

MAXIMUS FEDERAL SERVICES, INC.

Independent Bill Review
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Independent Bill Review Final Determination Reversed

2/6/2014

[REDACTED]
[REDACTED]
[REDACTED]

Re: Claim Number: [REDACTED]
Claims Administrator name: [REDACTED]
Date of Disputed Services: 6/15/2013 – 6/15/2013
MAXIMUS IBR Case: CB13-0000514

Dear [REDACTED]

Determination:

A Request for Independent Bill Review (IBR) was assigned to MAXIMUS Federal Services on 10/23/2013, 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 reversed. The Claims Administrator is required to reimburse you the IBR fee of \$335.00 and the amount found owing of \$978.22, for a total of \$1,313.22.**

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
- Official Medical Fee Schedule or negotiated contract: OMFS
- 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 6/15/2013. The facility services were billed on a UB-04/CMS1450 using revenue codes for services and supplies related to CPT 29823, CPT 29820 Modifier 51, CPT 29826, CPT 29805 Modifier 51, CPT 23700 Modifier 51 and CPT 20610. The Provider was reimbursed \$3,608.72 and is requesting additional reimbursement of \$15,195.82. The Claims Administrator reimbursed for the following billed procedure codes: 29805 and A4556. The Claims Administrator denied the billed procedure code 29823, 29820 and 29826 with the explanation "No separate payment was made because the value of the service is included within the value of another service performed on the same day." The Claims Administrator denied the billed procedure code 23700 and 20610 with the explanation "Recommendation of payment has been based on a procedure code which best describes services rendered."

The Provider is disputing the denial of CPT codes: 29823, 29826, 29820 Modifier 51, 23700 Modifier 51.

CPT 29823 - Arthroscopy, shoulder, surgical; debridement, extensive.

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

CPT 29826 - Arthroscopy, shoulder, surgical; decompression of subacromial space with partial acromioplasty, with coracoacromial ligament (ie, arch) release, when performed (List separately in addition to code for primary procedure).

CPT 29805 - Arthroscopy, shoulder, diagnostic, with or without synovial biopsy (separate procedure).

CPT 23700 - Manipulation under anesthesia, shoulder joint, including application of fixation apparatus (dislocation excluded).

CPT 20610 - Arthrocentesis, aspiration and/or injection; major joint or bursa (e.g., 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). The CPT codes: 29823, 29820, 29826, 29805, 23700 and 20610 have an assigned indicator of "T". The "T" indicator definition is "Significant procedure, multiple procedure reduction applies" and qualifies for separate APC payment.

NCCI edits define when two procedure 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 procedure codes were not billed with any of the above Modifiers.

The operative report documented the following procedures on the right shoulder: Arthroscopy of the right shoulder with extensive glenohumeral joint debridement; Arthroscopy subacromial bursectomy; Arthroscopic subacromial decompression; and Arthrocentesis and injection of 0.5% plain Marcaine. The operative report did not indicate a different session or patient encounter, different procedure or different site other than the right shoulder.

Based on a review of the multiple surgery guidelines and the National Correct Coding Initiative Version 19.1 (4/1/2013-6/30/2013), the billed procedure code 29823 is considered the primary procedure code and should have been reimbursed at 100% of the OMFS allowance. All other surgical procedures considered for reimbursement and subject to the multiple procedure guidelines should be considered at 50% of the OMFS allowance.

The billed CPT code 29805 is a diagnostic arthroscopic procedure. The CPT codes 29823 and 29826 are surgical arthroscopic procedures. When both a diagnostic and surgical arthroscopy are performed, the diagnostic arthroscopy is an inclusive component of the surgical arthroscopy and would not be reported separately. The billed CPT 29805 is included in or cannot be reported with CPT codes 29823 or 29826. The reimbursement of CPT 29805 and denial of 29823 and 29826 by the Claims Administrator was not correct. Reimbursement is warranted for CPT 29823 (100% OMFS \$3,595.25), and CPT 29826 (50% OMFS \$978.27). The billed CPT 29805 is not reimbursable when billed with CPT codes 29823 and 29826. There is no reimbursement warranted for the billed procedure code 29805. The reimbursement of CPT 29805 by the Claims Administrator was not correct.

The billed procedure code 23700 is not generally reported with procedure codes: 29805, 29820, 29823 and 29826. 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 service described by CPT code 23700 is typically included when performing the procedure described by CPT codes: 29805, 29820, 29823 and 29826 and is therefore bundled into CPT codes: 29805, 29820, 29823 and 29826. The arthroscopic procedures include the manipulation under anesthesia procedure (23700). The denial of CPT 23700 by the Claims Administrator was correct.

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 29823 is a more extensive procedure that includes 29820. Accordingly, only the more extensive procedure, CPT code 29823, should be reimbursed. The CPT code 29820 is bundled into CPT code 29823. The denial of CPT 29820 by the Claims Administrator was correct.

The additional reimbursement of \$978.22 is warranted for the surgical facility services, Official Medical Fee Schedule codes 29823 and 29826. There is no additional reimbursement warranted

and/or allowance for the surgical facility services, Official Medical Fee Schedule codes 29805, 29820 and 23700.

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

Validated Code	Dispute Amount	Total Fee Schedule Allowance	Provider Paid Amount	Allowed Recommended Reimbursement	Fee Schedule Utilized
ASC Services	\$15,195.82	\$4,586.94	\$3,608.72	\$978.22	OMFS

MAXIMUS Federal Services, as the Independent Bill Review Organization, has determined the Claims Administrator owes the Provider additional reimbursement. The Claims Administrator is required to reimburse the Provider for the IBR application fee (**\$335.00**) and the OMFS amount for CPT codes 29823 and 29826 (\$978.22) for a total of \$1,313.22.

The Claims Administrator is required to reimburse the provider \$1,313.22 within 45 days of date on this notice per section 4603.2 (2a). 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,

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