled nursing facility (31), *nursing facility* (32 - for Medicare patient not in a Part A stay), *independent clinic* (49), *comprehensive inpatient rehabilitation facility* (61), *comprehensive outpatient rehabilitation facility* (62), and *ESRD treatment facility* (65).

*The global service may be billed in the office* (11), *nursing facility* (32 - for Medicare patient not in a Part A stay), and *independent clinic* (49).


The Appellant billed for the services at issue with CPT codes “95920,” “95926,” and “95861.” The services were billed without modifiers, indicating Appellant was billing both professional and technical components. Addendum A to the 2010 physician fee schedule explains:

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 furnishes both the PC and the TC of the service.
For each of the four codes at issue here, Addendum B to the 2010 physician fee schedule contains separate listings for 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; fees schedules also available at http://www.cms.gov/PhysicianFeeSched/PFSFRN/list.asp#TopOfPage. Addendum A explains:

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 prospective payment system or bundled into the hospital inpatient prospective payment system.

Id. at 62015 (emphasis added).

**Services Paid Under the Hospital Inpatient Prospective Payment System**

“Payments made under the [inpatient] prospective payment systems ... are payment in full for all inpatient hospital services.” 42 C.F.R. § 412.50(a) (emphasis added). Under the PPS for hospital inpatient services, hospitals are paid “on the basis of prospectively determined rates and applied on a per discharge basis.” 42 C.F.R. §412.1(a). Types of discharges are classified according to a list of diagnosis related groups (DRGs). Hence, the payment amount for a given DRG constitutes payment in full to the hospital for inpatient operating costs. MCPM, Chapter 3, § 20.A.

Among other services, inpatient services paid under the PPS include diagnostic laboratory and radiology services. Id. Services paid under the inpatient PPS also include diagnostic testing provided to a beneficiary 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.” Id. at § 40.3.B.

Chapter 6, § 10 of the MBPM states, “Payment may be made under Part B for physician services and for the nonphysician medical and other health services listed below when furnished by a participating hospital (either directly or under arrangements) to an inpatient of the hospital, but only if payment for these services cannot be made under Part A.” Emphasis added. Services listed as payable under Part B only when payment is unavailable under Part A include “diagnostic x-ray tests, diagnostic laboratory tests, and other diagnostic tests.” Id. Conversely, Chapter 15, § 250 of the MBPM identifies services that, “when provided to a hospital or SNF inpatient, are covered under Part B,

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3 The MBPM describes circumstances in which payment cannot be made under Part A to include, *inter alia*, “patient exhaustion of benefit days before admission” and the “patient was not otherwise eligible for or entitled to coverage under Part A.”
even though the patient has Part A coverage for the hospital or SNF stay.” The only diagnostic testing services listed in § 250 are bone mass measurements.

The Appellant opined, “While we understand [the contractor] does not view this service payable for technical and professional components to the physician, this is the correct scenario under which Dr. Bianco should be paid.” Exh 3 at 10. The judge reasoned, “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 services or equipment.” Because the hospital did not furnish, and thus could bill for, the service, “the Appellant should be able to submit a claim for services rendered to an inpatient and be paid.” ALJ decision at 5. This determination is in error.

42 C.F.R. § 412.50(c) provides, “The hospital must furnish all necessary covered services to the beneficiary either directly or under arrangements.” Emphasis added. See also MCPM, Chapter 3, § 10.4 (“All items and nonphysician services furnished to inpatients must be furnished directly by the hospital or billed through the hospital under arrangements.”); MBPM, Chapter 6, § 10 (“every hospital must provide directly or arrange for any nonphysician service rendered to its inpatients, and a hospital can be paid under Part B for a service provided in this manner only if Part A coverage does not exist”). Medicare clearly contemplates scenarios in which a hospital may not be able to maintain equipment necessary to furnish all diagnostic tests and an entity other than the hospital will provide those services. In such circumstances, however, it is up to that entity and the hospital to make financial arrangements for the technical component of the diagnostic tests. Where the patient is in a covered Part A inpatient stay, the hospital is obligated to furnish these services either directly or under arrangements, and Part B Medicare pays only for the professional component of the tests.

The ALJ concluded, “the services provided are reasonable and necessary under §1862(a)(1)(A) of the Act.” However, the issue is not whether the services were medically necessary but whether separate payment may be made under Part B. Accordingly, the limitation on liability protection under § 1879 of the Act does not apply. Because payment made to the hospital under the hospital inpatient PPS constitutes payment in full for all inpatient services, including any necessary diagnostic testing (regardless of whether the hospital owned the equipment or furnished the tests), the Appellant may not bill the beneficiaries for the cost of the tests.

Conclusion:

In sum, all items and nonphysician services furnished to inpatients must be furnished directly by the hospital or billed through the hospital under arrangements. The payment amount for a particular DRG constitutes payment in full to the hospital for inpatient operating costs; this includes payment for the non-physician-service portion of
diagnostic tests (i.e. the technical component) furnished to hospital inpatients. Part B Medicare will only pay for the non-physician portion of diagnostic tests if payment is not available under Part A (e.g. exhaustion of benefit days). When the services at issue are furnished to a hospital inpatient, the physician may not bill for the technical component and may only bill for the professional component of the tests.

The ALJ erred in deciding that a physician should be paid for a technical component of diagnostic tests furnished to a hospital inpatient. Under the PPS, all items and nonphysician services furnished to inpatients are considered hospital services and must be furnished directly by the hospital or billed through the hospital under arrangements. 42 C.F.R. § 412.50(c). “Payments made under the prospective payment systems … are payment in full for all inpatient hospital services.” 42 C.F.R. § 412.50(a). In addition, contractor Policy Articles A46185 and A48366 address the services at issue and state a physician may bill only for the professional component when the tests are furnished to hospital inpatients. The physician may not bill globally.