Re: Claim Number: [redacted]
Claims Administrator name: [redacted]
Date of Disputed Services: 5/19/2013 – 5/19/2013
MAXIMUS IBR Case: CB13-0000516

Dear [redacted],

**Determination:**
A Request for Independent Bill Review (IBR) was assigned to MAXIMUS Federal Services on 10/23/2013, by the Administrative Director of the California Division of Workers' Compensation pursuant to California Labor Code section 4603.6. MAXIMUS Federal Services has determined that the **Claims Administrator's determination is upheld.** This determination finds that the Claims Administrator does not owe the Provider additional reimbursement.

**Pertinent Records and Other Appropriate Information Relevant to the Determination Reviewed:**
The following evidence was used to support the decision:

- The original billing itemization
- Supporting documents submitted with the original billing
- Explanation of Review in response to the original bill
- Request for Second Bill Review and documentation
- Supporting documents submitted with the request for second review
- The final explanation of the second review
- Other: OMFS Outpatient Hospital Fee Schedule, National Correct Coding Initiative Version 19.1 (4/1/2013-6/30/2013)
Supporting Analysis:
The dispute regards the payment for surgical facility services on date of service 5/19/2013. The facility services were billed on a UB-04/CMS1450 using revenue codes for services and supplies related to CPT 29881, CPT 29876 Modifier 51, CPT 29870 Modifier 51, CPT 27570 and CPT 20610. The Provider was reimbursed $2,996.13 and is requesting additional reimbursement of $6,103.20. The Claims Administrator reimbursed for the following billed surgical procedure codes: 29881 and 29876. The Claims Administrator denied the billed procedure code 29870, 27570 and 20610 with the explanation “No separate payment was made because the value of the service is included within the value of another service performed on the same day.”

The Provider is disputing the denial of CPT code 29870 Modifier 51, 27570 and 20610.

CPT 29881 - Arthroscopy, knee, surgical; with meniscectomy (medial OR lateral, including any meniscal shaving) including debridement/shaving of articular cartilage (chondroplasty), same or separate compartment(s), when performed.
CPT 29876 - Arthroscopy, knee, surgical; synovectomy, major, 2 or more compartments (e.g., medial or lateral).
CPT 29870 - Arthroscopy, knee, diagnostic, with or without synovial biopsy (separate procedure).
CPT 27570 - Manipulation of knee joint under general anesthesia (includes application of traction or other fixation devices).
CPT 20610 - Arthrocentesis, aspiration and/or injection; major joint or bursa (e.g., shoulder, hip, knee joint, subacromial bursa)
Modifier 51 - Multiple Procedures.

Pursuant to Labor Code section 5307.1(g)(2), the Administrative Director of the Division of Workers' Compensation orders that Title 8, California Code of Regulations, sections 9789.30 and 9789.31, pertaining to Hospital Outpatient Departments and Ambulatory Surgical Centers Fee Schedule in the Official Medical Fee Schedule, is amended to conform to CMS' hospital outpatient prospective payment system (OPPS). The Administrative Director incorporates by reference, the Centers for Medicare and Medicaid Services' (CMS) Hospital Outpatient Prospective Payment System (OPPS) certain addenda published in the Federal Register notices announcing revisions in the Medicare payment rates. The adopted payment system addenda by date of service are found in the Title 8, California Code of Regulations, Section 9789.39(b). Based on the adoption of the CMS hospital outpatient prospective payment system (OPPS), CMS coding guidelines and the hospital outpatient prospective payment system (OPPS) were referenced during the review of this Independent Bill Review (IBR) case.

Based on the provider type, the reimbursement for services is calculated on the Centers for Medicare and Medicaid Services (CMS) Outpatient Prospective Payment System (OPPS).

