

DEPARTMENT OF HEALTH AND HUMAN SERVICES
DEPARTMENTAL APPEALS BOARD

DECISION OF MEDICARE APPEALS COUNCIL
Docket Number: M-2010-357

In the case of

Ridgefield Surgical Center
(Appellant)

(Beneficiary)

National Government Services
(Contractor)

Claim for

Supplementary Medical
Insurance Benefits (Part B)

(HIC Number)

(ALJ Appeal Number)

The Medicare Appeals Council has decided, on its own motion, to review the Administrative Law Judge's (ALJ's) decision dated October 19, 2009, because there is an error of law material to the outcome of the claim. See 42 C.F.R. § 405.1110(c)(2). The ALJ determined that an "unlisted procedure, nose" (CPT code 30999), performed on the beneficiary on February 25, 2009, at the appellant ambulatory surgical center (ASC), was medically reasonable and necessary and, therefore, covered by Medicare.

By a December 9, 2009, memorandum, the Centers for Medicare & Medicaid Services (CMS) asked the Medicare Appeals Council to take own motion review of the ALJ's decision, on the basis that the ALJ's decision contains legal error material to the outcome of the claim. The CMS memorandum is admitted into the record as Exh. MAC-1. In essence, CMS argues that the ALJ erred in directing Medicare payment to the appellant ASC for a procedure billed using CPT code 30999 because this code is an unlisted procedure code not encompassed within the codes for which payment may be made to an ASC as a facility fee.

For the reasons articulated below, the Council reverses the ALJ's decision. The appellant ASC is not entitled to Medicare payment of a facility fee for a procedure billed using CPT code 30999.

DISCUSSION

The beneficiary was diagnosed with a deviated septum and chronic left maxillary sinusitis. On February 25, 2009, Dr. J.M. performed a septoplasty on the beneficiary at the appellant ASC.¹ The physician's Operative Report lists two procedures - septoplasty and left endoscopic middle meatal antrostomy. Exh. 1 at 2-3. The ASC billed Medicare for the procedures under CPT code 30520 (septoplasty or submucous resection, with or without cartilage scoring, contouring or replacement with graft); 31267 (nasal/sinus endoscopy, surgical, with maxillary antrostomy, with removal or tissue from maxillary sinus); and 30999 (unlisted procedure, nose). The Medicare contractor reimbursed the ASC for procedures coded 30520 and 31267, but not for the procedure coded 30999, on the basis that payment may not be made to an ASC for a procedure billed using an unlisted code of 30999. Exh. 4 at 8.

On reconsideration, the Qualified Independent Contractor (QIC) affirmed the contractor's decision essentially on the same basis. Exh. 5 at 20. The QIC also determined that the appellant ASC is "responsible for being aware of how to correctly bill Medicare for services provided . . . When the services are not correctly billed, the provider is held liable for the charges and cannot bill the patient for them." *Id.* at 19.

On further review, the ALJ reversed the QIC's decision, finding that the procedure coded 30999 is covered on the basis that the performance of an infraction of the middle turbinate (30999) was medically reasonable and necessary under section 1862(a)(1) of the Social Security Act, and ordered the contractor to reimburse the ASC in accordance with his decision. Dec. at 6-7.² The ALJ's rationale for reversal was as follows:

¹ The physician's billing is neither documented in the record, nor is at issue, in this case. See Exh. MAC-1 at 7, n.3. The issue in this case is Medicare reimbursement for an ASC facility fee as billed using CPT code 30999, and this is the sole issue for which CMS requested the Council's own motion review.

² As for the ALJ's determination that the performance of an infraction of the middle turbinate was medically reasonable and necessary, assuming that such a procedure was performed in this case, the issue in this case is not coverage based on medical necessity. As we explain below, this case turns on a determination of whether an ASC facility fee may be made for a procedure billed using an unlisted surgical procedure code.

The reason that code 30999 was used to describe the fracture of the (left) nasal middle turbinate is because the official CPT codebook designated that code to be used when describing fracture or the nasal middle turbinate or fracture of the nasal superior turbinate. [Footnote omitted.] Had it been necessary to perform an infraction of the nasal inferior turbinate, that procedure would be coded as 30930.

Dec. at 6 (Emphasis in original).

The ALJ is correct that the 2008 CPT codebook, for code 30930 (fracture nasal inferior turbinate(s), therapeutic),³ instructs the use of code 30999 for fracture of the superior or middle turbinate(s). This was the reason the appellant offered, at each stage of review below, to support its position that additional reimbursement is warranted for a procedure billed using code 30999. See Exhs. 4 at 6, 5 at 11, 6 at 41.

