

MAXIMUS FEDERAL SERVICES, INC.

Independent Bill Review
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Independent Bill Review Final Determination Upheld

3/28/2014

[REDACTED]
[REDACTED]
[REDACTED]

Re: Claim Number: [REDACTED]
Claims Administrator name: [REDACTED]
Date of Disputed Services: 6/26/2013 – 6/26/2013
MAXIMUS IBR Case: CB13-0000719

Dear [REDACTED]

Determination

A Request for Independent Bill Review (IBR) was assigned to MAXIMUS Federal Services on 12/9/2013, 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 6/26/2013. The facility services were billed on a UB-04/CMS1450 using revenue codes for services and supplies related to CPT 29827, CPT 29823 Modifier 59, CPT 29820 Modifier 51, CPT 20690, CPT 29826, CPT 29805 Modifier 51, CPT 23700 Modifier 51 and CPT 20610. The Provider was reimbursed \$7,082.50 and is requesting additional reimbursement. The Claims Administrator reimbursed \$7,082.50 with the explanation "Charge for a Separate Procedure that does not meet the criteria for payment. See the OMFS General Instructions for Separate Procedures rule."

The Provider is disputing the bundling of codes and lack of payment breakdown on the explanation of review.

CPT 29827 - Arthroscopy, shoulder, surgical; with rotator cuff repair

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

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

CPT 20690 - Application of a uniplane (pins or wires in 1 plane), unilateral, external fixation system

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)

CPT 20610 - Arthrocentesis, aspiration and/or injection; major joint or bursa (e.g., shoulder, hip, knee joint, subacromial bursa)

Modifier 51 - Multiple Procedures

Modifier 59 - Distinct Procedural Service

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 codes 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. The billed procedure code 81025 qualifies for a separate payment and the allowance is based on the OMFS Physician Services. The APC weights are determined by the APC code assigned by the Outpatient Prospective Payment System Calculator. 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 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; Mini-open rotator cuff repair; and Insertion of pain catheter device. 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 PPO 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 is 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, 29826 or 29827.

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 20690 is typically included when performing the procedure described by CPT code 23700 (manipulation under anesthesia) and is therefore bundled into CPT code 23700. Manipulation under anesthesia, shoulder joint code 23700 includes the application of fixation apparatus.

The billed procedure code 23700 is not generally reported with procedure codes: 29805, 29820, 29823, 29826 or 29827. 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, 29826 and 29827 and is therefore bundled into CPT codes: 29805, 29820, 29823, 29826 and 29827. The arthroscopic procedures include the manipulation under anesthesia procedure (23700).

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 arthrocentesis, aspiration and/or injection code 20610 should not be reported when performed concurrent with another intra-articular procedure (29823, 29826 or 29827). The code may be reported separately if the post-operative pain medication injection is performed at an anatomic site other than that of the intra-articular procedure (right shoulder). The operative report did not indicate the injection (20610) was performed at another anatomic site or encounter.

Based on a review of the medical record, the surgical procedures warranting separate reimburse are CPT 29823, 29826 and 29827 and the laboratory code 81025. The Claims Administrator reimbursed

