

MAXIMUS FEDERAL SERVICES, INC.

Independent Bill Review
P.O. Box 138006
Sacramento, CA 95813-8006
Fax: (916) 605-4280

Independent Bill Review Final Determination Upheld

1/10/2014

[REDACTED]
[REDACTED]
[REDACTED]

Re: Claim Number: [REDACTED]
Claims Administrator name: [REDACTED]
Date of Disputed Services: 3/19/2013 – 3/19/2013
MAXIMUS IBR Case: CB13-0000374

Dear [REDACTED],

Determination:

A Request for Independent Bill Review (IBR) was assigned to MAXIMUS Federal Services on 9/9/2014, 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: OMFS Outpatient Hospital Fee Schedule

Supporting Analysis:

The dispute regards the payment for surgical facility services on date of service 3/19/2013. The facility services were billed on a UB-04/CMS1450 using revenue codes for services and supplies related to a posterior spinal fusion. The Claims Administrator allowed reimbursement of \$8,523.03 for CPT 22612 RT, 22614 RT, 22614 LT, 22851, 22851 59 and 72110 . The Claims Administrator denied reimbursement for CPT 22612 LT indicating "Per CPT guidelines, this service can only be reported once per date of service." The Claims Administrator denied reimbursement for CPT 63048 and 63048 Modifier 59 indicating " This add-on code has been denied as the principal procedure was not billed." The Claims Administrator denied reimbursement on CPT 63047 indicating " Per CCI edits, the value of this procedure is included in the value of the comprehensive procedure." The Claims Administrator denied reimbursement on CPT 22842, 22630, 22632 and 20936 indicating "Allowance for this inpatient service is not appropriate when supplied in an outpatient setting, unless pre-authorized by the insurer." The Claims Administrator denied reimbursement on CPT 69990 with the explanation "This service is not covered under the California Hospital Outpatient Fee Schedule. There is no separate facility fee for this service."

CPT 63047 - Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root(s), [eq, spinal or lateral recess stenosis]), single vertebral segment; lumbar.

CPT 63048 - Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s], [eg, spinal or lateral recess stenosis]), single vertebral segment; each additional segment, cervical, thoracic, or lumbar (list separately in addition to code for primary procedure).

CPT 22612 - Arthrodesis, posterior or posterolateral technique, single level; lumbar (with lateral transverse technique, when performed).

CPT 22614 - Arthrodesis, posterior or posterolateral technique, single level; each additional vertebral segment (List separately in addition to code for primary procedure).

CPT 22842 - Posterior segmental instrumentation (eg, pedicle fixation, dual rods with multiple hooks and sublaminar wires); 3 to 6 vertebral segments (list separately in addition to code for primary procedure).

CPT 22630 - Arthrodesis, posterior interbody technique, including laminectomy and/or discectomy to prepare interspace (other than for decompression), single interspace; lumbar.

CPT 22632 - Arthrodesis, posterior interbody technique, including laminectomy and/or discectomy to prepare interspace (other than for decompression), single interspace; each additional interspace (List separately in addition to code for primary procedure).

CPT 20936 - Autograft for spine surgery only (includes harvesting the graft); local (eg, ribs, spinous process, or laminar fragments) obtained from same incision (list separately in addition to code for primary procedure).

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 (HOPPS). The Administrative Director incorporates by reference, the Centers for Medicare and Medicaid Services' (CMS) Hospital Outpatient Prospective Payment System (HOPPS) 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 (HOPPS), CMS coding guidelines and the hospital outpatient

prospective payment system (HOPPS) was referenced during the review of this Independent Bill Review (IBR) case.

The provider is considered an ambulatory surgical center (ASC) and is located in Santa Barbara County. 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 billed CPT 22612, 22614 and 22851 have an assigned indicator of "T". The "T" indicator definition is "Significant procedure, multiple procedure reduction applies" and qualifies for separate APC payment. The billed CPT codes 22842, 22630, 22632 and 20936 have an assigned indicator of "C". The "C" indicator definition is "Inpatient procedures, not paid under OPPS. Admit patient and bill as inpatient." All other billed supplies, drugs and services were considered an integral part of an the billed surgical procedures and not separately reimbursable.

Based on a review of the multiple surgery guidelines and the National Correct Coding Initiative/Outpatient Code Editor Version 19.0 (1/1/2013-3/31/2013), the billed procedure 63047 and 63048 generally cannot be reported with 22630. NCCI edits define when two procedure HCPCS/CPT codes may not be reported together except under special circumstances. The billed procedure codes 63047 and 63048 are an inherent part of the comprehensive billed procedure code 22630. The Claims Administrator's denial of the billed procedure codes 63047 and 63048 was correct.

The billed procedure code 22612 LT is not separately reimbursable. The procedure code 22612 is billed per interspace and segment. Each additional segments are billed with CPT 22614. Per the Operative report, the posterior spinal fusion was performed at L4-5 and L5-S1. The Provider billed and was reimbursed for CPT 22612 RT and for two units of CPT 22614. There is no additional reimbursement warranted for the CPT 22612 LT.

The billed procedure code 69990 is not considered a separately reimbursable procedure code. The code has a status code N and is packaged into the APC payment for the surgical procedure.

The billed procedure codes 22842, 22630, 22632 and 20936 are on the inpatient only list and are assigned the "C" status indicator. Per OMFS Hospital Outpatient Departments and Ambulatory Surgical Center fee schedule, Title 8 California Code of Regulations Section 9789.32(e), Hospital outpatient departments and ambulatory surgical centers shall not be reimbursed for procedures on the inpatient only list, referenced in Section 9789.31(a), Addendum E, except that pre-authorized services rendered are payable at the pre-negotiated fee arrangement. The pre-authorization must be provided by an authorized agent of the claims administrator to the provider. The fee agreement and pre-authorization must be memorialized in writing prior to performing the medical services. The documentation submitted included an authorization from the Claims Administrator. The authorization was dated 1/28/2013 and authorized the procedure "Posterior spinal fusion with transforminal lumbar interbody fusion at L4-5 and L5-S1. The authorization did not indicate inpatient only procedures (22842, 22630, 22632 and 20936) were authorized as an outpatient procedure or there was a pre-negotiated fee arrangement between the Provider and the Claims Administrator.

The disputed codes 22842, 22630, 22632 and 20936 were not authorized and no additional reimbursement is warranted.

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

Validated Code	Validated Units	Dispute Amount	Total Fee Schedule Allowance	Provider Paid Amount	Allowed Recommended Reimbursement	Fee Schedule Utilized
Outpatient Surgical Services	1	\$36,321.39	\$8,523.03	\$8,523.03	\$0.00	PPO Contract

Chief Coding Specialist Decision Rationale:

This decision was based on OMFS Outpatient Hospital fee schedule and comparison with explanation of review. This was determined correctly by the Claims Administrator and the payment of \$8,523.03 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,

██████████, RHIT

Copy to:

██
 ████████████████████████████████████
 ████████████████████████████████████

Copy to:

██
 ██
 ██