

MAXIMUS FEDERAL SERVICES, INC.

Independent Bill Review
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Independent Bill Review Final Determination Reversed

9/8/2014

[REDACTED]
[REDACTED]
[REDACTED]

IBR Case Number:	CB13-0000718	Date of Injury:	07/31/2012
Claim Number:	[REDACTED]	Application Received:	11/12/2013
Claims Administrator:	[REDACTED]		
Date(s) of service:	02/24/2013 – 02/24/2013		
Provider Name:	[REDACTED]		
Employee Name:	[REDACTED]		
Disputed Codes:	CPT 29821 51, CPT 29805 51 and CPT 23700 -51		

Dear [REDACTED]:

Determination:

A Request for Independent Bill Review (IBR) was assigned to MAXIMUS Federal Services on 03/28/14, 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 \$1,803.90, for a total of \$2,138.90.**

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: Medicare and Medicaid Services (CMS) Outpatient Prospective Payment System (OPPS, NCCI Version 19.0 (1/1/2013 - 3/13/2013)

Supporting Analysis:

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.

The dispute regards the payment for surgical facility services on date of service 2/24/2013. The facility services were billed on a UB-04/CMS1450 using revenue codes for services and supplies related to CPT 29823, CPT 29821 51, CPT 29826, CPT 29805 51 and CPT 23700 -51. The Claims Administrator reimbursed \$5,546.28 for the billed CPT codes 29823 and 29826. The Provider is disputing the non-payment/bundling of codes 29821, 29805 and 23700.

CPT 29821 51 was denied separate reimbursement by the Claims Administrator with the following 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 (29820, 29823). The charge exceeds the Official Medical Fee Schedule allowance. The charge has been adjusted to the scheduled allowance. The provider code billed does not accurately describe the services performed. Reimbursement was made for a code that is supported by the description and documentation submitted with the billing. In accordance with the clinical based edits (National Correct Coding Initiative/Outpatient Code Editor) Component codes of comprehensive surgery, musculoskeletal system procedure (20000 – 29999) has been disallowed."

CPT codes 29805 and 23700 denied separate reimbursement by the Claims Administrator with the following explanation "In accordance with the clinical based edits (National Correct Coding Initiative/Outpatient Code Editor) Component codes of comprehensive surgery, musculoskeletal system procedure (20000 – 29999) has been disallowed. No separate payment was made because the value of the service is included within the value of another service performed on the same day (29820, 29823)."

2013 AMA Current Procedural Terminology (CPT) code definitions:

- CPT 29823: Arthroscopy, shoulder, surgical; debridement, extensive
- CPT 29821: Arthroscopy, shoulder, surgical; synovectomy, complete
- CPT 29826: Arthroscopy, shoulder, surgical; decompression of subacromial space with partial acromioplasty, with coracoacromial ligament (i.e., 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)
- Modifier 51: Multiple Surgery

The National Correct Coding Initiative (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. (cms.gov).

The Claims Administrator bundled reimbursement of the billed synovectomy code (29821) into the debridement code (29823) indicating the “The provider code billed does not accurately describe the services performed” and assigned code 29820 as better describing the services performed.

2013 AMA Current Procedural Terminology (CPT) code definition:

CPT 29820: Arthroscopy, shoulder, surgical; synovectomy, partial

CPT Code 29821 is not identified as a code pair with the surgical CPT codes 29823 and 29826. The UB04 reflects CPT Code 29821 with the appropriate modifier (-51). The documentation, “... A **complete synovectomy** was performed next, removing all hypertrophied synovial tissue from the glenohumeral joint...” directly supports the coding of CPT 29821. CPT code 29821 was billed with a modifier - 51, identifying that the multiple procedure surgical rule applies, the correct modifier was appended to the code, and therefore it is recommended that CPT Code 29824 be reimbursed @ 50% of the listed value.

The second and final CPT codes in question are CPT 23700 and 29805. According to the NCCI edits, CPT Codes 29821, 29823 and 29826 are “Column 1” codes and are paired with 23700 and 29805 CPT Codes in column 2, with a Status Indicator of “1.”

The billed CPT codes 23700 and 29805 were not billed with an appropriate modifier identifying a separate reimbursable code when billed with CPT codes 29821, 29823 and 29826. The documentation submitted did not indicate a qualifying circumstance supporting the separate reimbursement and/or reporting of the CPT codes 23700 or 29805. The operative report did not indicate a different session or patient encounter, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury.

The services described by CPT code 23700 (manipulation under anesthesia) is typically included when performing the procedure described by CPT codes 29823, 29826 and 29821. As such, no additional reimbursement is recommended.

CPT code 29805 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. A surgical arthroscopy always includes a diagnostic arthroscopy." Given these guidelines, reimbursement is not recommended for CPT 29805

Additional reimbursement of \$1,803.90 is warranted for the Official Medical Fee Schedule Outpatient Hospital and Ambulatory Surgical Fee Schedule code 29821. No additional reimbursement is recommended for the CPT codes 23700 and 29805.

CPT 29821 OMFS Allowance 57.0137 (APC RW) X 77.17 (Adjusted Conversion Factor) x .82 = \$3,607.80 x 50% (Multiple Surgery Adjustment) = \$1,803.90

The chart below provides a comparison of billed charges and reimbursement rates for the codes and date 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
29821	51	1	\$9,975.82	\$1,803.90	\$0.00	\$1,803.90	OMFS
23700	51	1	\$2,704.94	\$0.00	\$0.00	\$0.00	OMFS
29805	51	1	\$5,189.12	\$0.00	\$0.00	\$0.00	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 code 29821 Modifier 51 (\$1,803.90) for a total of \$2,138.90.

The Claims Administrator is required to reimburse the provider \$2,138.90 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,

██████████, RHIT
Chief Coding Reviewer

Copy to:

[Redacted]
[Redacted]
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[Redacted]
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