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Medicare Quarterly Provider Compliance Newsletter

Guidance to Address Billing Errors Volume 7, Issue 2

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Comprehensive Error Rate Testing (CERT): Retinal Photocoagulation

Provider Types Affected: Physicians

Background

Retinal photocoagulation is a procedure in which the ophthalmologist/surgeon places laser burns outside the central retina. This laser therapy has a tendency to help reduce the formation of new blood vessels. This procedure is often indicated as a result of bleeding from new blood vessels arising on the optic disc or other places in the retina.

Description of Special Study

The CERT Review Contractor conducted a special study of claims with lines for retinal photocoagulation procedures billed with Healthcare Common Procedure Coding System (HCPCS) code 67228, submitted from July through September 2015. When CERT reviews a claim, all lines submitted on the claim undergo complex medical review. The long description of this HCPCS code is: Treatment of extensive or progressive retinopathy, 1 or more sessions; (e.g., diabetic retinopathy), photocoagulation. The consumer-friendly version of this HCPCS code descriptor is: laser destruction of leaking retinal blood vessels, 1 or more sessions.

Finding: Insufficient Documentation Causes Most Improper Payments

Most improper payments in this special study were due to insufficient documentation. Insufficient documentation means that something was missing from the medical record submitted. For example, there was:

- No documentation was submitted to adequately describe the service defined by the HCPCS code or HCPCS modifier billed
- No legible identifier
- No signature on a procedure note or progress note
- No intent to order diagnostic or lab test
- No diagnostic test result
- No signature log or attestation submitted
- No procedure note
- No documentation of the medical need for the procedure

Example of Improper Payments due to Insufficient Documentation – Missing signed clinical documentation

An ophthalmologist billed for HCPCS 67228 and in response to the CERT contractor's request for documentation submitted the following:

1. An unsigned office visit note for the billed date of service which documented diabetic retinopathy in both eyes, a plan for Pan-Retinal Laser Photocoagulation (PRP), and results of posterior segment examination of both eyes
2. An unsigned operative/procedure note for the billed date of service which documented PRP of left eye

The medical reviewer sent the initial request letter as well as an Additional Documentation Request (ADR) letter asking for additional documentation to support the HCPCS code that was billed. The provider submitted altered copies (signature added) of the office visit note and operative note. The documentation submitted did not meet the requirements of the Local Coverage Determination (LCD). The LCD applicable to this claim requires that the patient's medical record must contain documentation that fully supports the medical necessity for the services. This includes, but is not limited to, relevant medical history, physical examination, and results of pertinent diagnostic tests or procedures.

The submitted documentation was insufficient to support the medical necessity for the PRP since the documentation submitted was unsigned. Medicare requires that services provided/ordered be authenticated by the author. This claim was scored as an insufficient documentation error and the payment was recouped from the provider.

Note that the provider could have completed a [signature attestation](#) to correct this error.

Example of Improper Payments due to Insufficient Documentation – Missing clinical documentation

An ophthalmologist billed for HCPCS 67228 and in response to the CERT contractor's request for documentation submitted the following:

1. A signed operative note
2. A signed visit note
3. An unsigned fundus photography and angiography form which indicated that tests were ordered, however the tests were missing interpretations

The medical reviewer sent two request letters requesting additional documentation to support the HCPCS code that was billed, however none was submitted. In response to requests for additional documentation, the provider submitted the same documentation that was previously submitted. A copy of an authenticated report for fundus photography and angiography form for the billed date of service was still missing. This claim was scored as an insufficient documentation error and the payment was recouped from the provider.

Guidance on How Providers Can Avoid these Improper Payments

Understand the requirements for Medicare coverage of these services and make sure the medical record documentation meets Medicare requirements.

