

**MAXIMUS FEDERAL SERVICES, INC.**

Independent Bill Review  
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**Independent Bill Review Final Determination Reversed**

1/16/2014

[REDACTED]  
[REDACTED]  
[REDACTED]

Re: Claim Number: [REDACTED]  
Claims Administrator name: [REDACTED]  
Date of Disputed Services: 3/4/2013 – 3/4/2013  
MAXIMUS IBR Case: CB13-0000199

Dear [REDACTED],

**Determination:**

A Request for Independent Bill Review (IBR) was assigned to MAXIMUS Federal Services on 10/23/2013, 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 reversed. The Claims Administrator is required to reimburse you the IBR fee of \$335.00 and the amount found owing of \$1,023.33, for a total of \$1,358.33.**

**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: PPO Contract
- Other: Medicare and Medicaid Services (CMS) Outpatient Prospective Payment System (OPPS)

**Supporting Analysis:**

The dispute regards the payment for surgical facility services on date of service 3/4/2013. The facility services were billed on a UB-04/CMS1450 using revenue codes for services and supplies related to CPT 25609, CPT 20690, CPT 29845, CPT 29846 and CPT 29840. The Provider was reimbursed \$8,540.56, and is requesting additional reimbursement of \$13,128.69. The Claims Administrator allowed reimbursement on the following surgical CPT codes: 25609 RT, 25609 LT, 20690 (4), 29845 RT, 29845 LT, 29846 RT and 29846 LT. The Provider billed four units of 29846. The third and fourth units of 29846 and 29840 RT and 29840 LT were denied reimbursement with the following explanation "This item is packaged or bundled into another basic service or surgical procedure fee performed on this date of service, additional reimbursement disallowed."

CPT 25609 - Open treatment of distal radial intra-articular fracture or epiphyseal separation; with internal fixation of 3 or more fragments.

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

CPT 29845 - Arthroscopy, wrist, surgical; synovectomy, complete.

CPT 29846 - Arthroscopy, wrist, surgical; excision and/or repair of triangular fibrocartilage and/or joint debridement.

CPT 29840 - Arthroscopy, wrist, diagnostic, with or without synovial biopsy (separate procedure).

The Provider is disputing the denial of CPT 29840 and 29846 (2units), and the reimbursement amounts for the bilateral wrist procedures.

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 provider is considered an ambulatory surgical center (ASC) and is located in Orange county. 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 CPT 25609, 20690, 29845, 29846 and 29840 have an assigned indicator of "T". The "T" indicator definition is "Significant procedure, multiple procedure reduction applies" and qualifies for separate APC payment. 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 CPT codes from the original UB-04/CMS1450 claim form were entered into the Outpatient Prospective Payment System Calculator. The reimbursement amount was calculated based on multiple surgery guidelines, the primary procedure 25609 (1 unit) was considered at 100% of the PPO allowance and all other covered procedures were considered at 50% of the PPO allowance. The operative report documented the following bilateral procedures: Open reduction and internal fixation

of comminuted, intraarticular right and left distal radius fracture with flourosopic imaging; Wrist arthroscopy with debridement of right and left scapholunate joint ligament and thermal shrinkage; Multiple compartment synovectomy right and left wrist; and Debridement of TFCC tear, right and left wrist.

Based on a review of the multiple surgery guidelines and the National Correct Coding Initiative/Outpatient Code Editor Version 19.0 (1/1/2013-3/31/2013), the billed procedure code 29840 is not generally reported with procedure code 29845 and 29846. The narrative for many HCPCS/CPT codes includes a parenthetical statement that the procedure represents 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. The CPT code 29840 is designated as a "separate procedure". Therefore, if it is reported with CPT codes 29845 or 29846, HCPCS/CPT code 29840 is bundled into HCPCS/CPT code 29845 and 29846. The Provider billed bilateral procedure codes for 29840, 29845 and 29846. The billed procedure codes 29840 LT and 29840 RT were included in the reimbursement of the billed procedure codes 29845 LT and 29845 RT.

The billed procedure code 29846 is not generally reported with procedure code 29845. 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 29845 is a more extensive procedure that includes CPT code 29846. Accordingly, only the more extensive procedure, CPT code 29845 should be reported. The CPT code 29846 is bundled into CPT code 29845. Reporting the code 29845, and code 29846 within the same wrist during the same operative session is not appropriate. The Provider billed procedure codes 29845 RT, 29845 RT 51, 29845 LT, 29845 LT 51, 29846 RT, 29846 RT 51, 29846 LT and 29846 LT 51. The billed procedure codes 29846 RT and 29846 LT were considered in the reimbursement for 29845 RT and 29845 LT. The allowance was calculated for two of the four billed procedure codes for 29845 (CPT 29845 LT and 29845 RT). The correct reimbursement amount, based on the PPO contract for each covered arthroscopic procedure is \$863.26.

The billed procedure code 20690 is used to describe the placement of external fixation system (pins or wires in one plane). The Provider billed 20690 51 LT, 20690 51 LT, 20690 51 RT, and 20690 51 RT. Based on a review of the documentation, it appears a fixation device was placed on one plane on the right and left wrists. The reimbursement is based on the placement of two stabilization systems on the right and left wrists. The allowance was calculated for two of the four billed procedure codes (CPT 20690 51 LT and 20690 51 RT). The Claims Administrator reimbursed the provider less than the PPO allowance for the billed procedure codes 20690 LT and 20690 RT. The correct reimbursement amount based on the PPO contract for each covered procedure is \$943.32.

The additional reimbursement of \$1,023.33 is warranted for the surgical facility services for the date of service 3/4/2013.

