DEPARTMENT OF HEALTH AND HUMAN SERVICES
DEPARTMENTAL APPEALS BOARD

DECISION OF MEDICARE APPEALS COUNCIL
Docket Number: M-11-279

In the case of	**Claim for**
Junichiro Sageshima, MD (Appellant)	Supplementary Medical Insurance Benefits (Part B)
**** (Beneficiary)	**** (HIC Number)
First Coast Service Options (Contractor)	**** (ALJ Appeal Number)

The Administrative Law Judge (ALJ) issued a decision dated September 21, 2010, which concerned laparoscopy, surgical; donor nephrectomy, from a living donor (HCPCS[1] code 50547, modifier 62, GC)(kidney transplantation) performed on the beneficiary on December 10, 2008. The ALJ determined the appellant provided insufficient documentation to support that the service at issue was provided as billed. The ALJ also found the appellant liable for the non-covered services. The appellant has asked the Medicare Appeals Council to review this action. The appellant's request for review has been entered into the record as Exhibit (Exh.) MAC-1.

The Council reviews the ALJ's decision *de novo*. 42 C.F.R. § 405.1108(a). The Council will limit its review of the ALJ's action to the exceptions raised by the party in the request for review, unless the appellant is an unrepresented beneficiary. 42 C.F.R. § 405.1112(c).

[1] The Centers for Medicare & Medicaid Services (CMS) has developed the Healthcare Common Procedure Coding System (HCPCS) to establish "uniform national definitions of services, codes to represent services, and payment modifiers to the codes." 42 C.F.R. § 414.40(a). CMS also utilizes the American Medical Association (AMA)'s annual publication of Current Procedural Terminology (CPT) codes.

For the reasons set forth below, the Council reverses the ALJ's decision and finds that the services provided by the appellant in connection with the kidney transplantation at issue are covered by Medicare.

DISCUSSION

During the relevant period, the 55-year-old beneficiary was diagnosed with end-stage renal disease due to polycystic kidney disease and hypertension. Exh. 2, at 1. On December 10, 2008, the beneficiary received a kidney transplant from a living, unrelated donor at Jackson Memorial Hospital, a member of the University of Miami Health System. *Id.* at 1-7. The appellant in the instant case was the attending surgeon for removal of the kidney from the living donor. *Id.* at 5. A claim for Medicare coverage was submitted to the First Coast Service Options ("FCSO" or "the contractor") under the beneficiary's name, using HCPCS code 50547, modifiers 62, GC. *Id.* at 4.

Initially and on redetermination, FCSO denied coverage. On redetermination, the contractor found that the beneficiary's name on the claim did not match the name on the documentation submitted. Exh. 1, at 15-16.

On reconsideration, the Qualified Independent Contractor (QIC) affirmed FCSO's denial of coverage. Exh. 1, at 2-6. The QIC found that services at issue were billed with a -62 modifier, which indicates that co-surgeons were utilized in the kidney transplantation procedure. *Id.* at 4. The QIC concluded that the record did not support that co-surgeons were used in the transplantation procedure. *Id.*

A request for hearing was submitted on behalf of the University of Miami Health System, Division of Transplantation, and the appellant on October 21, 2009. Exh. 1, at 1. A telephonic hearing was conducted on February 9, 2010, at which the appellant appeared and provided testimony. Decision (Dec.) at 1. The ALJ issued a decision on September 21, 2010, finding that the evidentiary record did not support the use of the -62 modifier, indicative of multiple surgeons participating in the transplantation procedure at issue. *Id.* at 4. The ALJ noted that the record contained medical records for the beneficiary and one other individual and that the claim for the beneficiary was billed with the -62 modifier. *Id.* However, the ALJ concluded that the operative and procedure reports in the record did not reflect that multiple surgeons participated in the

transplantation. *Id.* Consequently, the ALJ denied coverage for the claim at issue, and upheld the QIC's finding that the appellant was liable for the cost of the non-covered services. *Id.* at 4-5.

Coding Error

First, the Council addresses the issue of use of the –62 modifier, which is the basis for denial of coverage by the QIC and the ALJ. In the Medicare Claims Processing Manual (MCPM), CMS discusses use of the -62 modifier and states that a -62 modifier denotes the use of "two surgeons (each in a different specialty) [who] are required to perform a specific procedure" within the same surgical operation. Medicare Claims Processing Manual (MCPM), Ch. 12, § 40.8.B.[2] It is unclear why the modifier was used in filing the claim with Medicare. Arguably, it could be the result of a "minor clerical error."