Resources

You will find information on avoiding insufficient documentation errors in the following resources:

- ✓ The relevant LCDs are available by searching the Medicare Coverage Database at <https://www.cms.gov/medicare-coverage-database/>.
- ✓ An example of a signature attestation statement is available at <https://certprovider.admedcorp.com/Content/AttestationLetters/SignatureAttestation.pdf>.
- ✓ More information about complying with CERT requests for records is available on the CERT Provider website at <https://www.certprovider.com/Home.aspx>.
- ✓ The “Medicare Claims Processing Manual,” Chapter 1, Section 110 contains information on provider retention of health insurance records and is available at <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c01.pdf>.
- ✓ The “Medicare Program Integrity Manual,” Chapter 3, Section 3 contains information on additional documentation requests, signature requirements, and signature attestation statements and is available at <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/pim83c03.pdf>.
- ✓ CMS’s CERT website is available at <https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/CERT/index.html?redirect=/CERT/>.

Comprehensive Error Rate Testing (CERT): Facet Joint Injection

Provider Types Affected: Physicians and Hospitals

Background

Facet joints are a common source of chronic low-back pain. Facet joint injection is a procedure using an imaging-assisted local injection and denervation technique. This procedure may be indicated when there is chronic low back pain. Destruction of a paravertebral facet joint nerve(s) requires the use of fluoroscopic guidance to confirm the proper positioning of the needle or electrode at the level of the involved paravertebral facet joint(s).

Description of Special Study

The CERT Review Contractor conducted a special study of claims with lines for facet joint injection procedures billed with Healthcare Common Procedure Coding System (HCPCS) code 64635, submitted from July through September 2015. When CERT reviews a claim, all lines submitted on the claim undergo complex medical review. The long description of this HCPCS code is: destruction by neurolytic agent, paravertebral facet joint

nerve(s), with imaging guidance (fluoroscopy or CT); lumbar or sacral, single facet joint. The consumer-friendly version of this HCPCS code descriptor is: destruction of lower or sacral spinal facet joint nerves using imaging guidance.

Finding: Insufficient Documentation Causes Most Improper Payments

Most improper payments in this special study were due to insufficient documentation. Insufficient documentation means that something was missing from the medical records submitted. For example, there was:

- No documentation to support the medical need for the procedure
- No procedure note
- No physician's signature on a procedure note, diagnostic report or progress note
- No valid physician order (includes physician signature or date)
- No preoperative surgeon's office notes
- No signature log or attestation submitted
- No documentation submitted to adequately describe the service defined by the HCPCS code or HCPCS modifier billed
- Though a valid ICD-9 code(s) was submitted, the ICD-9 code(s) alone was insufficient information

Example of Improper Payments due to Insufficient Documentation – Missing clinical documentation

A physician billed for HCPCS 64636 and, in response to the CERT contractor's request for documentation, submitted the following:

1. A record of informed consent for the procedure and anesthesia, signed by the patient and physician
2. A History and Physical (H&P) signed by the physician showing left L(lumbar) 3/4, L4/5, L5/SI (sacroiliac) radiofrequency ablation
3. Pre- and intra-anesthesia records
4. An order for procedural sedation and medication
5. An operative report for the billed procedure signed by the billing provider
6. Pre- and post-procedure pain management orders signed by the physician
7. A pain clinic nursing assessment showing starting pain level 1/10
8. A bilateral hip and SI joint x-ray
9. A dated progress note showing follow up from a SI joint injection under ultrasound, pain with palpation of facets and plan for billed ablation procedure
10. A dated operative report
11. A progress note dated more than one month after the claim date of service

The medical reviewer made phone calls and sent letters requesting additional documentation to support the HCPCS code that was billed. The provider did not submit clinical documentation to support that the patient had failed conservative treatment. The documentation submitted did not meet the requirements of the applicable Local Coverage Determination (LCD). The LCD applicable to this claim requires documentation that supports the patient has failed conservative treatment. Conservative treatments may include local heat, traction, non-steroidal anti-inflammatory medications, and an anesthetic.

