

**MAXIMUS FEDERAL SERVICES, INC.**

Independent Bill Review  
P.O. Box 138006  
Sacramento, CA 95813-8006  
Fax: (916) 605-4280

**Independent Bill Review Final Determination Upheld**

8/29/2014

████████████████████  
████████████████████  
████████████████████

IBR Case Number:	CB14-0000225	Date of Injury:	03/22/2013
Claim Number:	██████████	Application Received:	2/20/2014
Claims Administrator:	██		
Date(s) of service:	8/17/2013		
Provider Name:	██		
Employee Name:	████████████████████		
Disputed Codes:	29823, 29826 and 29824 -51		

Dear ████████████████████:

**Determination:**

A Request for Independent Bill Review (IBR) was assigned to MAXIMUS Federal Services on 03/19/2014 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 and Ambulatory Surgical Center Fee Schedule

## Supporting Analysis:

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 dispute regards the payment for surgical facility services on date of service 8/17/2013. The facility services were billed on a UB-04/CMS1450 using revenue codes for services and supplies related to CPT 29823, CPT 29820 -59, CPT 29826, CPT 29824 51 and CPT 23700 -51. The Claims Administrator bundled as services on one line with the exception of CPT 81025 and reimbursed \$2,742.32 with the following explanation, "The charge exceeds the Official Medical Fee Schedule allowance and has been adjusted to the schedule. Charge for a separate procedure that does not meet the criteria for payment. See the OMFS general Instructions for Separate Procedure rule."

On the "Provider's Request for Second Bill Review," the provider is asking Maximus for review of the allowance and/or non-payment of CPT codes 29823, 29826 and 29824 - 51. Due to the Claims Administrator bundling all services into one line, all surgical CPT codes pertinent to the claim in question will be reviewed and discussed to determine correct payment.

The American Medical Association (AMA) Current Procedural Terminology 2013 code descriptions for the CPT codes in question are as follows:

- CPT 29823: Arthroscopy, shoulder, surgical; debridement, extensive.
- CPT 29820 - 59: Arthroscopy, shoulder, surgical; synovectomy, partial
- CPT29826: 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 29824 - 51: Arthroscopy, shoulder, surgical; distal claviclectomy including distal articular surface (Mumford procedure)
- CPT 23700 - 51: Manipulation under anesthesia, shoulder joint, including application of fixation apparatus (dislocation excluded)
- Modifier 51: Multiple Procedures
- Modifier 59: Distinct Procedural Service

The Operative Report, for Date of Service 8/17/2013 under “Procedures,” give the following reasons for surgery:

- Arthroscopy of the right shoulder with extensive glenohumeral joint debridement
- Arthroscopic subacromial bursectomy
- Arthroscopic subacromial decompression
- Arthroscopic distal clavicle excision
- Insertion of pain catheter device

The National Correct Coding Initiative (NCCI) edits define when two procedure CPT codes may not be reported together except under special circumstances. If an edit allows use of NCCI-associated modifiers, the two procedure codes may be reported together when the two procedures are performed at different anatomic sites or different patient encounters. NCCI-associated modifiers may be utilized to allow payment of both codes of an edit. The documentation must support the use of the modifier. Modifiers that may be used under appropriate clinical circumstances to bypass an NCCI edit include: Anatomic modifiers: E1-E4, FA, F1-F9, TA, T1-T9, LT, RT, LC, LD, RC, LM, RI; Global surgery modifiers: 24, 25, 57, 58, 78, 79; other Modifiers: 27, 59, and 91. (cms.gov)

CPT Code 29823, per NCCI edits Version 19.2, is a “Column 2” code when paired with CPT code 29824. A “Modifier Indicator” of “1” is indicated for the column 2 code. In short, CPT code 29823 may be reported along with CPT code 29824 when supported by the documentation and Modifier 59 is appended to CPT 29823. The provided operative report did indicate “extensive debridement” in the glenohumeral joint; however, the UB04 form for this case indicates that a modifier was not appended to CPT Code 29823. Since CPT code 29823 was not submitted with a qualifying modifier to unbundle the procedure from its paired code, no additional reimbursement is recommended for CPT 29823.

CPT Code 29826 is the second of three CPT codes in question. This CPT Code is listed as a “Column 1” code on the NCCI edits Version 19.2, and is paired with CPT Code 23700 with a “1 Modifier Indicator.” Since the code in question is CPT 29826, and the provider, it appears, was reimbursed for this CPT in the bundled payment, the code pair rule is incidental to this discussion and thus, the reimbursement is upheld for this code.

The last CPT code in question is CPT 29824 -51. According to the NCCI edits, CPT Code 29824 is a “Column 1” code paired with two CPT Codes in column 2; CPT 29820 and 29823, with a status indicator of “1.” The UB04 reflects CPT Code 29820 with the appropriate modifier (-59). The documentation, “... debrided any hypertrophied synovial tissue” and “... to remove the distal 1cm of the clavicle...” supports the unbundling of the pair and indicates that the codes are to be billed separately and not as a bundled pair. Although CPT code 29824 was billed with a modifier - 51, identifying that the multiple procedure surgical rule applies, the correct modifier was appended to the relevant code pair, it is recommended that CPT Code 29824 be reimbursed @ 100% of the negotiated contracted rate.

Clarification on the use of Modifier 51 versus 59: 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 Modifier 51: Multiple Procedures (AMA, CPT, 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
29824	51	1	\$5,200.00	\$1,956.54	\$1,956.54	\$0.00	PPO Contract
29826		1	\$5,220.00	\$978.27	\$978.27	\$0.00	PPO Contract
29823		1	\$9,975.82	\$1,482.57	\$0.00	\$0.00	PPO Contract

29824 APC 0041 – T RW 29.6106 x 80.58 x .82 = \$1956.54

29826 APC 0041 – T RW 29.6106 x 80.58 x .82 = \$1,956.54 x 50% = \$978.27

PPO Contract 92% of OMFS

Total OMFS allowance \$2,934.81 x 92% (PPO Allowance) = \$2,700.03

**Chief Coding Specialist Decision Rationale:**

This decision was based on aforementioned resources and comparison with OMFS. This was determined correctly by the Claims Administrator and the payment of \$2,742.32 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,

██████████, MHA, BSN, CFE, CCS-P, CCS, CDC  
Chief Coding Reviewer

Copy to:

██  
████████████████████  
██

Copy to:

██  
██  
██