

MAXIMUS FEDERAL SERVICES, INC.

Independent Bill Review
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Independent Bill Review Final Determination Upheld

6/27/2014

[REDACTED]
[REDACTED]
[REDACTED]

IBR Case Number:	CB13-0000470	Date of Injury:	2/9/2013
Claim Number:	[REDACTED]	Application Received:	9/11/2013
Claims Administrator:	[REDACTED]		
Date(s) of service:	5/19/2013 – 5/19/2013		
Provider Name:	[REDACTED]		
Employee Name:	[REDACTED]		
Disputed Codes:	29870, 27570 and 20610		

Dear [REDACTED]

Determination

A Request for Independent Bill Review (IBR) was assigned to MAXIMUS Federal Services on 2/12/2014, 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, 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 UB-04/CMS1450 using revenue codes for services and supplies related to CPT 29881, CPT 29870 Modifier 51, CPT 29876 Modifier 51, and CPT 27570 Modifier 51. The Claims Administrator reimbursed \$2,756.44 for the following billed procedure codes: 29881, 29876 and E0114. The Claims Administrator denied the billed procedure codes: 29870, 20610 and 27570 with the explanation "No allowance change for CPT 29870 Diagnostic arthroscopy is always included in the major procedure. CPT 27570 is for manipulation under anesthesia is incidental to the major procedure. CPT 20610 for pain control is included in the global facility reimbursement. Procedure performed per OP Report: Partial meniscectomy, extensive synovectomy and injection of 0.5% Marcaine."

Per the Provider's appeal letter to the Claims Administrator, the Provider is disputing the "nonpayment of secondary codes: 29870, 27570 and 20610." The Independent Bill Review application indicated the dispute was regarding "nonpayment of secondary procedures, carrier denied as bundled."

The operative report documented the following procedures on the left knee: Arthroscopy of the left knee with partial medial meniscectomy; extensive synovectomy of the knee; and arthrocentesis and injection of 0.5% plain Marcaine.

- **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 29870:** Arthroscopy, knee, diagnostic, with or without synovial biopsy (separate procedure).
- **CPT 29876:** Arthroscopy, knee, surgical; synovectomy, major, 2 or more compartments (e.g., medial or lateral).
- **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 (eg, 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). Procedures are assigned APC weights and "Proposed Payment Status Indicators." The surgical CPT codes 29881,

29876, 29870 and 27570 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 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 services described by CPT code 27570 (manipulation under anesthesia) is typically included when performing the procedure described by CPT codes 29881 and 29876 and is therefore bundled into CPT code 29881 and 29876.

The CPT code 29870 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, orifice, or surgical approach. If CPT 29870 (diagnostic arthroscopy) is reported with CPT codes 29881 and 29876 (surgical arthroscopy), the CPT code 29870 is bundled into CPT code 29881 and 29876. A surgical arthroscopy always includes a diagnostic arthroscopy. Therefore, the denial of reimbursement for the billed CPT 29870 by the Claims Administrator was correct.

The CPT Code 20610, Arthrocentesis, aspiration and/or injection; major joint or bursa (eg, shoulder, hip, knee joint, subacromial bursa), should not be reported when performed concurrent with another intra-articular procedure (eg, knee arthroscopy). However, should the bupivacaine injection be performed at an anatomic site other than that of the knee arthroscopy, then the CPT 20610 should be reported, as appropriate, with modifier 59, Distinct procedural service, appended. The Operative Report did not indicate a separate and distinct anatomical site from the surgical procedure (left 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.

Validated Code	Validated Modifier	Validated Units	Dispute Amount	Total Fee Schedule Allowance	Provider Paid Amount	Allowed Recommended Reimbursement	Fee Schedule Utilized
27570	51	1	\$442.87	\$0.00	\$0.00	\$0.00	PPO Contract
29870	51	1	\$900.00	\$0.00	\$0.00	\$0.00	PPO Contract
20610		1	\$914.08	\$0.00	\$0.00	\$0.00	PPO Contract

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 \$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

Copy to:

[REDACTED]
[REDACTED]
[REDACTED]

Copy to:

[REDACTED]
[REDACTED] [REDACTED]
[REDACTED]