The submitted documentation was insufficient to support the medical necessity for the facet joint injection since there was no evidence in the documentation submitted that the patient had tried conservative treatment(s).

This claim was scored as an insufficient documentation error and the payment was recouped from the provider.

Example of Improper Payments due to Insufficient Documentation – Missing clinical documentation

A physician billed for HCPCS 64636 and in response to the CERT contractor's request for documentation submitted the following:

1. A progress note from the date of service that did not indicate that conservative treatment was tried and failed
2. A procedure note from the date of service
3. A consent form

The medical reviewer made phone calls and sent letters requesting additional documentation to support the HCPCS code that was billed. Duplicate documentation was received. The provider failed to submit documentation to support that the patient failed conservative treatment. Conservative treatment may include local heat, traction, nonsteroidal anti-inflammatory medications and anesthetic. There was no initial evaluation from the physician with a summary of diagnostic tests or procedures to justify the possible presence of facet joint pain, nor was there clinical documentation to rule out another etiology for the symptoms. CERT scored this claim as an insufficient documentation error and payment was recouped from the provider.

Guidance on How Providers Can Avoid these Improper Payments

Understand the requirements for Medicare coverage of facet joint injection services and make sure the medical record documentation meets Medicare requirements.

Resources

You will find information on avoiding insufficient documentation errors for facet joint injections in the following resources:

- ✓ The relevant LCDs are available by searching the Medicare Coverage Database at <https://www.cms.gov/medicare-coverage-database/>.
- ✓ The CERT provider website contains general information about submitting documentation at <https://www.certprovider.com/Home.aspx>
- ✓ The “Medicare Program Integrity Manual,” Chapter 3, Section 3 contains information on additional documentation requests, signature requirements, and signature attestation statements and is available at <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/pim83c03.pdf>.

Comprehensive Error Rate Testing (CERT): Radiation Therapy

Provider Types Affected: Physicians and Hospitals

Background

The April 2015 issue of the [Medicare Quarterly Provider Compliance Newsletter](#) provides information on improper payments for radiation therapy planning submitted by radiation oncologists. Radiation therapy is used to treat many types of tumors, may shrink tumors before a patient has surgery, may be used on tumors that cannot be removed with surgery or can relieve symptoms caused by tumors. This type of service is usually billed by a hospital outpatient department. Providing radiation therapy requires careful planning and calculations.

Description of Special Study

The CERT contractor conducted a special study of claims with lines for radiation therapy billed with HCPCS code 77300. The long description of HCPCS code 77300 is: basic radiation dosimetry calculation, central axis depth dose calculation, TDF, NSD, gap calculation, off axis factor, tissue inhomogeneity factors, calculation of non-ionizing radiation surface and depth dose, as required during course of treatment, only when prescribed by the treating physician.

Intensity Modulated Radiotherapy (IMRT) delivers a more precise radiation dose to a solid tumor while sparing the surrounding normal tissues by using non-uniform radiation beam intensities that are determined by various computer-based optimization techniques. IMRT is considered reasonable and necessary in instances where sparing the surrounding normal tissue is essential and the patient has met all the conditions for IMRT as defined in the applicable coverage policy. IMRT is an evolving technology and, as such, IMRT Local Coverage Determinations are reviewed and updated as often as necessary.

The IMRT plan (77301) is a separate and distinct step in the process of care whose product is the computerized plan developed by the physician, medical physicist, and dosimetrist and is required for the delivery of IMRT.

Improper payments for these services impact the improper payment rate for radiation oncology or for hospital outpatient services, depending on the billing entity. The 2015 improper payment rate for radiation oncology was 9.6 percent, accounting for 0.3 percent of the overall Medicare FFS improper payment rate. The projected improper payment amount for radiation oncology during the 2015 report period was \$137 million. The 2015 improper payment rate for hospital outpatient services was 4.9 percent, accounting for 5.7 percent of the overall Medicare Fee-For-Service (FFS) improper payment rate. The projected improper payment amount for hospital outpatient services during the 2015 report period was \$2.5 billion.

