

MAXIMUS FEDERAL SERVICES, INC.

Independent Bill Review
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Independent Bill Review Final Determination Upheld

7/15/2014

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IBR Case Number:	CB14-0000109	Date of Injury:	10/2/2012
Claim Number:	██████████	Application Received:	1/24/2014
Claims Administrator:	██		
Date(s) of service:	7/13/2013 – 7/13/2013		
Provider Name:	██		
Employee Name:	██		
Disputed Codes:	29880, 29870, 29871, 29875		

Dear ██████████,

Determination

A Request for Independent Bill Review (IBR) was assigned to MAXIMUS Federal Services on 2/20/2014, 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 Editor Version 19.2 (7/1/2013-9/30/2013)

Supporting Analysis:

The dispute regards the payment for surgical facility services on date of service 7/13/2013. The facility services were billed on UB-04/CMS1450 using revenue codes for services and supplies related to CPT 29880, CPT 29870 Modifier 51, CPT 29871, and CPT 29875. The Claims Administrator reimbursed \$2,930.07 for the following billed procedure codes: 29880 and 29875. The Claims Administrator denied the billed procedure code 29871 with the explanation "Included in another billed procedure. No separate payment was made because the value of the service is included within the value of another service performed on the same day." The Claims Administrator denied the billed procedure code 29870 with the explanation "Included in another billed procedure. A charge was made for a separate procedure that does not meet the criteria for separate payment."

The operative report documented the following procedures on the left knee: diagnostic arthroscopy; arthroscopic partial lateral meniscectomy; arthroscopy with lavage; and arthroscopy with limited synovectomy.

- **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 29870:** Arthroscopy, knee, diagnostic, with or without synovial biopsy (separate procedure).
- **CPT 29871:** Arthroscopy, knee, surgical; for infection, lavage and drainage
- **CPT 29875:** Arthroscopy, knee, surgical; synovectomy, limited (eg, plica or shelf resection) (separate procedure).

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 Centers for Medicare and Medicaid Services' (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, and 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.

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 CPT codes corresponding to more extensive procedures always include the CPT codes corresponding to less complex procedures. The CPT code 29880 is a more extensive procedure that includes CPT code 29871. Accordingly, only the more extensive procedure, CPT code 29880 should be reported when performed during the same session, patient encounter, anatomic location and surgical site. 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 CPT code 29871 is bundled into CPT code 29880.

Based on a review of the explanation of review, the Claims Administrator reimbursed the Provider for CPT 29880 and 29875 based on the OMFS Outpatient Hospital and Ambulatory Surgery Center Fee Schedule. 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. No additional reimbursement is recommended for the billed procedure code 29880 and 29875.

There is no additional reimbursement warranted per the OMFS Outpatient Hospital and Ambulatory Surgery Center Fee Schedule surgical facility services performed on 7/13/2013.

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
29870	1	\$3,380.00	\$0.00	\$0.00	\$0.00	OMFS
29880	1	\$3,380.00	\$1,953.38	\$1,953.38	\$0.00	OMFS
29871	1	\$3,800.00	\$0.00	\$0.00	\$0.00	OMFS
29875	1	\$3,380.00	\$976.69	\$976.69	\$0.00	OMFS

Chief Coding Specialist Decision Rationale:

This decision was based on medical record, explanation of review and comparison with OMFS Outpatient Hospital and Ambulatory Surgery Center Fee Schedule. This was determined correctly by the Claims Administrator and the payment of \$2,930.07 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

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