

Supporting Analysis:

The dispute regards the payment for surgical facility services on date of service 06/27/2013. The facility services were billed on a UB-04/CMS1450 using revenue codes for services and supplies related to CPT 64555, CPT 64555 modifier 59, CPT 64555 modifier 59 and CPT 64555 Modifier 59. The Provider was reimbursed \$8,217.02, and is now requesting additional reimbursement of \$30,000.00. The Claims Administrator allowed reimbursement for CPT 64555 and 64555 modifier 59, denied payment on 64555 Modifier 59 and 64555 Modifier 59 indicating "The number of units billed exceeds the threshold amount that has been determined for the procedure or service".

CPT 64555 - Percutaneous implantation of neurostimulator electrode array; peripheral nerve (excludes sacral nerve)

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 San Luis Obispo 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 64555 has an assigned indicator of "S". The "S" indicator definition is "Significant procedure, not discounted when multiple" and qualifies for separate APC payment. The APC weights are determined by the APC code assigned by the Outpatient Prospective Payment System Calculator. The Centers for Medicare & Medicaid Services (CMS) Medically Unlikely Edits (MUE's) for CPT 64555 has an MUE of 2. Per CMS "An MUE for a HCPCS/CPT code is the maximum units of service that a provider would report under most circumstances for a single beneficiary on a single date of service".

The operative report documented the superior cluneal nerve stimulator needles were placed bilaterally first at approximately the junction of L5 and S1 and then bilaterally approximately 3 cm below at the mid sacral region and the lower portion of the S1 joint area. Needles were placed in a fashion such that the electrodes reached the mid buttock region laterally.

Based on a review of the explanation of review (EOR) and CMS MUE edits, the reimbursement by the Claims Administrator was made according to the OMFS Outpatient Hospital and Ambulatory Surgical Center Fee Schedule. The reimbursement amount was calculated based on multiple surgery guidelines.

There is no additional reimbursement warranted per the Official Medical Fee Schedule for the surgical facility services on date of service 06/27/2013.

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

Validated Code	Validated Modifier	Validated Units	Dispute Amount	Total Fee Schedule Allowance	Provider Paid Amount	Allowed Recommended Reimbursement	Fee Schedule Utilized
64555	59	2	\$30,00.00	\$8,217.02	\$8,217.02	\$0.00	OMFS

Chief Coding Specialist Decision Rationale:

This decision was based on explanation of review (EOR), MUE Edits, medical record and comparison with OMFS Outpatient Hospital and Ambulatory Surgical Center Fee Schedule. This was determined correctly by the Claims Administrator and the payment of \$8,217.02 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)

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