MAXIMUS FEDERAL SERVICES, INC.
Independent Bill Review
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Independent Bill Review Final Determination Reversed

3/7/2014

[redacted]

Re: Claim Number: [redacted]
Claims Administrator name: [redacted]
Date of Disputed Services: 4/20/2013 – 4/20/2013
MAXIMUS IBR Case: CB13-0000289

Dear [redacted]

Determination:
A Request for Independent Bill Review (IBR) was assigned to MAXIMUS Federal Services on 11/1/2013, 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 $912.14, for a total of $1,247.14.**

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: OMFS
- 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 4/20/2013. The facility services were billed on UB-04/CMS1450 using revenue codes for services and supplies related to CPT 29876, CPT 29870 Modifier 51, CPT 29880, and CPT 27570. The Claims Administrator reimbursed $3,608.32 for the following billed procedure codes: 29880, S0020, E0114, A6260, and A4556. The Claims Administrator denied the billed procedure code 29876, 29870 and 27570 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 (29876, 29880)."

The Provider is disputing the denial of CPT codes 29870 Modifier 51, 29876 and 27570.
The operative report documented the following procedures on the left knee: Arthroscopy of the left knee with partial anterior horn medial meniscectomy; complete synovectomy of the knee; and arthrocentesis and injection of 0.5% plain Marcaine.

CPT 29880 - Arthroscopy, knee, surgical; with meniscectomy (medial AND lateral, including any meniscal shaving) including debridement/shaving of articular cartilage (chondroplasty), same or separate compartment(s), when performed.
CPT 29876 - Arthroscopy, knee, surgical; synovectomy, major, 2 or more compartments (e.g., medial or lateral).
CPT 29870 - Arthroscopy, knee, diagnostic, with or without synovial biopsy (separate procedure).
CPT 27570 - Manipulation of knee joint under general anesthesia (includes application of traction or other fixation devices).
Modifier 51 - Multiple Procedures: When multiple procedures, other than E/M services, Physical Medicine and Rehabilitation services or provision of supplies (e.g., vaccines), are performed at the same session by the same provider, the primary procedure or service may be reported as listed. The additional procedure(s) or service(s) may be identified by appending modifier 51 to the additional procedure or service code(s).

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 29880, 29876, 29870 and 27570 all have an assigned indicator of "T". The "T" indicator definition is "Significant procedure, multiple procedure reduction applies" and qualifies for separate APC payment.

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 services described by CPT code 27570 (manipulation under anesthesia) is typically included when performing the procedure described by CPT code 29880 and is therefore bundled into CPT code 29880.

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 29880 (surgical arthroscopy), the CPT code 29870 is bundled into CPT code 29880. A surgical arthroscopy always includes a diagnostic arthroscopy. Therefore, the denial of reimbursement for the billed CPT 29870 by the Claims Administrator was correct.

The third disputed code is the surgical code 29876 (complete synovectomy). The procedure code 29876 may be reported with the surgical arthroscopic procedure 29880 when a major or complete synovectomy is documented. The operative report documented a partial medial meniscectomy (29880) and a complete synovectomy, removing all hypertrophied synovial tissue from all three compartments of the knee. The operative report documented a major synovectomy. Reimbursement is warranted for the billed surgical procedure code 29876.

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 (29880) was considered at 100% of the allowance and all other covered surgical procedures (29876) were considered at 50% of the allowance.

The additional reimbursement of $912.14 is warranted for the surgical facility services, billed procedure code 29876 for the date of service 4/20/2013.

The chart below provides a comparison of billed charges and reimbursement rates for the codes and date of services at issue.

Validated Code	Validated Modifier	Validated Units	Dispute Amount	Total Fee Schedule Allowance	Provider Paid Amount	Allowed Recommended Reimbursement	Fee Schedule Utilized
29876		1	$5,189.12	$912.14	$0.00	$912.14	OMFS
29870	51	1	$5,189.12	$0.00	$0.00	$0.00	OMFS
27570		1	$2711.24	$0.00	$0.00	$0.00	OMFS

MAXIMUS Federal Services, as the Independent Bill Review Organization, has determined the Claims Administrator owes the Provider additional reimbursement. The Claims Administrator is required to reimburse the Provider for the IBR application fee (**$335.00**) and the OMFS amount for CPT code 29876 ($912.14) for a total of $1,247.14.

The Claims Administrator *is required to reimburse the provider $1,247.14 within* ***45 days of date on this notice per section 4603.2 (2a).*** *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]

Copy to:
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Copy to:
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