

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services



Official Information Health Care
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Medicare Quarterly Provider Compliance Newsletter

Guidance to Address Billing Errors Volume 7, Issue 1

ICN 909346/ October 2016

Comprehensive Error Rate Testing (CERT): Transluminal Balloon Angioplasty, Venous

Provider Types Affected: Physicians and Providers

Background

Percutaneous Transluminal Angioplasty (PTA) is a procedure that can open up a blocked blood vessel using a small, flexible plastic tube, or catheter, with a "balloon" at the end of it. When the tube is in place, it inflates to open the blood vessel so that normal blood flow is restored.

This procedure is commonly performed to preserve the function of hemodialysis fistulas. Hemodialysis fistulas are surgically created communications between the native artery and vein in an extremity and provide vascular access in patients on hemodialysis. One of the most challenging aspects of the long-term treatment of dialysis patients is the preservation of patent, well-functioning dialysis fistulas. Percutaneous techniques such as balloon angioplasty allow for the treatment of stenosis and fistula thrombosis without surgical thrombectomy and revision.

Description of Special Study

The CERT Review Contractor conducted a special study of claims with lines for venous transluminal balloon angioplasty procedures billed with Healthcare Common Procedure Coding System (HCPCS) code 35476 submitted from April through June 2015. When CERT reviews a claim, all lines submitted on the claim undergo complex medical review. The long description of this HCPCS code is: transluminal balloon

angioplasty, percutaneous; venous. The consumer-friendly version of this HCPCS code descriptor is: balloon dilation of narrowed or blocked vein, accessed through the skin.

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

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

An interventional radiologist billed for HCPCS 35476 and, in response to the CERT contractor's request for documentation, submitted the following:

1. A letter to the CERT program
2. A procedure note

The submitted documentation was missing a physician's authenticated clinical documentation to support the reason/need for procedure and missing a physician's order for or documentation to support intent to order transluminal balloon angioplasty.

The CERT medical reviewer requested additional documentation but did not receive any further documentation. The CERT program did not consider the provider's letter because there was no documentation in the beneficiary's medical record documentation to corroborate the information in the letter. The submitted documentation was insufficient to support the medical necessity for the Percutaneous Transluminal Angioplasty (PTA). CERT scored this claim as an insufficient documentation error and the Medicare Administrative Contractor (MAC) recovered the overpayment from the provider.

Note that physician attestations by themselves do **NOT** provide sufficient documentation of medical necessity, even if signed by the ordering physician. For Medicare to consider coverage and payment for any item or service, the information submitted by the supplier or provider must corroborate the documentation in the beneficiary's medical documentation and confirm that Medicare coverage criteria have been met.

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

A nephrologist billed for HCPCS 35476 and, in response to the CERT contractor's request for documentation, submitted the following:

1. A progress/procedure note
2. A referral form

The submitted documentation was missing a physician's order for or documentation to support intent to order a fistulagram and angioplasty. In addition, there was no authenticated physician clinical documentation to support the reason/need for procedure to be performed. CERT received no additional documentation despite phone calls and requests for additional documentation. CERT scored this claim as an insufficient documentation error and the MAC recovered the payment from the provider.

Example of Improper Payments due to Insufficient Documentation – Missing signature

A general surgeon billed for HCPCS 35476 and, in response to the CERT contractor's request for documentation, submitted the following:

1. A physician's progress note documenting clotted dialysis access to left upper arm arteriovenous (AV) graft needing a thrombectomy with the performance of thrombectomy with Tissue Plasminogen Activator (TPA) and multi-level angioplasty that is not signed

2. A duplicate progress note that was altered to include a signature (no attestation statement submitted)

The submitted documentation was missing the performing physician's attestation statement. CERT scored the claim as an insufficient documentation error and the MAC recovered the payment from the provider.

Guidance on How Providers Can Avoid these Improper Payments

According to the [“Medicare Program Integrity Manual \(PIM\),” Chapter 3, Section 3.3.2.4](#), if a signature is missing from medical documentation (other than an order), MACs, the Supplemental Medical Review Contractor (SMRC), and the CERT Contractor shall accept a signature attestation from the author of the medical record entry.

When making review determinations the MACs, CERT, Recovery Auditors, and Zone Program Integrity Contractors (ZPICs) shall consider all submitted entries that comply with the widely accepted Recordkeeping Principles described in the PIM, Chapter 3, Section 3.3.2.5. Note that the provider could have completed a signature attestation to correct this error. Providers can access an example of an attestation statement on the [CERT provider website](#).

