

MAXIMUS FEDERAL SERVICES, INC.

Independent Bill Review
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Independent Bill Review Final Determination Upheld

5/14/2014

[REDACTED]
[REDACTED]
[REDACTED]

IBR Case Number:	CB13-0000746	Date of Injury:	12/23/2007
Claim Number:	[REDACTED]	Application Received:	11/18/2013
Claims Administrator:	[REDACTED]		
Date(s) of service:	6/11/2013 – 6/11/2013		
Provider Name:	[REDACTED]		
Employee Name:	[REDACTED]		
Disputed Codes:	22851, 22851 Modifier 59, 22554, 72050 Modifier TC, 63081, 22845, 20936, 63082, 63082 Modifier 59, 22585, 93940, L8699, 95925, 95926, 69990, 95928, 95929 and 95861.		

Dear [REDACTED]

Determination:

A Request for Independent Bill Review (IBR) was assigned to MAXIMUS Federal Services on 12/19/2013, 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/Outpatient Code Editor Version 19.1 (4/1/2013-6/30/2013)

Supporting Analysis:

The dispute regards the payment for surgical facility services on date of service 6/11/2013. The facility services were billed on a UB-04/CMS1450 using revenue codes for services and supplies related to an anterior cervical decompression and fusion. The Claims Administrator allowed reimbursement of \$4,825.12 for CPT 22851, 22851 Modifier 59, 22554 and 72050 Modifier TC. The Claims Administrator denied reimbursement for CPT codes 63081, 22845, 20936, 63082, 63082 Modifier 59 and 22585 with the explanation "Service is only reimbursed on an inpatient basis." The Claims Administrator denied reimbursement for CPT codes 93940, L8699, 95925, 95926, 69990, 95928, 95929 and 95861 "No separate payment was made because the value of the service is included within the value of another service performed on the same day."

Disputed procedure codes and descriptions:

CPT 63081 – Vertebral corpectomy (vertebral body resection), partial or complete, anterior approach with decompression of spinal cord and/or nerve root(s); cervical, single segment

CPT 22845 – Anterior instrumentation; 2 to 3 vertebral segments (List separately in addition to code for primary procedure)

CPT 22851 – Application of intervertebral biomechanical device(s) (e.g., synthetic cage(s), methylmethacrylate) to vertebral defect or interspace (List separately in addition to code for primary procedure)

CPT 20936 – Autograft for spine surgery only (includes harvesting the graft); local (e.g., ribs, spinous process, or laminae fragments) obtained from same incision (List separately in addition to code for primary procedure)

CPT 63082 – Vertebral corpectomy (vertebral body resection), partial or complete, anterior approach with decompression of spinal cord and/or nerve root(s); cervical, each additional segment (List separately in addition to code for primary procedure)

CPT 22554 – Arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace (other than for decompression); cervical below C2

CPT 22585 – Arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace (other than for decompression); each additional interspace (List separately in addition to code for primary procedure)

CPT 95940 – Continuous intraoperative neurophysiology monitoring in the operating room, one on one monitoring requiring personal attendance, each 15 minutes (List separately in addition to code for primary procedure)

HCPCS L8699 – Prosthetic implant, not otherwise specified

CPT 95925 – Short-latency somatosensory evoked potential study, stimulation of any/all peripheral nerves or skin sites, recording from the central nervous system; in upper limbs

CPT 95926 – Short-latency somatosensory evoked potential study, stimulation of any/all peripheral nerves or skin sites, recording from the central nervous system; in lower limbs

CPT 69990 – Microsurgical techniques, requiring use of operating microscope (List separately in addition to code for primary procedure)

CPT 95928 – Central motor evoked potential study (transcranial motor stimulation); upper limbs

CPT 95929 – Central motor evoked potential study (transcranial motor stimulation); lower limbs

CPT 95861 – Needle electromyography; 2 extremities with or without related paraspinal areas

CPT 72050 – Radiologic examination, spine, cervical; 4 or 5 views

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, and 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 CPT codes 22851 and 22554 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 CPT codes 63081, 22845, 20936, 63082 and 22585 have an assigned indicator of "C". The "C" indicator definition is "Inpatient procedures, not paid under OPPS. Admit patient and bill as inpatient." The billed CPT codes 95940, 69990 and HCPCS L8699 have an assigned indicator of "N". The "N" indicator definition is "Payment is packaged into payment for other services, including outliers" and does not qualify for separate APC payment.

