

The dispute regards the payment for surgical facility services on date of service 2/12/2013. The facility services were billed on a UB-04/CMS1450 using revenue codes for services and supplies related CPT code 28730 and HCPCS C1713. The Claims Administrator allowed reimbursement of \$5,528.57 for the surgical procedure code 28730 with the explanation "The allowance for this service is determined from the State Fee Schedule." The Claims Administrator denied the billed HCPCS C1713 with the explanation "Disallowed – This procedure, service, equipment and/or supply is considered a duplicate or unbundling of other related operating room charges \$0.00."

The Provider is disputing the denial of HCPCS C1713 and is requesting an additional allowance of \$9,781.08.

- **HCPCS C1713:** Anchor/screw for opposing bone-to-bone or soft tissue-to-bone (implantable)

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) was 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 billed HCPCS C1713 has an assigned indicator of "N." The "N" indicator definition is "Payment is packaged into payment for other services, including outliers. Therefore, there is no separate APC payment." Procedure codes with an assigned status indicator of "N" and are considered an integral part of the surgical procedure are not separately payable.

Separate reimbursement is not warranted for facility fee emergency room and surgical codes for supplies, drugs, devices, blood products and biologicals with an assigned indicator of "N." Items with Status code "N" are packaged into the APC payment for the emergency room visit or surgical procedure and no additional fee is allowable. There is no additional reimbursement warranted per the billed HCPCS C1713.

There is no additional allowance recommended for the Official Medical Fee Schedule code HCPCS C1713.

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

Validated Code	Validated Units	Dispute Amount	Total Fee Schedule Allowance	Provider Paid Amount	Allowed Recommended Reimbursement	Fee Schedule Utilized
C1713	1	\$9,781.08	\$0.00	\$0.00	\$0.00	OMFS

Chief Coding Specialist Decision Rationale:

This decision was based on medical record, explanation of review (EOR) and comparison with OMFS Outpatient Hospital 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

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