**Independent Bill Review Final Determination Upheld**

6/20/2014

<table>
<thead>
<tr>
<th>IBR Case Number:</th>
<th>CB13-0000855</th>
<th>Date of Injury:</th>
<th>7/18/2012</th>
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<tbody>
<tr>
<td>Claim Number:</td>
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<td>Application Received:</td>
<td>12/12/2013</td>
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<td>Claims Administrator:</td>
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<tr>
<td>Date(s) of service:</td>
<td>7/31/2013 – 7/31/2013</td>
<td></td>
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<tr>
<td>Provider Name:</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Employee Name:</td>
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<td></td>
<td></td>
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<tr>
<td>Disputed Codes:</td>
<td>27625, 29898 and 20605</td>
<td></td>
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**Dear [Redacted]**

**Determination:**
A Request for Independent Bill Review (IBR) was assigned to MAXIMUS Federal Services on 2/3/2014, 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: Medicare and Medicaid Services (CMS) Outpatient Prospective Payment System (OPPS)
Supporting Analysis:
The dispute regards the payment for surgical facility services on date of service 7/31/2013. The facility services were billed on UB-04/CMS1450 using revenue codes for services and supplies related to CPT 27625, CPT 29898 Modifier 51, and CPT 20605. The Claims Administrator reimbursed $3,110.58 for the following billed procedure codes: 27625 and 29898. The Claims Administrator denied the billed procedure code 20605 with the explanation "A charge was made for a separate procedure that does not meet the criteria for separate payment. See Physician’s Fee Schedule General Instructions for Separate Procedures rule.”

CPT 27625 – Arthrotomy, with synovectomy, ankle;
CPT 29898 – Arthroscopy, ankle (tibiotalar and fibulotalar joints), surgical; debridement, extensive
CPT 20605– Arthrocentesis, aspiration and/or injection; intermediate joint or bursa (e.g., temporomandibular, acromioclavicular, wrist, elbow or ankle, olecranon bursa)

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, and 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). Procedures are assigned APC weights and "Proposed Payment Status Indicators." The surgical CPT codes 27625 and 29898 all have an assigned indicator of "T". The "T" indicator definition is "Significant procedure, multiple procedure reduction applies" and qualifies for separate APC payment.

The operative report listed the following operations performed on date of service 7/31/2013: Arthroscopic partial synovectomy, left ankle; Arthroscopic chondroplasty and debridement, left ankle; arthroscopic debridement of the ligament, left ankle; and injection of local block, left ankle.

Per coding guidelines, CPT code 20605 (Arthrocentesis, aspiration and/or injection) should not be reported when performed concurrent with another intra-articular procedure (left ankle arthroscopy). If the arthrocentesis, aspiration and/or injection is performed at an anatomic site other than that of the left ankle arthroscopy, then code 20605 may be reported with Modifier 59. The operative report did not indicate a site or location other than the left ankle; therefore, there is no separate reimbursement warranted for the billed procedure code 20605.

Based on a review of the Official Medical Fee Schedule (OMFS) multiple surgery guidelines, billed codes and the explanation of review, the Claims Administrator’s reimbursement of the billed codes 27625 and 29898 was correct. The reimbursement amount was calculated based on multiple surgery guidelines, the primary procedure (27625) was considered at 100% of the allowance and all other covered surgical procedures (29898) were considered at 50% of the allowance.

IBR Final Determination Upheld
Form Effective Date 7.23.13
There is no additional reimbursement warranted per the Official Medical Fee Schedule Outpatient Hospital/Ambulatory Surgery Center code 27625, 29898 and 20605.

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 Units</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>
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<tbody>
<tr>
<td>27625</td>
<td>1</td>
<td>$1,949.11</td>
<td>$2,133.89</td>
<td>$2,133.89</td>
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<td>29898</td>
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<td>20605</td>
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<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>OMFS</td>
</tr>
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</table>

**Chief Coding Specialist Decision Rationale:**
This decision was based on medical record, explanation of review (EOR) and comparison with OMFS Outpatient Hospital and Ambulatory Surgery Center Fee Schedule. This was determined correctly by the Claims Administrator and the payment of $3,110.58 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

Copy to:

[Name]

Copy to:

[Name]