

MAXIMUS FEDERAL SERVICES, INC.

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

11/20/2013

Independent Bill Review Final Determination Reversed

[REDACTED]
[REDACTED]
[REDACTED]

Re: Claim Number: [REDACTED]
Claims Administrator name: [REDACTED]
Date of Disputed Services: 5/1/2013 – 5/1/2013
MAXIMUS IBR Case: CB13-0000291

Dear [REDACTED]

Determination:

A Request for Independent Bill Review (IBR) was assigned to MAXIMUS Federal Services on 8/28/2013, 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 \$56.41, for a total of \$391.41.**

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: 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 5/1/2013. The facility services were billed on a UB-04/CMS1450 using revenue codes for services and supplies related to CPT 29881, CPT 29876, CPT 29870 modifier 51, CPT 27570 and CPT 20610. The Provider was reimbursed \$2701.85 and is requesting additional reimbursement of \$1,861.81. The Claims Administrator reimbursed \$2,701.85 indicating "Charge for a Separate Procedure that does not meet the criteria for payment. See the OMFS General Instructions for Separate Procedures rule."

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 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).

CPT 20610 - Arthrocentesis, aspiration and/or injection; major joint or bursa (e.g., shoulder, hip, knee joint, subacromial bursa).

HCPCS E0114 - Crutch underarm pair.

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).

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 surgical 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 billed HCPCS E0114 has an assigned status code of "Y". The "Y" indicator definition is "Non-implantable Durable Medical Equipment." Per Title 8 California Code of Regulations 9789.32(c)(6), the maximum allowable fee for durable medical equipment, prosthetics and orthotics shall be determined according to Section 9789.60. 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: Anesthesia, medical and surgical supplies and equipment.

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 29870, 27570 and 20610 are not generally reported with procedure codes 29881 and 29876. 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 billed procedure code CPT 29870 is identified as a "separate procedure." The codes designated as "separate procedure" should not be reported in addition to the code for the total procedure or service of which it is considered an integral component. The CPT 29870 is an integral component of the primary procedure code CPT 29881. The CPT 29570 and 20610 is included in the global surgical package of the primary procedure code 29881.

Based on a review of the Official Medical Fee Schedule (OMFS) and the PPO contract, an additional reimbursement of \$56.41 is warranted for the billed procedure code HCPCS E0114. There is no additional reimbursement warranted per the Original Medical Fee Schedule codes 29881, 29876, 29870, 27570 and 20610.

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
E0114		1	\$56.41	\$56.41	\$0.00	\$56.41	PPO Contract
29881		1	\$156.52	\$1800.02	\$1800.02	\$0.00	PPO Contract
29876		1	\$78.26	\$900.01	\$901.83	\$0.00	PPO Contract
29870		1	\$978.27	\$0.00	\$0.00	\$0.00	PPO Contract
27570		1	\$489.14	\$0.00	\$0.00	\$0.00	PPO Contract
20610		1	\$169.20	\$0.00	\$0.00	\$0.00	PPO Contract

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 HCPCS E0114 (\$56.41) for a total of \$391.41.

The Claims Administrator is required to reimburse the provider \$391.41 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,

██████████, RHIT

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