MAXIMUS, Inc. 3750 Monroe Avenue, Suite 705
Pittsford, NY 14534
Tel: [585] 425-5326 • Fax: [585] 869-3388

December 8, 2016

Summary: MAXIMUS has determined that no additional reimbursement[1] is warranted for CPT code 45121-80. The covered person's liability shall be limited to the copayment, deductible and/or coinsurance that would apply had the services been rendered by a network Provider.

MAXIMUS Case File Number: NJ16-000229
Enrollee Name:
Plan: Small Employer Group
Payer:
Provider:
Dates of Service: 03/24/2016

Dear

On 08/22/2016, you filed a Request for Arbitration pursuant to the New Jersey Health Claims Authorization, Processing and Payment Act. This arbitration filing was related to a claims appeal you filed with n 07/23/2016. We, MAXIMUS, are under contract with the New Jersey Department of Banking and Insurance to make Arbitration decisions in appeals such as yours. This means we employ health care claims professionals who study your case file and claims records to arbitrate the claims you have in dispute with MAXIMUS and all of our arbitrators are impartial and independent. We have no material affiliations with any health care provider, facility or Payer in the state of New Jersey.

[1] Where the Payer has made previous payments for the CPT code(s) at issue; where there are code(s) determined by MAXIMUS to be not reimbursable; or where there are copayments, deductibles and/or coinsurances that must be satisfied by the covered person, the actual amount to be paid by the carrier to the provider may be less than that amount contained in this arbitration award.

Case File Summary:

A Provider is seeking additional reimbursement for professional fees for CPT code 45121-80 59 performed on 03/24/2016. The Payer has denied this request indicating it has already reimbursed the Provider a reasonable amount for the CPT code at issue and has denied the provision of additional reimbursement to the Provider.

A review of the record indicates the Provider submitted the following billed charges for the following services:

1. CPT Code 45121-80: Provider billed $15,000.00 Payer allowed $2,400.00

According to the information provided for review, the Provider in this case is not contracted with the Payer. This was a non-emergency procedure performed during the patient's stay at an in network hospital. The Payer submitted the enrollee's applicable evidence of coverage, which defines its "Allowed Charge" as "an amount that is not more than the lesser of: the allowance for the service or supply as determined by based on a standard approved by the Board; or the negotiated fee schedule. The Board will decide a standard for what is considered an Allowed Charge under this Policy". Additionally, in a letter dated 10/03/2016, the Payer indicated that it paid these claims at 16% of the Providers billed charges in accordance with the Centers for Medicare and Medicaid Services (CMS) standard reimbursement for assistant at surgery.

At issue in this arbitration is whether additional reimbursement for the CPT code at issue is reasonable and appropriate and consistent with the enrollee's out-of-network benefit.

Analysis and Findings:

No additional reimbursement is warranted for CPT code 45121-80 in this case.

Based upon the information provided by both parties to the arbitration and review of the FAIR Health – Medical Benchmarks, MAXIMUS has determined the Provider should not receive additional reimbursement for the code at issue. The Provider in this case is not contracted with the Payer and requested the reimbursement to be considered according to New Jersey Administrative Code §11:22-5.8 (b)(c). According to the N.J.A.C. §11:22-5.8 (b) "All contracts issued by health maintenance organizations and health service corporations, and all SCA policies issued by insurance companies, shall provide the following: ….2. That a covered person's liability for services rendered during a hospitalization in a network hospital, including, but not limited to, anesthesia and radiology, where the admitting physician is an out-of-network provider, shall be limited to the copayment, deductible and/or coinsurance applicable to network services." N.J.A.C. §11:22-5.8 addresses the liability of covered persons for services rendered by out of network providers in certain situations. The regulation does not state that carriers must pay billed charges in these situations. Given the absence of any statute or regulation specifying how carriers should compute the benefit for these services, carriers should pay the fair value of the services rendered by out of network providers. FAIR Health – Medical Benchmarks provides a reasonable basis for such determination. New Jersey States Annotated 52:14-17.29(c)(3), which mandates that the State Health Benefits Plan use the 90th percentile of a nationally

