

INDEPENDENT BILLING REVIEW FINAL DETERMINATION

February 25, 2015

[REDACTED]
[REDACTED]
[REDACTED]

IBR Case Number:	CB14-0001787	Date of Injury:	02/20/2012
Claim Number:	[REDACTED]	Application Received:	11/21/2014
Claims Administrator:	[REDACTED]		
Assigned Date:	12/29/2014		
Provider Name:	[REDACTED]		
Employee Name:	[REDACTED]		
Disputed Codes:	29999		

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 \$250.00 for the review cost and \$341.25 in additional reimbursement for a total of \$591.25. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of \$591.25 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, MD, MPH
Medical Director

cc: [REDACTED]
[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
- Official Medical Fee Schedule
- Negotiated contracted rates: PPO Discount 10%
- National Correct Coding Initiatives
- Other: General Information and Instructions

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 is dissatisfied with denial of CPT code 29999
- Claims administrator denied code indication on the Explanation of Review “Payment adjusted because the payer deems the information submitted does not support this level of service.”
- Provider billed CPT code 29999 which does not have a value on OMFS and is reimbursed By Report. Provider documents a comparable code of 29840.
- Per General Information and Instructions, the value of By Report procedures may be determined using the value assigned to a comparable procedure. The comparable procedure should reflect the same amount of time, complexity, expertise, etc., as required for the procedure performed.
- Claims administrator sent documentation stating “Any diagnostic arthroscopy will be unbundled from surgical arthroscopy”
- CMS states surgical arthroscopy includes diagnostic arthroscopy which is not separately reportable. If a diagnostic arthroscopy leads to a surgical arthroscopy at the same patient encounter, only the surgical arthroscopy may be reported.
- Based on review of the operative report, provider states on page 2 paragraph 4: “Instruments were removed. The arthroscope was then placed in the posterior tibial tendon inferior portal. A tendoscopy was performed. There was no tenosynovitis. The

tendon had no tears and no injection. It appeared to be completely normal.” Provider billed for diagnostic tenoscopy of posterior tibial tendon.

- Documentation received included: The request for an Operative Arthroscopy, Extensive debridement tenoscopy of the posterior tibial tendon of the right ankle and subtalar at Center for Orthopedic Surgery is medically necessary. The claimant has ongoing ankle pain despite conservative care for 2 years. Therefore, the request surgery for the ankle tendon debridement and debridement of the subtalar joint is appropriate.
- Claims administrator approved tenoscopy of posterior tibial tendon and therefore reimbursement of code 29999 is warranted
- Multiple procedure reduction as well as a 10% PPO discount is to be applied to reimbursement.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Reimbursement of code 29999 is recommended.

Date of Service: 8/25/2014							
Physician Services							
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Units	Multiple Surgery	Workers' Comp Allowed Amt.	Notes
29999	\$1401.00	\$0.00	\$1401.00	1	N/A	\$341.25	DISPUTED SERVICE: Allow reimbursement \$341.25.

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