

MAXIMUS FEDERAL SERVICES, INC.

Independent Bill Review
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INDEPENDENT BILLING REVIEW FINAL DETERMINATION

March 21, 2016

[Redacted]

IBR Case Number:	CB16-0000226	Date of Injury:	08/21/2015
Claim Number:	[Redacted]	Application Received:	02/18/2016
Assignment Date:	03/09/2016		
Claims Administrator:	[Redacted]		
Date(s) of service:	09/23/2015 – 09/23/2015		
Provider Name:	[Redacted]		
Employee Name:	[Redacted]		
Disputed Codes:	29822, 29824, 29828, and 64415		

Dear [Redacted]

MAXIMUS Federal Services has completed the Independent Bill Review (“IBR”) of the above Workers’ Compensation case. This letter provides you with the IBR Final Determination and explains how the determination was made.

Final Determination: OVERTURN. MAXIMUS Federal Services has determined that additional reimbursement is warranted. The Claims Administrator’s determination is reversed and the Claim Administrator owes the Provider additional reimbursement of \$195.00 for the review cost and \$534.51 in additional reimbursement for a total of \$729.51. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of **\$729.51** within 45 days of the date on this letter per section 4603.2 (2a) of the California Labor Code. The determination of MAXIMUS Federal Services and its expert reviewer is deemed to be the Final Determination of the Administrative Director of the Division of Workers’ Compensation. This determination is binding on all parties. In certain limited circumstances, you can appeal the Final Determination. Appeals must be filed with the Workers’ Compensation Appeals Board within 20 days from the date of this letter. For more information on appealing the final determination, please see California Labor Code Section 4603.6(f).

Sincerely,

Paul Manchester, M.D., M.P.H.
Medical Director

[Redacted]

DOCUMENTS REVIEWED

Pertinent documents reviewed to reach the determination:

- The Independent Bill Review Application
- 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
- NCCI Policy Manual for Medicare Services, Chapter 1, 4
- OMFS

HOW THE IBR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services Chief Coding Specialist reviewed the case file and researched pertinent coding and billing standards to reach a determination. In some cases a physician reviewer was employed to review the clinical aspects of the care to help make a determination. He/she has no affiliation with the employer, employee, providers or the claims administrator. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/services.

ANALYSIS AND FINDING

Based on review of the case file the following is noted:

- **ISSUE IN DISPUTE: Provider seeking remuneration for 29822, 29824, 29828 and 64415 submitted for date of service 09/23/2016.**
- The Claims Administrator's denial of CPT 29822 reflects NCCI rationale.
- **CCR § 9789.12.13 Correct Coding Initiative**
 - (a) The National Correct Coding Initiative Edits ("NCCI") adopted by the CMS shall apply to payments for medical services under the Physician Fee Schedule. Except where payment ground rules differ from the Medicare ground rules, claims administrators shall apply the NCCI physician coding edits and medically unlikely edits to bills to determine appropriate payment. Claims Administrators shall utilize the **National Correct Coding Initiative Coding Policy Manual for Medicare Services**.
- NCCI Edits indicate the following with Modifier indicator of 1:
 - short description for column 1 code
 - | Column 1 | Column 2 | CCI Edit Description |
|--------------|--------------|--|
| <u>29822</u> | <u>64415</u> | Misuse of column two code with column one code |
| | | <input type="checkbox"/> N BLOCK INJ BRACHIAL PLEXUS |
 - short description for column 2 code
 - SHOULDER ARTHROSCOPY/SURGERY

