MAXIMUS FEDERAL SERVICES, INC.
Independent Bill Review
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Independent Bill Review Final Determination Upheld

2/25/2014

[redacted]

Re: Claim Number: [redacted]
Claims Administrator name: [redacted]
Date of Disputed Services: 6/1/2013 – 6/1/2013
MAXIMUS IBR Case: CB13-0000635

Dear [redacted],

Determination:
A Request for Independent Bill Review (IBR) was assigned to MAXIMUS Federal Services on 11/18/2013, 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 Version 19.1 (4/1/2013-6/30/2013)

Supporting Analysis:
The dispute regards the payment for surgical facility services on date of service 6/1/2013. The facility services were billed on a UB-04/CMS1450 using revenue codes for services and supplies related to CPT 29870, CPT 29880, CPT 29871, CPT 29876, CPT 29877 and CPT 29888. The Provider was reimbursed $6,399.86 for the billed surgical codes 29888 and 29880, and is requesting additional reimbursement of $24,801.45. The Claims Administrator denied the CPT codes 29870, 29871, and 29877 with the explanation "Included in 29880 per CCI edits." The Claims Administrator denied CPT 29876 with the explanation "Included in 29888 per CCI edits."

CPT 29888 – Arthroscopically aided anterior cruciate ligament repair/augmentation or reconstruction
CPT 29870 - Arthroscopy, knee, diagnostic, with or without synovial biopsy (separate procedure).
CPT 29880 – Arthroscopy, knee, surgical; with meniscectomy (medial AND lateral, including any meniscal shaving) including debridement/shaving of articular cartilage (chondroplasty), same or separate compartment(s), when performed
CPT 29871 - Arthroscopy, knee, surgical; for infection, lavage and drainage
CPT 29876 - Arthroscopy, knee, surgical; synovectomy, major, 2 or more compartments (e.g., medial or lateral).
CPT 29877 - Arthroscopy, knee, surgical; debridement/shaving of articular cartilage (chondroplasty)

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'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.

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.

The operative report documented the following procedures on the left knee: Left knee diagnostic arthroscopy; Left knee arthroscopic partial medial and lateral meniscectomy; Left knee arthroscopic lavage; Left knee arthroscopy with major synovectomy; Left knee arthroscopy with shaving of the

medial tibial plateau and medial femoral condyle; and Left knee arthroscopically assisted ACL reconstruction.

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 or orifice, or surgical approach. When both a diagnostic and surgical arthroscopy are performed, the diagnostic arthroscopy (29870) is an inclusive component of the surgical arthroscopy (29881 and 29880) and would not be reported separately. If CPT 29870 is reported with CPT codes 29881 and 29880, the CPT code 29870 is bundled into CPT codes 29881 and 29880. 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 29870 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 codes 29880 and 29888 are more extensive procedures that include CPT code 29871. Accordingly, only the more extensive procedures, CPT codes 29880 and 29888 should be reported. The CPT code 29871 is bundled into CPT codes 29880 and/or 29888. The inclusion of CPT 29871 in the reimbursement of CPT codes 29880 by the Claims Administrator was correct.

The CPT code 29876 is bundled into CPT code 29888 as CPT 29888 is the more extensive procedure and the more extensive procedure CPT 29888 should be reported. The inclusion of CPT 29876 in the reimbursement of CPT code 29888 by the Claims Administrator was correct.

The CPT code 29877 should not be reported separately from code 29880, unless performed in a different compartment. The operative report indicated both arthroscopic procedures 29877 and 29880 were performed in the same knee compartment (medial). Therefore, CPT code 29877 does not warrant separate reimbursement.

There is no additional reimbursement warranted per the Official Medical Fee Schedule for the surgical facility services on date of service 6/1/2013.

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 facility services	$24,801.45	$6,399.86	$6,399.86	$0.00	OMFS

Chief Coding Specialist Decision Rationale:
This decision was based on OMFS Outpatient Hospital and Ambulatory Sugery Center Fee Schedule and comparison with explanation of review (EOR). This was determined correctly by the Claims Administrator and the payment of $6,399.86 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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