

MAXIMUS FEDERAL SERVICES, INC.

Independent Bill Review
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Independent Bill Review Final Determination Upheld

8/20/2014

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| IBR Case Number: | CB14-0000190 | Date of Injury: | 4/28/2004 |
| Claim Number: | ██████████ | Application Received: | 2/14/2014 |
| Claims Administrator: | ██ | | |
| Date(s) of service: | 11/14/2013 – 11/14/2013 | | |
| Provider Name: | ██ | | |
| Employee Name: | ██ | | |
| Disputed Codes: | 64722 59 | | |

Dear ██████████:

Determination

A Request for Independent Bill Review (IBR) was assigned to MAXIMUS Federal Services on 3/13/2014, 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: Medicare and Medicaid Services (CMS) Outpatient Prospective Payment System (OPPS)

Supporting Analysis:

The dispute regards the payment for surgical facility services on date of service 11/14/2013. The facility services were billed on UB-04/CMS1450 using revenue codes for services and supplies related to CPT 63047, 64722 59, 63048, and 62264 59. The Claims Administrator reimbursed \$6,768.12 for the following billed procedure codes: 72100 TC, 63047, 63048 and 62264 59. The Claims Administrator denied the billed procedure code 64722 59 with the explanation "Per CCI edits, the value of this procedure is included in the value of the comprehensive 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."

- **CPT 63047:** Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s], [eg, spinal or lateral recess stenosis]), single vertebral segment; lumbar
- **CPT 64722 59:** Decompression; unspecified nerve(s) (specify)
- **CPT 63048:** Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s], [eg, spinal or lateral recess stenosis]), single vertebral segment; each additional segment, cervical, thoracic, or lumbar (List separately in addition to code for primary procedure)
- **CPT 62264 59:** Percutaneous lysis of epidural adhesions using solution injection (eg, hypertonic saline, enzyme) or mechanical means (eg, catheter) including radiologic localization (includes contrast when administered), multiple adhesiolysis sessions; 1 day
- **Modifier 59:** Distinct Procedural Service: Under certain circumstances, it may be necessary to indicate that a procedure or service was distinct or independent from other non-E/M services performed on the same day. Modifier 59 is used to identify procedures/services, other than E/M services, that are not normally reported together, but are appropriate under the circumstances. Documentation must support a different session, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same individual. However, when another already established modifier is appropriate it should be used rather than modifier 59. Only if no more descriptive modifier is available, and the use of modifier 59 best explains the circumstances, should modifier 59 be used. Note: Modifier 59 should not be appended to an E/M service. To report a separate and distinct E/M service with a non-E/M service performed on the same date, see modifier 25.

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.

Under CMS coding guidelines, "all services necessary to complete a procedure based upon standard medical/surgical practice are included in the procedure." Many procedures that are typically necessary to complete a more comprehensive procedure have been assigned independent HCPCS/CPT codes because they may be performed independently in other settings. The service described by HCPCS/CPT code 64722 is typically included when performing the procedure described by 63047 and 62264, and is therefore bundled into HCPCS/CPT codes 63047 and 62264.

Per the Operative Report, "Prior laminectomy scar delineated and avoided. This was circumferentially delineated. Blunt probe was used to identify the pedicle. A high-speed bur was used to perform a partial

laminectomy ant L4 and L5 burring down the heavy lamina of L4 and L5 down to the deep cortex with midline structures left intact throughout the entire procedure. ...I removed the minimum amount of facet to do the decompression. Nonetheless, this was a significant amount of facet joint but need to be done to safely decompress the neural elements. The primary goal here was to take the pressure off of the nerve, which was quite compressed.”

The Provider appended Modifier 59 to CPT code 64722, indicating the services provided were distinct and/or independent of the other surgical services performed on 11/14/2013. However, the nerve decompression services performed and documented in the operative report are included in the facetectomy and lysis procedures (63047 and 62264 – refer to the aforementioned code definitions). The Claims Administrator reimbursed the Provider for the billed CPT codes 63047 and 62264; therefore, based on the CPT guidelines, no additional reimbursement is recommended for the CPT code 64722.

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 |
|----------------|--------------------|-----------------|----------------|------------------------------|----------------------|-----------------------------------|-----------------------|
| 64722 | 59 | 1 | \$551.34 | \$0.00 | \$0.00 | \$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 Surgical Center Fee Schedule. This was determined correctly by the Claims Administrator and the payment of \$0.00 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,

██████████, RHIT

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