

MAXIMUS FEDERAL SERVICES, INC.

Independent Bill Review
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Independent Bill Review Final Determination Upheld

6/6/2014

[REDACTED]
[REDACTED]
[REDACTED]

IBR Case Number:	CB13-0000981	Date of Injury:	10/22/2012
Claim Number:	[REDACTED]	Application Received:	12/27/2013
Claims Administrator:	[REDACTED]		
Date(s) of service:	8/29/2013 – 8/29/2013		
Provider Name:	[REDACTED]		
Employee Name:	[REDACTED]		
Disputed Codes:	23120, 20690, and 29805		

Dear [REDACTED]:

Determination

A Request for Independent Bill Review (IBR) was assigned to MAXIMUS Federal Services on 1/27/2014, 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 Version 19.2 (7/1/2013-9/30/2013)

Supporting Analysis:

The dispute regards the payment for surgical facility services on date of service 8/29/2013. The facility services were billed on a UB-04/CMS1450 using revenue codes for services and supplies related to CPT 29827, CPT 29823, CPT 23120 Modifier 59, CPT 29826, CPT 29805 Modifier 51 and CPT 20690. The Provider was reimbursed \$6,380.25 and is requesting additional reimbursement of \$3,106.51. The Claims Administrator reimbursed \$6,380.25 for the following billed codes: 29827; 29823; 29826 and 81025. The Claims Administrator denied the billed procedure code 23120 with the explanation "The charge was denied as the report / documentation does not indicate that the service was performed." The Claims Administrator denied the billed procedure code 20690 with the explanation "A charge was made for a separate procedure that does not meet the criteria for separate payment." The Claims Administrator denied the billed procedure code 29805 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."

CPT 29827 - Arthroscopy, shoulder, surgical; with rotator cuff repair

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

CPT 29826 - Arthroscopy, shoulder, surgical; decompression of subacromial space with partial acromioplasty, with coracoacromial ligament (i.e., 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 23120 - Claviclectomy; partial

CPT 20690 - Application of a uniplane (pins or wires in 1 plane), unilateral, external fixation system

Modifier 59 - Distinct Procedural Service

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 29827, 29823, 23120, 20690, 29826 and 29805 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 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.

The Operative report listed the following surgical procedures performed 8/29/2013 on the right shoulder: Diagnostic arthroscopy; arthroscopic rotator cuff repair; debridement of partial tear biceps tendon; chondroplasty, humeral head; subacromial decompression with bursectomy, subacromial deltoid region; release of coracoacromial ligament with acromioplasty; insertion of pain pump; and injection of right shoulder joint.

The Claims Administrator denied the billed procedure code 23120 due to insufficient documentation of services performed. The billed procedure code is used to report a partial removal of collar bone (Partial claviclectomy). The Operative Report did not list the partial claviclectomy in the "Operative Procedures" section of the report, nor document a partial claviclectomy within the "Procedure in Detail" portion of the Operative Report. The denial of the procedure code 23120 by the Claims Administrator was correct.

The procedure code CPT 20690 was denied by the Claims Administrator due to the services did not warrant separate reimbursement. The use of this code requires an application of an internal or external fixation device during the treatment of a fracture and/or dislocation. The Operative Report documented the use of a "shoulder traction device" during the procedure. The use of a traction device during a procedure is considered a service directly related and integral to the procedures performed and included in the payment for the procedures. The service billed using procedure code 20690 is inclusive to the surgical procedure codes (CPT 29827, 29823, 29826 and 29805) performed on 8/29/2013, and are not separately reimbursable.

The CPT code 29805 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 29805 (diagnostic arthroscopy) is reported with CPT code 29823, 29826 and 29827 (surgical arthroscopy), the CPT code 29805 is bundled into CPT codes 29823, 29826 and 29827. A surgical arthroscopy always includes a diagnostic arthroscopy. Therefore, the denial of reimbursement for the billed CPT 29805 by the Claims Administrator was correct.

Based on a review of the Official Medical Fee Schedule (OMFS) Outpatient Hospital Schedule and the Claims Administrator's explanation of review (EOR), the reimbursement of \$6,380.25 was correct. The reimbursement included allowances for the following billed procedure codes: 29827, 29823, 29826 and 81025. The reimbursement amount was calculated based on multiple surgery guidelines, the primary procedure (29823) was considered at 100% of the listed allowance and all other covered surgical procedures (29827 and 29826) were considered at 50% of the listed allowance.

There is no additional reimbursement warranted for the surgical facility services, procedure codes 23120, 20690 and 29805.

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
29823		1	\$0.00	\$3,595.25	\$3,595.25	\$0.00	OMFS
29826		1	\$0.00	\$978.27	\$978.27	\$0.00	OMFS
29827		1	\$0.00	\$1797.63	\$1797.63	\$0.00	OMFS
23120	59	1	\$1,068.68	\$0.00	\$0.00	\$0.00	OMFS
20690		1	\$1,068.68	\$0.00	\$0.00	\$0.00	OMFS
29805	51	1	\$978.27	\$00.00	\$0.00	\$0.00	OMFS

Chief Coding Specialist Decision Rationale:

This decision was based on medical record, explanation of review (EOR) and comparison with Original Medical Fee Schedule (OMFS) Outpatient Hospital Schedule. This was determined correctly by the Claims Administrator and the payment of \$6,380.25 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 Signature]

[Redacted Title]

[Redacted Address]