Resources

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

- ✓ The CERT provider website at <https://www.certprovider.com>
- ✓ 42 CFR 424.5 (a) (6) at <https://www.gpo.gov/fdsys/pkg/CFR-2005-title42-vol2/pdf/CFR-2005-title42-vol2-sec424-5.pdf>
- ✓ “The National Coverage Determinations Manual,” Chapter 1, Section 20.7 at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/ncd103c1_Part1.pdf
- ✓ The “Medicare Program Integrity Manual (PIM),” Chapter 3, Sections 3.3.2.4, 3.6.2.2, and 3.3 at <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/pim83c03.pdf>

Comprehensive Error Rate Testing (CERT): Endovenous Ablation Therapy of Incompetent Vein

Provider Types Affected: Physicians and Providers

Background

Endovenous procedures are far less invasive than surgery for varicose veins and have lower complication rates with similar results. Endoluminal radiofrequency ablation is a percutaneous catheter-based procedure in which the vein is ablated from within by resistive heating. This procedure provides a minimal access alternative to the classical high saphenous tie and strip. This procedure generally results in minimal post-operative pain and allows early return to normal activities.

Description of Special Study

The CERT contractor conducted a special study of claims with lines for Endovenous Ablation Therapy (EVAT) of incompetent veins billed with HCPCS code 36475 submitted from April through June 2015. When CERT reviews a claim, all lines submitted on the claim undergo complex medical review. The long description of this HCPCS code is: endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, radiofrequency; first vein treated. The consumer-friendly version of this HCPCS code descriptor is: destruction of insufficient vein of arm or leg, accessed through the skin.

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. For example, there was:

- No documentation to support the medical need for the procedure
- No duplex ultrasound from before the surgery
- No operative procedure note
- No physician's signature on a procedure note, diagnostic report or progress note

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

A vascular surgeon billed for HCPCS 36475 and, in response to the CERT contractor's request for documentation, submitted the following:

1. Lower extremity arterial segmental pressure report
2. A procedure note
3. Progress notes
4. A signature log

The Local Coverage Determination (LCD) applicable to this claim requires that a 3-month trial of conservative therapy, such as exercise, periodic leg elevation, weight loss, compressive therapy, and avoidance of prolonged immobility where appropriate, has failed. The CERT staff made additional requests for documentation, but the provider sent duplicate documentation. CERT scored the claim as an insufficient documentation error and the MAC recovered the payment from the provider.

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

A cardiologist billed for HCPCS 36475 and, in response to the CERT contractor's request for documentation, submitted the following:

1. An authenticated progress note for a beneficiary with leg pain, cramping, and difficulty walking, an exam showing no LE swelling, an assessment of varicose veins with inflammation, and plan for elastic stockings, leg elevation and increased exercise, with a follow up in 2 weeks
2. An authenticated operative report for radiofrequency ablation
3. An authenticated post-operative progress note showing beneficiary with leg pain and no swelling in legs
4. An EKG

The submitted documentation was missing the physician's clinical documentation supporting the failure of an adequate trial of conservative management. The LCD applicable to this claim requires documentation of failed conservative treatment. In response to requests for additional documentation, additional post-operative progress notes were submitted. However, this did not meet the requirements for pre-operative documentation of medical need. This claim was scored as an insufficient documentation error and the payment was recovered from the provider.

Example of Improper Payments due to Insufficient Documentation – Missing operative report

A cardiologist billed for HCPCS 36475 and in response to the CERT contractor's request for documentation submitted the following:

1. A signed "Encounter Summary" note which documented "1st Vein Treated: Left GSV" and "2nd Vein Treated: Left ASV" with no detailed documentation of the actual procedure
2. A physician's note which documented presence of edema and varicosities of bilateral lower legs with recommendation to wear compression hose and leg elevation
3. A physician's note which documented results of venous mapping (significant left sided reflux of GSV) and patient report of bilateral lower leg pain despite compression hose and plan for ablation
4. A Venous Insufficiency Report
5. A Venous Ablation Consent
6. A Pre-op Checklist
7. Post venous ablation instructions
8. Advance Beneficiary Notices (BNs)
9. Unsigned procedure implant log
10. Post-operative recovery room nurses' notes
11. A physician's progress note post ablation, which documented successful radiofrequency ablation

Duplicates of the above documents were submitted in response to requests for additional documentation. Despite the supporting documentation provided, the operative report was missing. CERT scored this claim as an insufficient documentation error.