recognized database of prevailing health care charges to determine the allowance for services of out of network providers, supports use of the 90th percentile of FAIR Health – Medical Benchmarks in this situation." Although the Payer has not provided detailed objective information establishing why the amount it has reimbursed the Provider is considered reasonable, persuasive evidence in determining a reasonable reimbursement rate is found in the N.J.S.A. 52:14-17.29(C)(3) which states that "Reasonable and Customary Charges" means charges based upon the 90th percentile of the usual, customary, and reasonable (UCR) fee schedule determined by the Health Insurance Association of America or similar nationally recognized database of prevailing health care charges. Based upon this information, the Provider should be reimbursed the lesser of the Provider's actual billed charges or the amount set by the 90th percentile of FAIR Health, subject to the appropriate payment reductions, for CPT code 45121-80.

According to the CMS, the standard reimbursement for assistant at surgery (modifier 80) is set at 16%. In this case, CPT code 45121-80 performed on 03/24/2016 are eligible for assistant at surgery reimbursement. Therefore, CPT code 45121-80 is being reimbursed at the lesser of 100% of the Provider's actual billed charges or 16% of the amount set by the 90th percentile of FAIR Health.

The chart below provides a comparison of billed charges and reimbursement rates for the codes and dates of services at issue.

CPT Service Code	Provider Billed	Payer Reimbursed	90th Percentile FAIR Health (assistant at surgery reduction applied)	MAXIMUS Additional Reimbursement
Date of Service: 03/24/2016				
45121-80	$15,000.00	$2,400.00	$2,068.00	$0.00

Based upon the information set forth above, MAXIMUS has determined that the Payer has reimbursed the provider $2,400.00 for CPT code 45121-80. The Payer has reimbursed the Provider the lesser of 100% of the Provider's actual billed charges or 16% of the amount set by the 90th percentile of FAIR Health for CPT code 45121-80. Therefore, no additional reimbursement is warranted for this code. The covered person's liability shall be limited to the copayment, deductible and/or coinsurance that would apply had the services been rendered by a network Provider.

Evidence Supporting Decision:

The following evidence was relied upon in arriving at the arbitration decision.

1. New Jersey Administrative Code §11:22-5.8 (b)(c).

2. New Jersey States Annotated 52:14-17.29

3. Centers for Medicare and Medicaid Services - FY 2016 Medicare – Physician Fee Schedule Relative Value Table.

4. FAIR Health – Medical Benchmarks, November 2015.

5. Centers for Medicare and Medicaid Services – National Correct Coding Initiative Physician Version 22.1.

6. Payer Evidence of Coverage.

Arbitrator's Qualifications:

I am an attorney with over 5 years of health claims processing experience. I have no affiliation with the Payer, the Provider or the Enrollee involved in this arbitration.

Appeal of MAXIMUS Decision:

This decision is binding. You cannot appeal this decision and Providers should not bill the covered person for the difference between billed charges and the amount allowed by this decision. The New Jersey Department of Banking and Insurance does not accept appeals of a MAXIMUS decision. Pursuant to the New Jersey Health Claims Authorization, Processing and Payment Act the decision of MAXIMUS is final.

Explanation of MAXIMUS Services:

Please be aware that MAXIMUS is providing an independent arbitration service. MAXIMUS is not engaged in the practice of law or medicine. Decisions about the use or nonuse of health care are the sole responsibility of the patient and that patient's physician. MAXIMUS is not liable for any consequences arising from these decisions.

Sincerely,
MAXIMUS, Inc.

Andrew Iserson, Esq.
Claims Arbitrator

Ian Maitin, MD
Medical Director

pc: Gale Simon, Assistant Commissioner
NJ Dept. of Banking and Insurance