Finding: Insufficient Documentation Causes Most Improper Payments

Insufficient documentation means that something was missing from the medical record submitted. Claims are placed into this category when the medical documentation submitted is inadequate to support payment for the services billed. In other words, the CERT contractor reviewers could not conclude that the billed services were actually provided, were provided at the level billed, and/or were medically necessary. Claims are also placed into this category when a specific documentation element that is required as a condition of payment is missing, such as a physician signature on an order, or a form that is required to be completed in its entirety.

For example, the medical record was missing one or more of the following:

- No radiation therapy plan was submitted
- The documentation submitted did not adequately describe the service defined by the HCPCS code
- The correct date of service
- A physician's signature
- A signature log or attestation for an illegible signature

Example of Improper Payments due to Insufficient Documentation - Missing clinical documentation

A hospital outpatient department billed for HCPCS 77301 and 77300 along with weekly continuing medical physics consultation, IMRT treatment delivery with stereotactic guidance (HCPCS codes 77336, 77418 and 77421). The submitted documentation included a signed radiation oncology consultation report, an evaluation for IMRT and concomitant chemotherapy, Computed Tomography (CT) simulation with serial scans, IMRT therapy

planning notes, and a summary report of the radiation therapy provided. This documentation supported the medical necessity for the treatments. However, the hospital outpatient department did not submit the following documentation:

- Radiation oncologist's IMRT order/prescription
- Planning notes including treatment fields, physics, and dosimetry calculations signed by the radiation oncologist and the medical physicist
- Documentation to support review of the CT or MRI based images of the target and all critical structures
- Weekly physics consult review with calculations for treatment delivery

CERT scored this claim as an insufficient documentation error and payment was recouped from the provider.

Guidance on How Providers Can Avoid these Improper Payments

Understand the requirements for Medicare coverage of radiation therapy services and make sure the medical record documentation meets Medicare requirements.

Resources

You will find information on avoiding insufficient documentation errors for radiation therapy services in the following resources:

- ✓ The “Medicare Claims Processing Manual,” Chapter 4, Section 200.3 entitled Billing Codes for Intensity Modulated Radiation Therapy (IMRT) and Stereotactic Radiosurgery (SRS) is available at <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c04.pdf>.
- ✓ The “Medicare Claims Processing Manual,” Chapter 12, Section 70 entitled Payment Conditions for Radiology Services is available at <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c12.pdf>
- ✓ The “Medicare Claims Processing Manual,” Chapter 13, Section 70 entitled Radiation Oncology - Therapeutic Radiology is available at <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c13.pdf>
- ✓ The “Medicare Program Integrity Manual,” Chapter 3, Section 3 contains information on additional documentation requests, signature requirements, and signature attestation statements and is available at <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/pim83c03.pdf>.
- ✓ The April 2015 issue of the “Medicare Quarterly Provider Compliance Newsletter” is available at <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/MedQtrlyComp-Newsletter-ICN909208.pdf>.
- ✓ The relevant LCDs are available by searching the Medicare Coverage Database at <https://www.cms.gov/medicare-coverage-database/>.

Office of Inspector General (OIG) Finding: Stem Cell Transplants

Provider Types Affected: Hospitals

Background

Medicare Part A provides inpatient hospital insurance benefits, and Medicare Part B provides supplementary medical insurance for medical and other health services, including coverage of hospital outpatient services. Medicare pays inpatient hospital costs at predetermined rates for patient discharges. The rates vary according to the Medicare Severity Diagnosis-Related Group (MS-DRG) to which a patient's stay is assigned. The MS-DRG payment is, with certain exceptions, intended to be payment in full to the hospital for all inpatient costs associated with the patient's stay.