However, as CMS points out (see Exh. MAC-1 at 7), and, having reviewed the physician's Operative Report (Exh. 1 at 2-3) the Council agrees, the physician himself listed two procedures (septoplasty and endoscopy), not three. On this point, while we do not have the benefit of a review of the physician's billing records in this case, we note that CMS stated that its review of the CMS Health Insurance Master Record revealed no record of the doctor's billing for code 30999; only 30520 and 31267 were billed. See Exh. MAC-1 at 7, n.3. And, the language of the Operative Report strongly suggests that there was no third primary (or even ancillary) procedure specific to the middle turbinate to account for the ASC's use of a third code. The Report provides:

Inspection of the left nasal passage revealed a large amount of fungal debris in the middle meatus. The middle turbinate was in-fractured and the concha bullosa was compressed by blunt pressure. This

³ The decision indicates that the ALJ consulted *Current Procedural Terminology 2008, Professional Edition*. See Dec. at 6, n.5. However, it is possible that he consulted *Current Procedural Terminology 2009, Professional Edition*, but inadvertently stated that he consulted the 2008 edition, as the claim file includes two copies of what appear to be page 134 from the 2009 codebook. See Exhs. 1 at 1, 6 at 22. There is no assertion, however, that the 2008 and 2009 editions of the codebook contain materially different provisions with respect to the specific codes at issue in this case.

afforded a good view of the middle meatus so *it was elected not to resect the middle turbinate.*

Exh. 1 at 3 (emphasis added). Although we cannot definitively conclude as much based on the record before us, it is possible that the physician considered that a procedure performed with respect to the in-fractured middle turbinate, *if any*, was included within either code 30520 or 31267. We make these observations because the appellant ASC has consistently argued that additional payment based on 30999 is due because the beneficiary had an infracture of the middle turbinate. The appellant apparently assumes that the notation of an infracture of the middle turbinate could permit the use of 30999, or that the physician actually performed some additional procedure for which an additional ASC fee should be paid.

Assuming that a third procedure was performed, as CMS also points out, and we agree, an ASC may not be paid an ASC fee using code 30999. This specific code is explicitly excluded from payment to ASCs, for calendar year 2009. See January 2009 ASC Approved HCPCS Codes and Payment Rates, Addendum EE titled "Final ASC Surgical Procedures Excluded from Payment in ASCs for CY 2009," page 6.⁴ See also Medicare Claims Processing Manual (MCPM), CMS Pub. 100-04, Ch. 14, Sections 10 ("Medicare does not pay an ASC for procedures that are excluded from the list of covered surgical procedures."); 10.2 ("Covered ASC services are those surgical procedures that are identified by CMS on a listing that is updated at least annually . . . Medicare makes facility payments to ASCs only for the specific ASC covered surgical procedures on the ASC list of covered surgical procedures.").

We also acknowledge CMS's argument that code 30999, when performed in an ASC, as in this case, is subject to a coverage exclusion pursuant to 42 C.F.R. § 416.166(c). As CMS states, section 416.166(c)(7) excludes coverage of services that "can only be reported using a CPT unlisted surgical procedure code." Exh. MAC-1 at 1 and 5, citing 42 C.F.R. § 416.166(c)(7).⁵ In this case, it is undisputed that the appellant ASC billed using three codes, two of which resulted in payment, and the third using 30999, and that 30999 is explicitly defined as an

⁴ See http://www.cms.hhs.gov/ASCPayment/11_Addenda_Updates.asp#TopOfPage

⁵ As CMS also points out, and it is consistent with the QIC's decision, 30999 is not among the list of ASC-covered surgical procedures for 2009. See Exh. MAC-1 at 6, citing 73 Fed. Reg. 68,840-68,933 (Nov. 18, 2008), Addendum AA, "ASC Covered Surgical Procedures for CY 2009"; Exh. 5 at 19 (QIC decision).

"unlisted" surgical procedure. We concur with the position taken in the CMS referral memorandum that an ASC facility fee may not be paid based on a billing using an unlisted procedure code, 30999.

We reverse the ALJ's decision accordingly.

MEDICARE APPEALS COUNCIL

/s/ Susan S. Yim
Administrative Appeals Judge

/s/ Clausen J. Krzywicki
Administrative Appeals Judge

Date: February 18, 2010