

MAXIMUS FEDERAL SERVICES, INC.

Independent Bill Review
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Independent Bill Review Final Determination Upheld

7/17/2014

[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]

IBR Case Number:	CB14-0000121	Date of Injury:	3/8/2012
Claim Number:	[REDACTED]	Application Received:	1/29/2014
Claims Administrator:	[REDACTED]		
Date(s) of service:	8/10/2013 – 8/10/2013		
Provider Name:	[REDACTED]		
Employee Name:	[REDACTED]		
Disputed Codes:	29805, 29821, 29807, 29826, 29827, 29819 and 29999		

Dear [REDACTED]:

Determination

A Request for Independent Bill Review (IBR) was assigned to MAXIMUS Federal Services on 2/21/2014, 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 8/10/2013. The facility services were billed on a UB-04/CMS1450 using revenue codes for services and supplies related to CPT 29805, CPT 29821, CPT 29807, CPT 29826, CPT 29827, CPT 29819 and CPT 29999. The Provider was reimbursed \$6,360.82 and is requesting additional reimbursement. The Claims Administrator reimbursed \$6,360.82 for the following procedure codes: 29826, 29827 and 29821. The Claims Administrator denied CPT 29805 with the explanation "NCCI Comprehensive Component Edit for surgery codes 20000-29999." The CPT 29807 and 29819 was denied with the following explanation "Allowance adjusted in accordance with OPPS multiple procedures rule." The CPT 29999 was denied with the following explanation "Svc/procedure cannot be billed in multiple increments on the same day or exceeds max # for claim."

- **CPT 29805:** Arthroscopy, shoulder, diagnostic, with or without synovial biopsy (separate procedure).
- **CPT 29821:** Arthroscopy, shoulder, surgical; synovectomy, complete
- **CPT 29807:** Arthroscopy, shoulder, surgical; repair of SLAP lesion.
- **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 29827:** Arthroscopy, shoulder, surgical; with rotator cuff repair
- **CPT 29819:** Arthroscopy, shoulder, surgical; with removal of loose body or foreign body
- **CPT 29999:** Unlisted procedure, arthroscopy

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 Operative Report listed the following procedures performed on the left shoulder: video arthroscopy; arthroscopic synovectomy; arthroscopic debridement of type I SLAP lesion superior labrum anterior posterior; subacromial decompression arthroscopically; AC joint decompression on its undersurface; arthroscopic rotator cuff repair; arthroscopic lavage; and arthroscopic bursectomy.

The billed CPT code 29805 is a diagnostic arthroscopic procedure. The CPT code 29821, 29826, and 29827 are surgical arthroscopic procedures. When both a diagnostic and surgical arthroscopy is performed, the diagnostic arthroscopy is an inclusive component of the surgical arthroscopy and would not be reported separately. The billed CPT 29805 is included in or cannot be reported with CPT codes 29821, 29826 or 29827.

The Provider documented in the Operative Report, "debridement of the type I SLAP lesion was complete. Superior labrum anteroposterior of the biceps labral complex was probed and was found to be intact and stable." The type I SLAP procedure was coded as CPT 29807. The CPT 29807 is report when a repair is performed; repairs of type II and IV SLAP lesions are reported as CPT 29807. Debridement of Type I SLAP lesion is coded as 29822. The description of CPT 29822 is "Arthroscopy, shoulder, surgical; debridement, limited." The debridement and removal of loose bodies are actually part of the bigger and more extensive procedures performed and billed for date of service 8/10/2013. The debridement of the type I SLAP procedure is included in the more extensive

arthroscopic procedures (29827 and 29821) performed on 8/10/2013. Reimbursement is not recommended for the billed procedure code 29807.

The CPT 29819 is included in the more extensive procedures performed. Removal of loose body/bodies is included in the synovectomy and debridement codes unless the loose or foreign body is large enough to require a separate incision to remove it. The Operative Report did not document a separate incision or the size of the loose/foreign bodies was greater than 5mm. The billed CPT 29819 is included in the billed CPT 29821; therefore, reimbursement is not recommended for billed CPT 29819.

The bursectomy procedure documented and billed as CPT 29999 is included in the billed CPT 29826. Per the Operative Report, the bursectomy was documented as “utilizing the arthroscopic shaver as well as the arthroscopic burr and the ArthroCare wand, a progressive bursectomy was complete within the subacromial space. The undersurface of the acromial was smoothing with the help of the motorized and arthroscopic burr and then a partial acromioplasty was completed to increase the acromiohumeral interval and to relieve impingement. Hemostasis was achieved and a bursectomy was completed over the superior surface of rotator cuff.” The bursectomy services performed are included in the services provided by the reported CPT 29826. Per coding guidelines, CPT 29826 should be reported for the surgical arthroscopy of the shoulder with a partial acromioplasty, arch decompression, and excision of bursal tissue and release of the coracoacromial ligament. Reimbursement is not recommended for the billed CPT 29999.

Based on a review of the explanation of review, the Claims Administrator reimbursed the Provider for CPT 29826, 29827 and 29821 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 (29827) was considered at 100% of the allowance and all other covered surgical procedures (29826 and 29821) were considered at 50% of the allowance. No additional reimbursement is recommended for the billed CPT codes 29805, 29807, 29819 and 29999.

The is no additional reimbursement warranted per the OMFS Outpatient Hospital and Ambulatory Surgery Center Fee Schedule surgical facility services performed on 8/10/2013.

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
29805	1	\$3,565.00	\$0.00	\$0.00	\$0.00	OMFS
29821	1	\$3,333.29	\$1,794.71	\$1,794.71	\$0.00	OMFS
29807	1	\$3,649.00	\$0.00	\$0.00	\$0.00	OMFS
29826	1	\$5,141.32	\$976.68	\$976.68	\$0.00	OMFS
29827	1	\$2,910.57	\$3,589.43	\$2,589.43	\$0.00	OMFS
29819	1	\$6,118.00	\$0.00	\$0.00	\$0.00	OMFS
29999	1	\$3,259.55	\$0.00	\$0.00	\$0.00	OMFS

Chief Coding Specialist Decision Rationale:

This decision was based on medical record, explanation of review (EOR) and comparison with OMFS Outpatient Hospital and Amubulatory Surgery Center Fee Schedule. This was determined correctly by the Claims Administrator and the payment of \$6,360.82 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]
[REDACTED]
[REDACTED]