The regulation at 42 C.F.R. § 405.927 provides that "minor errors or omissions in an initial determination must be corrected only through the contractor's reopening process under § 405.980(a)(3). The Medicare Claims Processing Manual (MCPM) provides further guidance at chapter 34, section 10.4:

> Section 937 of the Medicare Modernization Act required CMS to establish a process, separate from appeals, whereby providers, physicians and suppliers could correct minor errors or omissions. We equate the MMA's minor error or omission to fall under our definition of clerical error, located at § 405.980(a)(3). We believe that it is neither cost efficient nor necessary for contractors to correct clerical errors through the appeal process. Thus, § 405.927 and § 405.980(a)(3) require that clerical errors be processed as reopenings rather than appeals.

In this case, the use of an inappropriate modifier resulted in more than a minor clerical error. According to CMS, the use of the -62 modifier resulted in denial of coverage. Therefore, the Council finds that the claim denial based on insufficient documentation in support of the use of multiple surgeons (modifier 62) constitutes more than a minor clerical error and is subject to this appeals process.

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[2] All manual provisions are located at http://www.cms.gov/manuals/downloads/clm104c12.pdf.

Medicare Coverage

In the request for review, the appellant argues that the operative report for the beneficiary at issue does not identify the use of co-surgeons in the procedure performed on the beneficiary. Exh. MAC-1, at 3. The appellant asserts that co-surgeons were used during the procedure which removed the kidney from the live donor, as documented in the December 10, 2008, operative report for that procedure. *Id.* The appellant notes that the MBPM indicates that "the service for the donor is billed 100% on the account of the [donor] recipient." *Id.*

Section 1881(b)(1) of the Social Security Act (Act) provides, among other things:

> Payments under this title with respect to services, in addition to services for which payment would otherwise be made under this title, furnished to individuals who have been determined to have end stage renal disease shall include (A) payments on behalf of such individuals to providers of services, . . . transplantation services, ...

Additionally, the Medicare Benefit Policy Manual (MBPM) provides that physician services to a donor in a kidney transplantation "are treated as though the recipient had incurred them." MBPM, Ch. 11, § 80.4. The MBPM also explicitly provides:

> Payment for physician services to a live donor provided in connection with a kidney donation to an entitled beneficiary is made 100 percent of the allowed amount. These services include donor's preoperative surgical care, kidney excision inpatient stay and any subsequent related postoperative period. There is no deductible or coinsurance charged for services furnished to live donors. The Part B claim includes the home address, and health insurance number of the recipient as well as the home and address of the live donor.

Id.

The appellant's contentions are supported by the documentary record. The CMS-1500 claim form submitted by the University of Miami, Division of Transplantation, for the December 10, 2008, kidney transplantation identifies the beneficiary and HCPCS code

50547. But, the claim form does not document the donor's name and address as noted in the MBPM. Exh. 2, at 4. This fact aside, other parts of the record do adequately demonstrate that the services provided by the appellant were in connection with a kidney transplantation to an entitled beneficiary.[3] The donor and recipient operative reports both indicate that the appellant, and a co-surgeon, removed the left kidney of the live donor, which was ultimately implanted into the kidney recipient. Exh. 2, at 1-3, 5-7.

Therefore, the Council finds that the services at issue, billed under HCPCS code 50547, are covered by Medicare. Having found that the transplantation services at issue are covered by Medicare, the Council need not address the issue of liability under section 1879 of the Act.

DECISION

It is the decision of the Medicare Appeals Council that laparoscopy, surgical; donor nephrectomy, from a living donor (HCPCS code 50547)(kidney transplantation) performed on the beneficiary on December 10, 2008, is covered by Medicare. Therefore, we reverse the ALJ's decision.

MEDICARE APPEALS COUNCIL

/s/ Susan S. Yim
Administrative Appeals Judge

/s/Constance B. Tobias, Chair
Departmental Appeals Board

Date: June 27, 2011

[3] The beneficiary is an "entitled beneficiary" for the transplantation procedure, pursuant to MBPM, Ch. 11, § 80.4.