

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

1/28/2014

[REDACTED]
[REDACTED]
[REDACTED]

Re: Claim Number: [REDACTED]
Claims Administrator name: [REDACTED]
Date of Disputed Services: 3/13/2013 – 3/13/2013
MAXIMUS IBR Case: CB13-0000408

Dear [REDACTED],

Determination:

A Request for Independent Bill Review (IBR) was assigned to MAXIMUS Federal Services on 9/25/2013, 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/Outpatient Code Editor Version 19.0 (1/1/2013-3/31/2013)

Supporting Analysis:

The dispute regards the payment for surgical facility services on date of service 3/13/2013. The facility services were billed on a UB-04/CMS1450 using revenue codes for services and supplies related to CPT 29881, CPT 29876, CPT 29870 Modifier 51, CPT 29884 Modifier 51, CPT 20680, CPT 27570 Modifier 51 and CPT 20610. The Provider was reimbursed \$4,865.09 and is requesting additional reimbursement of \$1,049.35. The Claims Administrator reimbursed \$4,865.09 for the following billed procedure codes: 29881, 29876, 29870, 20680, 27570, S0020, E0114 and 81025. The Claims Administrator denied the billed procedure code 20680 with the explanation "Post -op pain management is included in the global surgical package." The Claims Administrator denied the billed procedure code 29884 Modifier 51 with the explanation "This separate independent procedure is considered an integral part of the total services performed and does not warrant a separate charge."

The Provider is disputing the denial of CPT codes 20610 and 29884 Modifier 51.

The operative report documented the following procedures on the left knee: EUA and arthroscopy, left knee; Partial lateral meniscectomy; Multicompartment synovectomy; Multiple chondroplasties; Lysis of multiple adhesions; and Removal of exostosis and hardware, left proximal tibia.

CPT 29884 - Arthroscopy, knee, surgical; with lysis of adhesions, with or without manipulation (separate procedure).

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 20680 - Removal of implant; deep (e.g., buried wire, pin, screw, metal band, nail, rod or plate).

CPT 20610 - Arthrocentesis, aspiration and/or injection; major joint or bursa (e.g., shoulder, hip, knee joint, subacromial bursa).

HCPCS E0114 - Crutch underarm pair.

Modifier 51 - Multiple Procedures: When multiple procedures, other than E/M services, Physical Medicine and Rehabilitation services or provision of supplies (e.g., vaccines), are performed at the same session by the same provider, the primary procedure or service may be reported as listed. The additional procedure(s) or service(s) may be identified by appending modifier 51 to the additional procedure or service code(s).

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.

The provider is considered an ambulatory surgical center (ASC) and is located in Orange 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 surgical CPT's billed all have an assigned indicator of "T". The "T" indicator definition is "Significant procedure, multiple procedure reduction applies" and qualifies for separate APC payment. All other services not considered for reimbursement were costs that were directly related and integral to performing the procedure or furnishing the service on an outpatient basis. These costs include but are not limited to: Anesthesia, medical and surgical supplies and equipment.

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 procedures were not billed with any of the above Modifiers.

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 CPT 20610 is not generally reported with CPT codes 29870, 29876 or 29881. The service described by CPT 20610 is typically included when performing the procedures described by CPT 29870, 29876 and 29881 and, therefore, no separate payment is allowed for CPT 20610. The Claims Administrator reimbursed the Provider for the billed CPT codes 29870, 29876 and 29881 according the OMFS Outpatient Hospital and Ambulatory Surgery Center Fee Schedule. The denial of the billed procedure code 20610 by the Claims Administrator was correct.

The CPT code 29884 is designated as 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. If CPT 29884 is reported with CPT codes 29876 or 29881, the CPT code 29884 is bundled into CPT codes 29876 and 29881. The operative report did not indicate a different session or patient encounter, different procedure or surgery, different site. Therefore, the denial of reimbursement for the billed CPT 29884 by the Claims Administrator was correct.

Based on a review of the explanation of review (EOR) and the PPO contract, the reimbursement by the Claims Administrator was made according to the OMFS Outpatient Hospital and Ambulatory Surgical Center Fee Schedule. The reimbursement amount was calculated based on multiple surgery guidelines. The primary procedure 29870 was considered at 100% of the PPO allowance and all other covered surgical procedures were considered at 50% of the PPO allowance.

There is no additional reimbursement warranted per the Official Medical Fee Schedule for the surgical facility services on date of service 3/13/2013.

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

Validated Code	Dispute Amount	Total Fee Schedule Allowance	Provider Paid Amount	Allowed Recommended Reimbursement	Fee Schedule Utilized
ASC Services	\$1,049.35	\$4,865.09	\$4,865.09	\$0.00	PPO Contract

Chief Coding Specialist Decision Rationale:

This decision was based on OMFS Outpatient Hospital and Ambulatory Sugery Center Fee Schedule, PPO Contract and comparison with explanation of review (EOR). This was determined correctly by the Claims Administrator and the payment of \$4,865.09 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,

[Redacted], RHIT

Copy to:

[Redacted]
[Redacted]
[Redacted]

Copy to:

[Redacted]
[Redacted]
[Redacted]