

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:	CB14-0000245	Date of Injury:	09/17/2012
Claim Number:	████████████████	Application Received:	02/21/2014
Claims Administrator:	██		
Date(s) of service:	08/09/2013 – 08/09/2013		
Provider Name:	██		
Employee Name:	████████████████		
Disputed Codes:	29877 LT, 59, 22, 29877 LT 51, 59 & 29877 LT 51, 59, 22		

Dear ██████████:

Determination:

A Request for Independent Bill Review (IBR) was assigned to MAXIMUS Federal Services on 03/21/14, 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 Included the Following Evidence Used to Support this 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
- Official Medical Fee Schedule or Negotiated Contract: PPO Contract & OMFS
- Other: Web: CMS/NCCI: AAOS: AHIMA: MediRegs

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 coding guidelines, the hospital outpatient prospective payment system (OPPS), and the OMFS Fee Schedule 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 8/9/2013. The facility services were billed on UB-04/CMS1450 using nine (9) revenue codes for services and supplies related to CPT 29877 LT 51 59 22. The Claims Administrator reimbursed \$959.38 for supplies and services relating to primary procedure code 29877, but did not reimburse the surgeon for the primary procedure, which was listed three times. To clarify, the provider submitted one CPT code three times with modifiers as follows:

CPT 29877 LT 59 22

CPT 29877 LT 51 59

CPT 29877 LT 51 59 22

The Claims Administrator denied the billed procedure code with the following explanations: 1) Per national correct coding initiative edits, this code is not separately reimbursable. 2) National correct coding initiative edit – either mutually exclusive of or integral to another service performed on the same day. 3) The Benefit for this service is included in the payment/allowance for another service /procedure that has already been adjudicated. 4) No separate payment was made because the value of the service is included within the value of another service performed on the say day.

The American Medical Association Current Procedural Terminology defines the above CPT codes as follows:

- **CPT 29877:** Arthroscopy, knee, surgical; for infection, lavage and drainage; debridement/shaving of articular cartilage (chondroplasty).
- **Modifier LT:** Left side (used to identify procedures performed on the left side of the body).
- **Modifier 59:** Distinct procedural service.
- **Modifier 22:** Increased procedural service.
- **Modifier 51:** Multiple Procedures

The Operative Report for Date of Service 8/9/2013 under the heading "Procedures Performed " the provider states, "Arthroscopic diagnostic examination, left knee; Arthroscopic non-abrasive debridement/chondroplasty of chondral 1.5 cm chondral lesion of the medial femoral joint including bone, left knee; Arthroscopic non-abrasive chondroplasty of the patellofemoral joint including trochlear area, left knee; Arthroscopic non-abrasive chondroplasty of the medial and lateral tibial plateaus, left knee; Arthroscopic synovectomy of left knee joint." Additionally, "The patellofemoral showed advanced changes down to bone and significant wearing of the articular surface of the trochlea with crab meat appearance on the undersurface of the patella. We did non-abrasive chondroplasty. The lateral compartment was inspected. Lateral meniscus was normal, but the lateral tibial plateau showed chondromalacia. I did also non-abrasive chondroplasty. Quite a bit of synovitis was present. We did synovectomy on this patient. A large chondral lesion was present on the weightbearing area down to bare bone. That area was debrided and shaved. Chondroplasties were done as well of the tibial plateau. The patient had changes on the patellofemoral, chondromalacia of the medial and lateral plateaus, and chondral lesions on the medial condyle."

As indicated above, the documentation does refer to work performed on three separate compartments. However, according to the National Correct Coding Initiative, CPT Code 29877 may not be reported with more than one unit regardless of the number of compartments accessed or documented. A 2003 quote from Niles R. Rosen, MD, Medical Director at the National Correct Coding Initiative, AdminaStar Federal, Inc., stated, "CMS will modify NCCI so that claims for 29880+29877 or 29881+29877 when performed in the different compartments of the knee can be paid if the date of service is prior to March 1, 2003. Since G0289 (arthroscopy, knee, surgical, for removal of loose body, foreign body, debridement/shaving of articular cartilage (chondroplasty) at the time of other surgical knee arthroscopy in a different compartment of the same knee) will be effective March 1, 2003, NCCI will be modified to disallow 29877 when billed with 29880 or 29881 for a date of service on or after that date." Meaning, code G0289 can be billed with 29877 to allow for services performed in a separate compartment. G0289 is still utilized today. In fact, coding assistance for 29877 and G0289 can be found on the American Academy of Orthopedic Surgeon's web site. However, based on the coding sequence submitted and the coding guidelines we must adhere to, additional reimbursement is not recommended for the second and third submitted codes, CPT 29877 LT, 51, 59 and 29877 LT 59, 22.

The first CPT Code, CPT 29877 with modifiers LT, 51, 59, and 22, is the final code in question. NCCI edits show this CPT in the second column and paired with CPT 29875 in the first column, with a modifier indicator of "0." A "0" in the Modifier Indicator column has the following definition: "modifier not appropriate; services represented by code combination not paid separately." Meaning, no modifier can unbundle this paired code. The provider was reimbursed for CPT 29875. Based on the coding sequence submitted and the coding guidelines we must adhere to, additional reimbursement is not recommended for CPT 29877 LT, 51, 59, 22.

Regarding modifier -22, per CMS' hospital outpatient prospective payment system (OPPS) , Modifier – 22 is not listed as an "allowable" Hospital Outpatient modifier for CPT 29877 and thus was not factored into the reimbursement equation.

The chart below provides a comparison of billed charges and reimbursement rates for the codes and date 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
29877	LT 51 59 22	1	\$4,750.00	\$0.00	\$0	\$0.00	PPO
29877	LT 51 59	1	\$4,750.00	\$0.00	\$0	\$0.00	PPO
29877	LT 51 59	1	\$4,750.00	\$0.00	\$0	\$0.00	PPO

Chief Coding Specialist Decision Rationale:

This decision was based on the aforementioned guidelines and comparison with OMFS Outpatient Hospital and Ambulatory Surgery Center Fee Schedule. This was determined correctly by the Claims Administrator and the payment of \$959.38 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

Copy to:

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

Copy to:

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