

MAXIMUS FEDERAL SERVICES, INC.

Independent Bill Review
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Independent Bill Review Final Determination Upheld

5/15/2014

[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]

IBR Case Number:	CB13-0000845	Date of Injury:	7/16/2010
Claim Number:	[REDACTED]	Application Received:	12/7/2013
Claims Administrator:	[REDACTED]		
Date(s) of service:	6/8/2013 – 6/8/2013		
Provider Name:	[REDACTED]		
Employee Name:	[REDACTED]		
Disputed Codes:	27442, 29870, 29881 and 29875		

Dear [REDACTED]

Determination:

A Request for Independent Bill Review (IBR) was assigned to MAXIMUS Federal Services on 12/27/2013, 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: Medicare and Medicaid Services (CMS) Outpatient Prospective Payment System (OPPS), NCCI Version 19.1 (4/1/2013 - 6/30/2013)

Supporting Analysis:

The dispute regards the payment for surgical facility services on date of service 6/8/2013. The facility services were billed on UB-04/CMS1450 using revenue codes for services and supplies related to CPT 27442, CPT 29870, CPT 29881, and CPT 29875. The Claims Administrator reimbursed \$1,953.38 for the following billed procedure code 29881. The Claims Administrator reimbursed \$976.69 for the billed procedure code 29875. The Claims Administrator based its reimbursement of the billed procedure code 27442 on 29877 with the explanation "The documentation does not support the level of service billed. Reimbursement was made for a code that is supported by the description and documentation submitted with the billing." The Claims Administrator denied the billed procedure code 29870 with the 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."

CPT 27442 – Arthroplasty, femoral condyles or tibial plateau(s), knee;

CPT 29877 – Arthroscopy, knee, surgical; debridement/shaving of articular cartilage (chondroplasty)

CPT 29881 – Arthroscopy, knee, surgical; with meniscectomy (medial OR lateral, including any meniscal shaving) including debridement/shaving of articular cartilage (chondroplasty), same or separate compartment(s), when performed

CPT 29870 – Arthroscopy, knee, diagnostic, with or without synovial biopsy (separate procedure)

CPT 29875 – Arthroscopy, knee, surgical; synovectomy, limited (e.g., plica or shelf resection) (separate procedure)

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) 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 29881, 29875, 29870 and 29877 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 Operative Report documented the following operations performed: Arthroscopy right knee; Arthroscopic partial medial meniscectomy; Chondroplasty lateral tibial plateau; and Excision medial patellofemoral plica.

The Claims Administrator based its reimbursement of CPT 27442 on CPT 29877 due to the documentation did not support the billed procedure code 27442. The Operative Report documented a debridement and chondroplasty of the lateral tibial plateau. Per the Operative Report "The lateral meniscus was carefully probed, noted to be free of tear, lateral tibial plateau was debrided with smoothing of cartilage." The operative report did not document the knee arthroplasty procedure code

27442. The reimbursement and code assignment of CPT 29877 by the Claims Administrator was correct.

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. If CPT 29870 (diagnostic arthroscopy) is reported with CPT code 29881 (surgical arthroscopy), the CPT code 29870 is bundled into CPT code 29881. A surgical arthroscopy always includes a diagnostic arthroscopy. 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 code 29881 is a more extensive procedure that includes CPT code 29875. Accordingly, only the more extensive procedure, CPT code 29881 should be reported. The CPT code 29875 is bundled into CPT code 29881. No additional reimbursement is recommended for the billed procedure code 29875.

The procedure codes 29881 and 29877 can be separately reported when performed during the same session on different knee compartments. Per the Operative Report, the surgical procedures were performed on the medial and lateral compartments: 29881 (medial); and 29877 (lateral). The Claims Administrator reimbursed the procedure code 29881 as the primary procedure (100%) and the procedure code 29877 as the secondary (50%). Per a review of the explanation of review (EOR), the reimbursement was calculated based on the OMFS Hospital Outpatient Fee Schedule; therefore, no additional reimbursement is recommended. The reimbursement of the procedure codes 29881 and 29877 by the Claims Administrator was correct.

There is no additional reimbursement warranted per the Official Medical Fee Schedule codes 29881, 29877, 29875 and 29870.

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
29881	1	\$1,426.62	\$1,953.38	\$1,953.38	\$0.00	OMFS
27442 (29877)	1	\$3,368.76	\$976.69	\$976.69	\$0.00	OMFS
29875	1	\$2,403.31	\$0.00	\$976.69	\$0.00	OMFS
29870	1	\$3,380.00	\$0.00	\$0.00	\$0.00	OMFS

Chief Coding Specialist Decision Rationale:

This decision was based on OMFS Hospital Outpatient Fee Schedule and comparison with explanation of review (EOR). This was determined correctly by the Claims Administrator and the payment of \$3,906.76 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

Copy to:

[REDACTED]
[REDACTED]
[REDACTED]

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[REDACTED]
[REDACTED] [REDACTED]
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