

MAXIMUS FEDERAL SERVICES, INC.

Independent Bill Review
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Independent Bill Review Final Determination Upheld

1/31/2014

[REDACTED]
[REDACTED]
[REDACTED]

Re: Claim Number: [REDACTED]
Claims Administrator name: [REDACTED]
Date of Disputed Services: 6/11/2013 – 6/11/2013
MAXIMUS IBR Case: CB13-0000458

Dear [REDACTED],

Determination:

A Request for Independent Bill Review (IBR) was assigned to MAXIMUS Federal Services on 10/7/2013, 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 19.1 (4/1/2013-6/30/2013)

Supporting Analysis:

The dispute regards the payment for surgical facility services on date of service 6/11/2013. The facility services were billed on a UB-04/CMS1450 using revenue codes for services and supplies related to CPT 29819 Modifier 59 RT, CPT 29820 Modifier 59 RT, and CPT 29822. The Provider was reimbursed \$2,351.59 and is requesting additional reimbursement of \$6,481.76. The Claims Administrator reimbursed \$2,351.59 for the billed procedure code 29822. The Claims Administrator denied billed procedure codes 29819 and 29820 with the explanation "Use of modifier 59 with this code is not supported by the documented services per AMA definitions & Correct Coding Initiative (CCI) guidelines. Included in 29822 per Medicare CCI Edits when performed in the same shoulder same operative session."

The Provider is disputing the denial of CPT codes 29819 Modifier 59, RT and 29820 Modifier 59, RT.

CPT 29819 - Arthroscopy, shoulder, surgical; with removal of loose body or foreign body.

CPT 29820 - Arthroscopy, shoulder, surgical; synovectomy, partial.

CPT 29822 - Arthroscopy, shoulder, surgical; debridement, limited.

Modifier 59 – Distinct Procedural Service.

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 procedures 29819 and 29820 were billed with the Modifiers RT and 59, however, the documentation did not support the use of the Modifiers.

The operative report documented the following procedures on the right shoulder: right shoulder arthroscopy with arthroscopic intraarticular synovectomy; Arthroscopic debridement of subacromial adhesions; Arthroscopic removal of foreign body. The operative report did not indicate a different session or patient encounter, different procedure or different site. The procedures (29819, 29820 and

29822) are not reported together when performed on the same site during the same patient encounter.

Some procedures can be performed at varying levels of complexity. The CPT codes corresponding to more extensive procedures always include the CPT codes corresponding to less complex procedures. The CPT code 29822 is a more extensive procedure that includes CPT code 29819 and 29820. Accordingly, the more extensive procedure, CPT code 29822 was reimbursed by the Claims Administrator. The CPT codes 29819 and 29820 were bundled into the reimbursement of CPT code 29822.

There is no additional reimbursement due for the surgical facility services, Official Medical Fee Schedule codes 29819 and 29820 billed for date of service 6/11/2013.

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

Validated Code	Validated Modifier	Validated Modifier	Validated Units	Dispute Amount	Total Fee Schedule Allowance	Provider Paid Amount	Allowed Recommended Reimbursement	Fee Schedule Utilized
29819	59	RT	1	\$4,321.17	\$0.00	\$0.00	\$0.00	OMFS
29820	59	RT	1	\$2,160.59	\$0.00	\$0.00	\$0.00	OMFS

Chief Coding Specialist Decision Rationale:

This decision was based on Official Medical Fee Schedule (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 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

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[Redacted]
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