

MAXIMUS FEDERAL SERVICES, INC.

Independent Bill Review
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Independent Bill Review Final Determination Reversed

2/10/2014

[REDACTED]
[REDACTED]
[REDACTED]

Re: Claim Number: [REDACTED]
Claims Administrator name: [REDACTED]
Date of Disputed Services: 3/18/2013 – 3/18/2013
MAXIMUS IBR Case: CB13-0000574

Dear [REDACTED]

Determination:

A Request for Independent Bill Review (IBR) was assigned to MAXIMUS Federal Services on 11/4/2013, 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 \$717.06, for a total of \$1052.06.**

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: PPO Contract
- 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 3/18/2013. The facility services were billed on a UB-04/CMS1450 using revenue codes for services and supplies related to CPT 64483 Modifier 50 and CPT 64484 Modifier 50. The Provider was reimbursed \$1,107.39, and is requesting additional reimbursement of \$1,111.71. The Claims Administrator allowed reimbursement on the following billed CPT codes: 64483 Modifier 50, 64484 Modifier 50, 72100, 76000, and 96374. The Claims Administrator denied the billed CPT 94760 with the explanation "Procedure code not separately payable under Medicare and/or Fee Schedule guidelines."

The Provider is disputing the amount paid for the CPT codes 64483 Modifier 50, 64484 Modifier 50, 72100, 76000 and the denial of CPT code 94760.

CPT 64483 - Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or CT); lumbar or sacral, single level

CPT 64484 - Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or CT); lumbar or sacral, each additional level (List separately in addition to code for primary procedure)

CPT 72100 - Radiologic examination, spine, lumbosacral; 2 or 3 views

CPT 76000 - Fluoroscopy (separate procedure), up to 1 hour physician or other qualified health care professional time, other than 71023 or 71034 (e.g., cardiac fluoroscopy)

CPT 94760 - Noninvasive ear or pulse oximetry for oxygen saturation; single determination
Modifier 50 – Bilateral 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 (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 CPT 64483 and 64484 have an assigned indicator of "T". The "T" indicator definition is "Significant procedure, multiple procedure reduction applies" and qualifies for separate APC payment. The CPT 94760 has an assigned status indicator of "N". The "N" status indicator definition is "Items and services packaged into APC rates." The CPT 72100 has a status indicator "X". The status indicator "X" definition is "Ancillary services." The CPT code 76000 has a status indicator "Q1". The definition of status indicator "Q1" is "Packaged services subject to separate payment under OPPS payment criteria." All other services billed are considered costs that are directly related and integral to performing a procedure or furnishing a service on an outpatient basis. These costs include but are not limited to: Anesthesia, medical and surgical supplies and equipment.

The billed CPT 64483 and 64484 were billed with a modifier 50. The Modifier 50 indicates the service was performed bilaterally and payment adjustment is 150% of the fee schedule amount for a single code. The operative report documented the bilateral procedures: Fluoroscopic-guided cannulation of left/right L4-L5 epidural interspace via transforaminal approach for infusion of local anesthetic and steroid; Fluoroscopic-guided cannulation of left/right L5-S1 epidural interspace via transforaminal approach for infusion of local anesthetic and steroid. Based on a review of the PPO contract, OMFS, bilateral and multiple surgery guidelines, reimbursement of CPT 64483 Modifier 50 and 64484 Modifier 50 by the Claims Administrator was not correct.

Based on a review of the multiple surgery guidelines and the National Correct Coding Initiative Version 19.0 (1/1/2013-3/31/2013), the billed procedure code 64483 is considered the primary procedure code and should have been reimbursed at 100% of the PPO allowance. All other surgical procedures considered for reimbursement and subject to the multiple procedure guidelines should be considered at 50% of the PPO allowance. Additional reimbursement is warranted based on the PPO contract for CPT 64483 (\$1,009.00), and CPT 64484 (\$263.17).

Per Title 8 California Code of Regulations, Section 9789.32(a)(1), the following status codes are not separately payable when: (1) the item has a status code N and is packaged into the APC payment for the emergency room visit or surgical procedure (in which case no additional fee is allowable) or, For services rendered on or after March 1, 2008: the item has a status code N or Q and is packaged into the APC payment for the emergency room visit or surgical procedure (in which case no additional fee is allowable) or, For services rendered on or after March 1, 2009: the item has a status code N, Q1, Q2, or Q3 and is packaged into the APC payment for the emergency room visit or surgical procedure (in which case no additional fee is allowable). The billed procedure code 94760 has a status indicator of "N". The billed procedure code 76000 has a status indicator of Q1, and is packaged into the APC payment for surgical procedure code 64483. There is no additional reimbursement and/or allowance for CPT codes 94760 and 76000.

The billed CPT 72100 has a status indicator of "X". The maximum allowable fees for non-surgical ancillary services with a status code indicator "X" shall be determined according to Title 8, California Code of Regulations, Section 9789.10 and Section 9789.11. The Claims Administrator's reimbursement of the billed procedure code 72100 was correct.

The additional reimbursement of \$717.06 is warranted per the Official Medical Fee Schedule codes 64483 and 64484. There is no additional reimbursement warranted per the Official Medical Fee Schedule codes 72100, 76000 and 94760.

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
Outpatient Hospital Services	\$1,111.71	\$1,824.45	\$1,107.39	\$717.06	PPO Contract

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 Outpatient Hospital Services (\$717.06) for a total of \$1052.06.

The Claims Administrator is required to reimburse the provider \$1052.06 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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