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 can find the LCD that applies to your jurisdiction using the Medicare Coverage Database at <https://www.cms.gov/medicare-coverage-database/search/search-results.aspx?SearchType=Advanced&CoverageSelection=Local&ArticleType=SAD%7cEd&PolicyType=Both&s=All&CptHcpcsCode=36475>

Comprehensive Error Rate Testing (CERT): Blepharoplasty

Provider Types Affected: Physicians

Background

Blepharoplasty is a procedure in which the surgeon removes excess eyelid skin, fat, and/or muscle. This procedure is often done to correct a deficit in the field of vision due to drooping of the eyelid. When performed to improve abnormal function, Medicare considers it reasonable and necessary. When performed only to improve appearance for cosmetic reasons, it is not covered by Medicare.

Description of Special Study

The CERT contractor conducted a special study of claims with lines for blepharoplasty procedures billed with HCPCS code 15823 submitted from January through March 2015. When CERT reviews a claim, all lines submitted on the claim undergo complex medical review. The long description of this HCPCS code is: blepharoplasty, upper eyelid; with excessive skin weighting down lid. The consumer-friendly version of this HCPCS code descriptor is: removal of excessive skin and fat of upper eyelid.

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. For example, there was:

- No authenticated/signed visual field testing
- No authenticated/signed and interpreted photographs from before the surgery
- No operative procedure note
- No documentation of the medical need for the operative procedure
- No physician's signature on a procedure note or progress note

Example of Improper Payments due to Insufficient Documentation – Missing documentation

An ophthalmologist billed for HCPCS 15823 and, in response to the CERT contractor's request for documentation, submitted the following:

1. A signed operative report
2. Signed post-operative notes
3. An unsigned visual field testing report
4. A signed progress note that documented the plan for surgery

The CERT staff made phone calls and sent letters asking for additional documentation. However, the provider did not submit any further documentation. The progress note submitted did not meet the requirements of the LCD. The LCD required that a functional deficit or disturbance secondary to eyelid and/or brow abnormalities must be documented, such as interference with vision or visual field that impacts an activity of daily living (such as difficulty reading or driving). In addition, the documentation should show that the eye being considered for surgery has physical signs consistent with the functional deficit or abnormality. The submitted documentation was insufficient to support the medical necessity for the blepharoplasty. This claim was scored as an insufficient documentation error and the payment was recovered from the provider.

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

An Ambulatory Surgical Center billed for HCPCS 15823 and, in response to the CERT contractor's request for documentation, submitted the following:

1. A signed operative report
2. A completed consent form
3. An unsigned visual field exam graph

The LCD applicable to this claim required photographs to support that upper eyelid surgery was reasonable and necessary. No photographs were received. Note that the visual field testing might have provided support for the medical necessity of blepharoplasty, but was not specifically required by the applicable LCD. The submitted documentation, without the required photographs, was insufficient to support the medical necessity for blepharoplasty. Despite phone calls and additional request letters, no additional documentation was received. This claim was scored as an insufficient documentation error and the payment was recovered from the provider.

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

An ophthalmologist billed for HCPCS 15823 and in response to the CERT contractor's request for documentation submitted the following:

1. A signed operative report
2. A signed consent form
3. An unsigned pre-operative note with a plan for blepharoplasty

The LCD applicable to this claim required photographs to support that upper eyelid surgery was reasonable and necessary. The provider did not send any photographs to CERT. In response to requests for additional documentation, the provider submitted copies of the same documents previously submitted. CERT scored the claim as an insufficient documentation error and the MAC recovered the payment from the provider.

Example of Improper Payments due to Insufficient Documentation – Missing signature/signature attestation; missing documentation

An ophthalmologist billed for HCPCS 15823 and in response to the CERT contractor's request for documentation submitted the following:

1. A signed operative report
2. A signed consent form
3. Anesthesia records
4. Photographs without a beneficiary identifier that were too dark to view
5. Visual field testing graphs (marked taped and un-taped) that did not include a provider signature or interpretation

The LCD applicable to this claim provides instructions on how to submit photographs and includes requirements that photographs must be of good quality and must be identified with the beneficiary's name and the date. In response to requests for additional documentation, the provider submitted copies of the same documents previously submitted. CERT scored this claim as an insufficient documentation error and the MAC recovered the payment 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 can find the LCD that applies to your jurisdiction using the Medicare Coverage Database: <https://www.cms.gov/medicare-coverage-database/search/search-results.aspx?SearchType=Advanced&CoverageSelection=Local&ArticleType=SAD%7cEd&PolicyType=Both&s=All&CptHcpcsCode=15823>. In addition, review:

- ✓ Chapter 16, Section 120 (Cosmetic Surgery) in the "Medicare Benefit Policy Manual" at <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c16.pdf>

Comprehensive Error Rate Testing (CERT): Transurethral Resection of the Prostate

Provider Types Affected: Physicians

Background

A surgeon/urologist performs a Transurethral Resection of the Prostate (TURP) by inserting an instrument through the urethra to remove the sections of the prostate that are blocking urine flow. A TURP is the most common surgery for treating benign enlargement of the prostate gland.

Description of the Special Study

The CERT contractor conducted a special study of claims with lines for TURP procedures billed with HCPCS code 52601 submitted from January through March 2015. When CERT reviews a claim, all lines submitted on the claim undergo complex medical review. The long description of this HCPCS code is: Transurethral electro-surgical resection of prostate, including control of postoperative bleeding, complete (vasectomy, meatotomy, cystourethroscopy, urethral calibration and/or dilation, and internal urethrotomy are included). The consumer-friendly version of this HCPCS code descriptor is: Electro-removal of prostate through bladder canal (urethra) with control of bleeding using an endoscope.

Finding: Insufficient Documentation Causes Most Improper Payments

Most improper payments were due to insufficient documentation. A small number of improper payments occurred because the surgeons did not submit medical records or billed the procedure incorrectly.

Example of Improper Payments due to Insufficient – Missing signature/signature attestation

A urologist billed for HCPCS 52601 and, in response to the CERT contractor's request for documentation, submitted the following:

1. An unsigned operative report
2. An unsigned history and physical examination office note
3. A pathology report
4. Diagnostic test reports
5. An unsigned discharge summary
6. Progress notes

The medical reviewer made additional requests in an attempt to obtain a signature attestation. However, the provider did not submit any additional documentation. CERT scored the claim as an insufficient documentation error and the MAC recovered the payment from the provider.

Note that the provider could have completed a signature attestation to correct the missing signature error. Providers can access an example of an attestation statement on the [CERT Provider website](#).

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

A urologist billed for HCPCS 52601, but did not submit any medical documentation in response to our requests. The only reply to our request was a letter that stated “We show no dates of treatment for the dates/types of records specified.” Despite phone calls and additional request letters, no additional documentation was received. This claim was scored as an insufficient documentation error and the payment was recovered from the provider.

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

A urologist billed for HCPCS 52601 and, in response to the CERT contractor's request for documentation, submitted the following:

1. A signed operative report
2. A signed progress note on the day of surgery
3. A diagnostic test on the day of surgery

However, the submitted documentation did not include information to support the medical necessity of the procedure. Despite additional phone calls and additional request letters, no additional documentation was received. This claim was scored as an insufficient documentation error and the payment was recovered from the provider.

Example of Improper Payments due to Incorrect Coding – Recode to 52630

A urologist billed for HCPCS 52601. According to the progress notes and operative report, the beneficiary had a TURP 20 years previously. The urologist correctly submitted the authenticated operative report, progress notes, laboratory results, a pathology report and nurses' notes. The submitted documentation supported a recode from 52601 to 52630 (transurethral resection; residual or re-growth of obstructive prostate tissue including control of postoperative bleeding, complete). This claim was scored as an incorrect coding error.

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. Understand the necessity of responding to Medicare's requests for additional medical record documentation in order to assure Medicare reviewers can review your claim completely. Providers can complete a signature attestation to correct a missing signature error. A copy of this statement is on the [CERT Provider website](#).

Resources

Additional information to help you avoid these errors includes:

- ✓ Chapter 3, Section 3.6.2.2 of the “Medicare Program Integrity Manual” at <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/pim83c03.pdf>
- ✓ Chapter 1, Section 110 of the “Medicare Claims Processing Manual” at <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c01.pdf>

Recovery Auditor Finding: Post Acute Care Transfer

Provider Types Affected: Hospitals

Background

The Recovery Auditors conducted an automated review to identify patient discharge status codes improperly reported under Medicare’s Inpatient Prospective Payment System (IPPS) Post-Acute Care Transfer (PACT) Policy. This policy applies to qualifying Diagnosis Related Groups (DRGs) and involves the following patient discharge status codes:

- 01 - Discharge to home of self-care (Routine Discharge)
- 03 - Discharged/transferred to skilled nursing facility (SNF) with Medicare certification in anticipation of covered skilled care
- 05 - Discharged/transferred to designated cancer center or children’s hospital
- 06 - Discharged/transferred to home under care of organized home health service organization in anticipation of covered skilled care
- 62 - Discharged/transferred to designated to an inpatient rehabilitation facility including distinct part units of a hospital
- 63 - Discharged/transferred to long term care hospital (LTCH)
- 65 - Discharged/transferred to a psychiatric Hospital or psychiatric distinct part unit of a hospital

Under the PACT policy, cases with a length of stay less the Geometric Mean for the PACT DRG will not reimburse the full Diagnosis Related Group (DRG) payment when the patient is transferred to a post-acute care setting. For reviews conducted on and after September 11, 2015, the auditors identified some overpayments.

If a qualifying claim is submitted with a discharge status code 01 (Discharge to home of self-care (Routine Discharge)), Medicare’s overpayment edit will look for:

- The presence of a transfer claim to a Skilled Nursing Facility, Cancer Hospital, Psychiatric Hospital, Children’s Hospital, Inpatient Rehab Facility, or Long Term Care Facility that commences or continues within one day of the acute care discharge, or
- A transfer claim to Home Health Care that commences or continues within three days of the acute care discharge.

Finding

Analysis of discharge status codes and secondary claim data identified improper payments. Where a hospital used discharge status code 01, but should have shown a transfer to another care setting with a different discharge status code, the hospital may be overpaid for the inpatient services. It is crucial that hospitals place the correct discharge status code on claims to avoid subsequent overpayment identification and recovery.

Guidance on How Providers Can Avoid these Problems

Hospitals should take steps to assure claims coders understand that the patient discharge status code is a crucial data element in determining payment for inpatient stays.

Resources

You will find more information on avoiding these errors in the following resources:

- ✓ MLN Matters® article SE0801-Clarification of Patient Discharge Status Codes and Hospital Transfer Policies, which is at <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE0801.pdf>
- ✓ Office of Inspector General (OIG) Report A-06-93-0009 at <https://oig.hhs.gov/oas/reports/region6/69300095.pdf>
- ✓ OIG Report A-04-04-03000 at <https://oig.hhs.gov/oas/reports/region4/40403000.pdf>

Recovery Auditor Finding: Skilled Nursing Facility Coding Validation

Provider Types Affected: Hospitals

Background

The Recovery Auditors are reviewing claims submitted by Skilled Nursing Facilities (SNFs) to determine the extent to which the Minimum Data Set (MDS) is accurate and supported by the resident's medical records as required by "[Medicare Benefit Policy Manual, Chapter 8](#), Section 30.2 and the [CMS MDS 3.0 RAI Manual Chapter 6](#), Section 6.4. It is important that SNFs remember the relationship of the assessments to support correct SNF Prospective Payment System (PPS) reimbursement.

To verify that the Medicare bill accurately reflects the assessment information, three data items derived from the MDS assessment must be included on the Medicare claim:

1. Assessment Reference Date (ARD): The ARD must be reported on the Medicare claim. If an MDS assessment was not completed, the ARD is not used and the claim must be billed at the default rate. CMS has developed mechanisms to link the assessment and billing records.
2. The RUG IV Group: The Resource Utilization Group (RUG) is calculated from the MDS assessment data. The software used to encode and transmit the MDS assessment data calculates the appropriate RUG group.
3. Health Insurance PPS (HIPPS) Codes represent specific sets of patient characteristics (or case-mix groups) on which payment determinations are made.

Finding

The auditors found a number of claims in each State being reviewed where claims were in error and payments were made incorrectly. The auditors determined that incorrect resident assessments led to a number of the incorrect payments.

Guidance on How Providers Can Avoid these Problems

It is important that SNFs remember the relationship of the assessments to support correct SNF Prospective Payment System (PPS) reimbursement. The MDS is used to calculate the Resource Utilization Group classification that is necessary for payment.

Resources

The following will assist providers in preparing accurate assessments:

- ✓ Chapter 8 of the “Medicare Benefit Policy Manual” at <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c08.pdf>
- ✓ Chapter 6 of the CMS MDS 3.0 RAI Manual at <https://downloads.cms.gov/files/MDS-30-RAI-Manual-V114-October-2016.pdf>



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