A CMS software program called the Medicare Severity Diagnosis Related Grouper (Grouper) determines the MS-DRG for each claim on the basis of the hospital's reported billing data, which include diagnosis and procedure codes. To detect billing errors, the Grouper's Medicare Code Editor (MCE) has coding, coverage, and clinical edits, such as consistency checks for correct use of diagnosis and procedure codes.

Patients with various kinds of blood-related cancers, such as leukemia and lymphoma, receive transplants of bone marrow and peripheral blood stem cells to restore stem cells that were destroyed by high doses of chemotherapy, radiation therapy or both. After being treated with anticancer drugs or radiation, the patient receives the harvested stem cells, which travel to the bone marrow and begin to produce new blood cells. Stem cell transplantation is not on CMS's list of inpatient-only procedures, and according to an independent medical review contractor, stem cell transplantation is routinely performed as an outpatient procedure. However, with respect to stem cell transplants that are billed as inpatient services under Medicare Part A, the procedure codes for these services primarily fall under one of four MS-DRGs and have Geometric Mean Lengths of Stay (GMLoS) from 10 to 21 days, as determined and published by CMS.

Description of the Special Study

For calendar year 2012, Medicare paid hospitals \$185.9 million for inpatient claims related to bone marrow and stem cell transplant procedures (which we collectively refer to as "stem cell transplants"). Recent OIG reviews identified Medicare overpayments to two hospitals that did not always comply with Medicare billing requirements for inpatient claims for stem cell transplants, resulting in overpayments of approximately \$4 million. The lengths of stay for the claims reviewed were 1 to 2 days, but generally the lengths of stay for claims with these procedures are from 10 to 21 days. Because claims with these disparities are at risk for billing errors, the OIG performed this review to determine whether Medicare paid selected inpatient claims for stem cell transplants in accordance with Medicare requirements.

Finding

Medicare paid 10 of the 143 selected inpatient claims for stem cell transplants in accordance with Medicare requirements. However, 133 claims did not comply with those requirements. The lengths of stay for these claims were 1 to 2 days. For 120 of these claims, the hospitals incorrectly billed Medicare Part A for patient stays that should have been billed as outpatient or outpatient with observation services. These claims did not have clinical evidence supporting that an inpatient level of care was required before, during, or after the transplant procedures were performed. For the remaining 13 claims, the hospitals billed incorrect MS-DRGs. As a result of the 133 errors, Medicare overpaid the hospitals by \$6,341,441. This overpayment amount consisted of claims within the 3-year recovery period totaling \$4,574,228 and claims outside of the 3-year recovery period totaling \$1,767,213.

Guidance on How Providers Can Avoid these Improper Payments

Understand the requirements for Medicare coverage of stem cell transplant services and make sure the claims for stem cell transplants are supported by medical record documentation that meets Medicare requirements.

Resources

You will find information on avoiding claims errors for stem cell transplant services in the following resources:

- ✓ The OIG report is available at <https://oig.hhs.gov/oas/reports/region9/91402037.pdf>.
- ✓ Transmittal 1805 is available at <https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R1805A3.pdf>.
- ✓ The section of the “National Coverage Determinations Manual” that deals with stem cell transplants for treatment of certain conditions is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/ncd103c1_Part2.pdf.

You may want to review the following MLN Matters articles for further information:

- MM9620 - “Stem Cell Transplantation for Multiple Myeloma, Myelofibrosis, and Sickle Cell Disease, and Myelodysplastic Syndromes” is available at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM9620.pdf>.
- MM6416 - “April 2009 Update of the Hospital Outpatient Prospective Payment System (OPPS)” is available at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM6416.pdf>.
- MM4173 - “Stem Cell Transplantation” is available at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM4173.pdf>.
- MM3797 - “Updated Requirements for Autologous Stem Cell Transplantation (AuSCT) for Amyloidosis” is available at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM3797.pdf>.

