

MAXIMUS FEDERAL SERVICES, INC.

Independent Bill Review
P.O. Box 138006
Sacramento, CA 95813-8006
Fax: (916) 605-4280

11/12/2013

Independent Bill Review Final Determination Upheld

[REDACTED]
[REDACTED]
[REDACTED]

Re: Claim Number: [REDACTED]
Claims Administrator name: [REDACTED]
Date of Disputed Services: 4/1/2013 – 4/1/2013
MAXIMUS IBR Case: CB13-0000279

Dear [REDACTED]

Determination:

A Request for Independent Bill Review (IBR) was assigned to MAXIMUS Federal Services on 8/20/2013, 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 4/1/2013. The facility services were billed on a UB-04/CMS1450 using revenue codes for services and supplies related to CPT 25118, CPT 25118 modifier 51, CPT 25000 modifier 51, CPT 64510 and 20605. The Provider was reimbursed \$3,920.47 and is requesting additional reimbursement. The Claims Administrator bundled CPT 25000 with CPT 25118 indicating "No separate payment was made because the value of the service is included within the value of another service performed on the same day (25000, 25118)." The Claims Administrator denied CPT 64510 indicating "In accordance with clinical based coding edits (National Correct Coding Initiative/Outpatient Code Editor), component code of comprehensive surgery: endocrine, nervous, eye and ocular adnexa, auditory systems procedure (60000-69999) has been disallowed." The Claims Administrator denied 20605 indicating "In accordance with clinical based coding edits (National Correct Coding Initiative/Outpatient Code Editor), component code of comprehensive surgery: musculoskeletal system procedure (20000 - 29999) has been disallowed."

The Provider is disputing the payment amount of 25118 and denial of 25000. The Claims Administrator's explanation of review (EOR) in response to the Provider's Second Bill Review request indicated the original payment amount for CPT 25118 and 25118 Modifier 51 was overpaid. The Claims Administrator's EOR indicated the original EOR resulted in a \$710.52 overpayment.

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's 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 APC weights are determined by the APC code assigned by the Outpatient Prospective Payment System Calculator.

Based on a review of the multiple surgery guidelines and the National Correct Coding Initiative/Outpatient Code Editor Version 19.1 (4/1/2013-6/30/2013), the billed procedures 64510, 20605 and 25000 are not generally reported with procedure code 25118. NCCI edits define when two procedure HCPCS/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, 91. The billed procedures were not billed with any of the above Modifiers.

The documentation did not indicate that the procedures were distinct or independent from other services (25118) performed that day. 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 denial of the billed procedure codes 25000, 64510 and 20605 by the Claims Administrator was correct.

Based on a review of the Original Medical Fee Schedule (OMFS) Outpatient Hospital Schedule the correct allowance for the surgical facility services (25118 and 25118 Modifier 51) on date of service