▫ SHOULDER ARTHROSCOPY/SURGERY

*29824 **29822** *More extensive procedure

▫ SHOULDER ARTHROSCOPY/SURGERY

▫ ARTHROSCOPY BICEPS TENODESIS

29828 **29822** CPT Manual or CMS manual coding instructions

▫ SHOULDER ARTHROSCOPY/SURGERY

- NCCI Policy Manual for Medicare Services - Effective January 1, 2014, Chapter 4, (E) **Arthroscopy; Paragraph 4** States the following: “With the exception of the knee joint, **arthroscopic debridement should not be reported separately with a surgical arthroscopy procedure when performed on the same joint at the same patient encounter.**”
- Although the Modifier indicator is “1,” NCCI Manual refers to the shoulder joint as one anatomical site. Additionally, the modifier submitted and reflected on the UB-04 is Modifier – 25. Modifier 25, significant, separately identifiable evaluation and management [E/M] service by the same physician on the same day of the procedure or other service, and is not the appropriate modifier to unbundle a coded surgical pair.
- **Article 5.5.0. Rules § 9792.5.7.** Requesting Independent Bill Review (b)(2) The proper selection of an analogous code **or formula based** on a fee schedule adopted by the Administrative Director, or, if applicable, a contract for reimbursement rates under Labor Code section 5307.11, unless the fee schedule or contract allows for such analogous coding.
- **Medicare Billing Manual, Chapter 1, page I-6, paragraph 1:** Each edit table contains edits which are pairs of HCPCS/CPT codes that in general should not be reported together. Each edit has a column one and column two HCPCS/CPT code. **If a provider reports the two codes of an edit pair, the column two code is denied,** and the column one code is eligible for payment.
 - Final **EOR reflects Column 1 CPT 29824 reimbursement** with denial of Column 2 CPT 29822
- **Effective December 1, 2014,** For services rendered on or after December 1, 2014, section 9789.31, subsections (a) and (b) are amended to incorporate by reference selected sections of the updated calendar year 2014 version of CMS’ hospital outpatient prospective payment system (HOPPS) published in the Federal Register on December 10, 2013, the updated fiscal year **2014** versions of CMS’ IPPS Tables 2, 4A, 4B, 4C, and 4J in the final rule of August 19, 2013.
- **42 C.F.R. § 419.44** (a) Multiple surgical procedures. When more than one surgical procedure for which payment is made under the hospital outpatient prospective payment system is performed during a single surgical encounter, the Medicare program payment amount and the beneficiary copayment amount are based on the following
 - (1) The full amounts for the procedure with the highest APC payment rate; and
 - (2) One-half of the full program and the beneficiary payment amounts for all other covered procedures.
- CPT 29824, 29828 and 64415 are status indicator “T” codes subject to MPPR.
- Initial EOR dated 11/12/2015 reflects **CPT 29824** reimbursed as Primary Procedure.
 - 2nd EOR, dated 01/14/2016 reflects 29824 as Primary Procedure with a **deduction from Initial EOR of “57.56.”**
 - Total EOR Reimbursement for Primary Procedure = \$6,789.52
 - $58.6059 * 101.46947 * 1.212 = \text{OMFS} * 95\% \text{ PPO}$

- **As the Primary Procedure, Additional Reimbursement is due for 29824.**
- CPT 29824 and **CPT 29828** are **equal in weight**; 29828 reimbursed as Secondary Procedure. However, EOR calculations for MPPR and applicable contractual discount for 29828 is incorrect. The correct APC formula is as follows:
 - $58.6059 * 101.46947 * 1.212 = \text{OMFS} * 95\% \text{ PPO}$
 - 2nd EOR, dated 01/14/2016 reflects 29828 with a deduction from Initial EOR of "100.14."
 - Additional reimbursement is due for **CPT 29828.**
- 2nd EOR Reflect 64415 reimbursed with MPPR rational @ \$291.20, reversing initial EOR decision of \$0.00.
 - $4.871 * 101.46947 * 1.212 = \text{OMFS} * 95\% \text{ PPO}$
 - Overpayment of \$6.66 is indicated, additional reimbursement is not indicated.
- **Based on the aforementioned documentation and guidelines, additional reimbursement is indicated for CPT 29824 & 29828 and is not indicated for 29822 and 64415.**

The table on the page 5 describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: 29822, 29824, 29828 and 64415

Date of Service: 09/23/2016							
HOPPS							
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Assist Surgeon	Units	Workers' Comp Allowed Amt.	Notes
29822	\$8,760.33	\$0.00	\$1,783.69	N/A	1	\$0.00	Refer to Analysis
29824	\$8,760.33	\$6,789.52	\$357.97	NA	1	\$6,847.04	PPO (-) Reimbursed Amount = \$57.52 (-) \$6.66 *Overpayment for CPT 64415 = \$50.86 Due Provider Refer to Analysis
29828	\$8,760.33	\$2,939.67	\$562.72	N/A	1	\$3,423.52	PPO (-) Reimbursed Amount = \$483.85 Due Provider Refer to Analysis
64415	\$1,709.50	\$291.20	\$309.03	NA	1	\$284.54	*Overpayment of Refer to Analysis

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

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