For more information on observation services, you may want to review the following:

- ✓ There is a fact sheet on the Two-Midnight rule at <https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2015-Fact-sheets-items/2015-10-30-4.html>.
- ✓ CMS provides further guidance on the Two-Midnight rule with responses to frequently asked questions at https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medical-Review/Downloads/QAsforWebsitePosting_110413-v2-CLEAN.pdf.
- ✓ Additional information is in a transcript of an MLN Connects® conference call discussing the Two-Midnight rule, which is available at <https://www.cms.gov/Outreach-and-Education/Outreach/NPC/Downloads/2-27-14MidnightRuleTranscript.pdf>.

Recovery Auditor Finding: Long-Term Acute Care (LTAC)-Stays up to 5 Days Longer than the Short Stay Outlier (SSO) Threshold

Provider Types Affected: Hospitals

Description of the Special Study

The Recovery Auditor conducted studies to determine whether all covered, paid days associated with LTAC confinement equal to the SSO threshold plus up to 5 days are reasonable, necessary and appropriate for LTAC.

The following Medicare Severity-Long Term Care-Diagnostic Related Groups (MS-LTC-DRGs) were selected for review: 064, 177, 189, 193, 194, 207, 208, 689, 690, 870, 871, and 872.

Cases not reasonable and necessary are not payable; cases with lengths of stay at or less than the SSO receive a reduced payment from CMS. During medical necessity review, the case may be referred to a coding specialist to validate the reportability of diagnosis and procedure codes impacting the level of claim payment.

This error and recovery audit finding related to claims specific to the states of Ohio, Kentucky, Indiana, Michigan, Illinois, Minnesota, and Wisconsin.

Findings

In one study, the Recovery Auditor reviewed 137 claims from 11 providers, covering 11 MS-LTC-DRGs. The Recovery Auditor adjusted the Length of Stay (LOS) in 72 audits (53%) based on the review of reasonable and necessary stays at the LTAC level of care.

In another study, the Recovery Auditor reviewed 63 claims from six providers covering five MS-LTC-DRGs. The Recovery Auditor adjusted the LOS in 35 audits (56%), based on the review of reasonable and necessary stays at the LTAC level of care.

Guidance on How Providers Can Avoid These Errors

Ensure that patients receive reasonable and necessary care that is appropriate for the diagnosis and condition of the patient at any time during the stay. The patient must demonstrate signs and/or symptoms severe enough to warrant the need for medical care and must receive services of such intensity that they can be furnished safely and effectively only on an inpatient basis.

Documentation must demonstrate a continual progression in care that supports the appropriateness of the setting. A discharge plan should be established at the outset, and its goals should be demonstrably worked toward and achieved as efficiently as the patient's condition and comorbidities allow, without unjustified stalled or repetitive care. A sustained plateau indicates that a lower level of care is more appropriate.

Discharge should not be delayed when the patient is medically stable, and continued hospitalization is unnecessary, or nursing home placement or discharge to home with home care would have been appropriate in providing needed care without posing a threat to the health or safety of the patient.

Resources

You can find a wealth of resources on the CMS Long-Term Care Hospital PPS webpage. Those resources include:

- ✓ The "LTCH Training Guide," Chapter 3, Clinical Issues: Coverage, Coding and Medical Review may be of particular interest for the issues discussed in this finding. These materials are available at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/LongTermCareHospitalPPS/lrch_train.html.

- ✓ The CMS Report “Determining Medical Necessity and Appropriateness of Care for Medicare Long Term Care Hospitals,” March 2011, is available at <https://www.cms.gov/About-CMS/Legislative-Affairs/OfficeofLegislation/downloads/RTC-long-term-care-hospitals-final.pdf>.
- ✓ The “Medicare Program Integrity Manual,” Chapter 6, Sections 6.5, 6.5.2, and 6.5.6 found at <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/pim83c06.pdf> contain relevant information regarding the review of LTAC services.



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