The billed procedure codes 63081, 22845, 20936, 63082 and 22585 are on the inpatient only list and are assigned the "C" status indicator. Per OMFS Hospital Outpatient Departments and Ambulatory Surgical Center fee schedule, Title 8 California Code of Regulations Section 9789.32(e), Hospital outpatient departments and ambulatory surgical centers shall not be reimbursed for procedures on the inpatient only list, referenced in Section 9789.31(a), Addendum E, except that pre-authorized services rendered are payable at the pre-negotiated fee arrangement. The pre-authorization must be provided by an authorized agent of the claims administrator to the provider. The fee agreement and pre-authorization must be memorialized in writing prior to performing the medical services. The documentation submitted included an authorization from the Claims Administrator. The authorization was dated 4/5/2013 and authorized the procedure "Anterior cervical decompression and fusion C5-6, C6-7." The authorization did not indicate inpatient only procedures (63081, 22845, 20936, 63082 and 22585) were authorized to be performed as outpatient procedures or there was a pre-negotiated fee arrangement between the Provider and the Claims Administrator.

The billed procedure codes CPT 69990, CPT 95940 and HCPCS L8699 are not considered separately reimbursable procedure codes. The codes have a status indicator N and are packaged into the APC payment for the surgical procedure.

Per coding guidelines, all services necessary to complete a procedure based upon standard medical/surgical practice are included in the procedure. Procedures that are typically necessary to complete a more comprehensive procedure have been assigned independent HCPCS/CPT codes because they may be performed independently in other settings. The services described by CPT codes 95925, 95926, 95928, 95929 and 95861 are typically included when performing the procedures described by CPT code 22554, 22585, 22845, 63081 and 22851 and are therefore, bundled into CPT codes 22554, 22585, 22845, 63081 and 22851.

The billed procedure codes 22554, 22851 and 22851 Modifier 59 are separately reimbursable and subject to multiple procedure reduction guidelines. The billed procedure code 72050 Modifier TC is separately reimbursable and the allowance is based on the Official Medical Fee Schedule Physician Services (Section 9789.10 and Section 9789.11)

Per a review of the explanation of review (EOR), the reimbursement was based on a PPO contract. The surgical procedure code 22554 was reimbursed as the primary procedure at 100% of the PPO allowance. The reimbursement for CPT 22851 and 22851 Modifier 59 was based on multiple surgery reduction guidelines, 50% of the PPO allowance. The reimbursement for 22554 was \$2,967.52 and a PPO discount of \$523.68 was applied. The OMFS Outpatient Hospital allowance for CPT 22554 is \$3,491.20. The reimbursement for CPT 22851 was \$910.63 and a PPO discount of \$160.70; reimbursement for CPT 22851 Modifier 59 was \$910.63 and a PPO discount of \$160.70. The OMFS Outpatient Hospital allowance for CPT 22851 with the multiple surgery reduction of 50% applied is \$1,071.33. The reimbursement for the billed procedure code 72050 Modifier TC was \$36.34 with a PPO discount of \$6.41. The OMFS Physician service allowance for CPT 72050 Modifier 27 is \$42.75.

Based on a review of the medical record, OMFS Outpatient Hospital Fee Schedule and explanation of review (EOR) the outpatient hospital facility services were reimbursed correctly. There is no additional reimbursement warranted per the disputed Official Medical Fee Schedule Outpatient Hospital Fee Schedule codes: 22851, 22851 Modifier 59, 22554, 72050 Modifier TC, 63081, 22845, 20936, 63082, 63082 Modifier 59, 22585, 93940, L8699, 95925, 95926, 69990, 95928, 95929 and 95861.

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 services (22554, 22851 and 22851 59)	\$26,148.18	\$4,825.12	\$4,825.12	\$0.00	PPO Contract

Chief Coding Specialist Decision Rationale:

This decision was based on OMFS Outpatient Hospital fee schedule and comparison with explanation of review (EOR). This was determined correctly by the Claims Administrator and the payment of \$4,825.12 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,

██████████, RHIT

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