

MAXIMUS FEDERAL SERVICES, INC.

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

12/6/2013

Independent Bill Review Final Determination Upheld

[REDACTED]
[REDACTED]
[REDACTED]

Re: Claim Number: [REDACTED]
Claims Administrator name: [REDACTED]
Date of Disputed Services: 4/20/2013 – 4/20/2013
MAXIMUS IBR Case: CB13-0000293

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 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 4/20/2013. The facility services were billed on a UB-04/CMS1450 using revenue codes for services and supplies related to CPT 29823, CPT 29807, CPT 29820 Modifier 51, CPT 29826, CPT 29805 Modifier 51 and CPT 23700 Modifier 51. The Provider was reimbursed \$6,098.33 and is requesting additional reimbursement. The Claims Administrator reimbursed \$6,098.33 indicating "Charge for a Separate Procedure that does not meet the criteria for payment. See the OMFS General Instructions for Separate Procedures rule."

CPT 29823 - Arthroscopy, shoulder, surgical; debridement, extensive.

CPT 29807 - Arthroscopy, shoulder, surgical; repair of SLAP lesion.

CPT 29820 - Arthroscopy, shoulder, surgical; synovectomy, partial.

CPT 29826 - Arthroscopy, shoulder, surgical; decompression of subacromial space with partial acromioplasty, with coracoacromial ligament (ie, arch) release, when performed (List separately in addition to code for primary procedure).

CPT 29805 - Arthroscopy, shoulder, diagnostic, with or without synovial biopsy (separate procedure).

CPT 23700 - Manipulation under anesthesia, shoulder joint, including application of fixation apparatus (dislocation excluded).

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

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 codes 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 procedure code 81025 and A6531 qualify for a separate payment and their allowance is based on the OMFS Physician Services and DMEPOS Fee Schedule. The APC weights are determined by the APC code assigned by the Outpatient Prospective Payment System Calculator. 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.

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 20610, 23700, 29820 and 29805 are not generally reported with procedure codes 29807, 29823 and 29826. 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 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 procedure codes 20610, 23700, 29820 and 29805 are included in the global service package of the primary or comprehensive surgical codes.

Based on a review of the Original Medical Fee Schedule (OMFS) Outpatient Hospital Schedule, PPO contract and the Claims Administrator's explanation of review (EOR), the reimbursement of \$6,098.33 was correct. The reimbursement included allowances for the following billed procedure codes: 29807, 29823, 29826, 81025 and A6531.

There is no additional reimbursement warranted per the Original Medical Fee Schedule for the surgical facility services on date of service 4/20/2013.

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
29807, 29823, 29826, 81025, A6531	1	\$3,530.08	\$5,916.72	\$6,098.33	\$0.00	PPO Contract

Chief Coding Specialist Decision Rationale:

This decision was based on Original Medical Fee Schedule (OMFS) Outpatient Hospital Schedule, PPO contract and comparison with explanation of review (EOR). This was determined correctly by the Claims Administrator and the payment of \$6,098.33 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]

Copy to:

[REDACTED]
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[REDACTED]