NCCI edits define when two procedure HCPCS/CPT codes may not be reported together except under special circumstances. If an edit allows use of NCCI-associated modifiers, the two procedure codes may be reported together when the two procedures are performed at different anatomic sites or different patient encounters. NCCI-associated modifiers may be utilized to allow payment of both codes of an edit. The documentation must support the use of the modifier. Modifiers that may be used under appropriate clinical circumstances to bypass an NCCI edit include: Anatomic modifiers: E1-E4, FA, F1-F9, TA, T1-T9, LT, RT, LC, LD, RC, LM, RI; Global surgery modifiers: 24, 25, 57, 58, 78, 79; other Modifiers: 27, 59, and 91. The billed surgical procedure codes 29870, 27570 and 20610 were not billed with any of the above Modifiers.
The operative report documented the following procedures on the right knee: Arthroscopy of the right knee with partial lateral meniscectomy; complete synovectomy of the knee; Surface chondroplasty of the lateral and patellofemoral compartment; and Arthrocentesis and injection of 0.5% plain Marcaine. The operative report did not indicate a different session or patient encounter, different procedure or different site other than the right knee. The two procedures 29870 and 27570 are not reported with 29881 or 29876 when performed on the same site during the same patient encounter.

The narrative for many CPT codes includes a parenthetical statement that the procedure represents a "separate procedure". The inclusion of this statement indicates that the procedure can be performed separately but should not be reported when a related service is performed. A “separate procedure” should not be reported when performed along with another procedure in an anatomically related region through the same skin incision or orifice, or surgical approach. The CPT code 29870 is designated as a "separate procedure". Therefore, if it is reported with CPT codes 29876 or 29881, CPT code 29870 is bundled into CPT codes 29876 and 29881.

All services necessary to complete a procedure based upon standard medical/surgical practice are included in the procedure. Many procedures that are typically necessary to complete a more comprehensive procedure have been assigned independent CPT codes because they may be performed independently in other settings. The service described by CPT code 27570 is typically included when performing the procedure described by CPT codes 29876 and 29881 and is therefore bundled into CPT codes 29876 and 29881.

The global service package for the arthroscopic procedures CPT 29876 and CPT 29881 include the diagnostic knee arthroscopy (CPT 29870) and manipulation under anesthesia (CPT 27570). When both a diagnostic and surgical arthroscopy are performed, the diagnostic arthroscopy is an inclusive component of the surgical arthroscopy.

The CPT code 20610 should not be reported when performed concurrently with another intra-articular procedure (CPT 29881 or 29876). The CPT code 20610 bundles into 29881, so it would not be reported separately. The CPT code 20610 may be reported separately if done on a separate and distinct anatomical site than the surgical procedure and billed with a Modifier 59. The operative report did not indicate a separate and distinct anatomical site from the surgical procedure (right knee). The denial of reimbursement for CPT 20610 by the Claims Administrator was correct.

There is no additional reimbursement due for the surgical facility services, Official Medical Fee Schedule codes 27570, 29870 and 20610 billed for date of service 5/19/2013.

The chart below provides a comparison of billed charges and reimbursement rates for the codes and dates of services at issue.

<table>
<thead>
<tr>
<th>Validated Code</th>
<th>Validated Modifier</th>
<th>Dispute Amount</th>
<th>Total Fee Schedule Allowance</th>
<th>Provider Paid Amount</th>
<th>Allowed Recommended Reimbursement</th>
<th>Fee Schedule Utilized</th>
</tr>
</thead>
<tbody>
<tr>
<td>29870</td>
<td>51</td>
<td>$5,189.12</td>
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<td>$0.00</td>
<td>$0.00</td>
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<tr>
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<td>$0.00</td>
<td>$0.00</td>
<td>OMFS</td>
</tr>
<tr>
<td>20610</td>
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<td>$914.08</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>OMFS</td>
</tr>
</tbody>
</table>
Chief Coding Specialist Decision Rationale:
This decision was based on OMFS Outpatient Hospital Fee Schedule and comparison with explanation of review (EOR). This was determined correctly by the Claims Administrator and the payment of $0.00 for the billed CPT codes 29870, 27570 and 20610 is upheld.

This decision constitutes the final determination of the Division of Workers' Compensation Administrative Director, is binding on all parties, and is not subject to further appeal except as specified in Labor Code section 4603.6(f)

Sincerely,

[Name], RHIT

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[Name]

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[Name]