

MAXIMUS FEDERAL SERVICES, INC.

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



INDEPENDENT BILLING REVIEW FINAL DETERMINATION

July 27, 2015

[Redacted]
[Redacted]
[Redacted]

IBR Case Number:	CB15-0001063	Date of Injury:	03/12/2013
Claim Number:	[Redacted]	Application Received:	06/30/2015
Claims Administrator:	[Redacted]		
Date(s) of service:	10/25/2014		
Provider Name:	[Redacted]		
Employee Name:	[Redacted]		
Disputed Codes:	Rev 0360		

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 \$962.52 in additional reimbursement for a total of \$1157.52. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of \$1157.52 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:
- National Correct Coding Initiatives
- Medicare and Medicaid Services (CMS) Outpatient Prospective Payment System (OPPS)

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 codes 29870, 29877-LT-59 x 2 and 29871.
- Claims Administrator denied code 29877-LT-59 x 2 indicating on the Explanation of Review “No separate payment was made because the value of the service is included within the value of another service performed on the same day(29877-LT-59, 29880-LT-59)
- Provider billed code 29877-LT-59 x 2 along with reimbursed code 29876 and 29880.
- As pair codes exist between 29877 and 29876, also, 29877 and 29880, modifier indicator column shows ‘0’ which states these codes are to never be billed together.
- Per National Correct Coding Initiative Policy Manual for Medicare Services, CPT codes 29874 (Surgical knee arthroscopy for removal of loose body or foreign body) and 29877 (Surgical knee arthroscopy for debridement/shaving of articular cartilage) should not be reported with other knee arthroscopy codes (29866-29889).
- Reimbursement of 29877-LT-59 x 2 is not warranted.

- Claims Administrator also denied code 29871 indicating on the Explanation of Review “This service is included in primary or more extensive procedure”
- As a pair code exists between 29871 and reimbursed code 29876, modifier indicator shows ‘1’ which states that if an approved modifier is appended to the column two code, and documentation is submitted to support billed code, then the edit may be overridden.
- Provider appended approved modifiers –LT and -59.
- Provider’s procedure report submitted documents “Antibiotic-laden lavage was completed”
- Pursuant §9789.16.5. Surgery - Multiple Surgeries and Endoscopies, (a) General Multiple surgeries are separate procedures performed by a single physician or physicians in the same group practice on the same patient at the same operative session or on the same day for which separate payment may be allowed. Co-surgeons, surgical teams, or assistants-at-surgery may participate in performing multiple surgeries on the same patient on the same day.
- Multiple surgeries are distinguished from procedures that are components of or incidental to a primary procedure. These intra-operative services, incidental surgeries, or components of more major surgeries are not separately billable.
- NCCI note for paired codes indicates 29871 as column 2 code and is included in the more extensive procedure 29876.
- Based on information reviewed, reimbursement of 29871-LT-59 is not warranted.
- Last code being disputed is 29870 which Claims Administrator denied as “According to the Official Medical Fee Schedule this service has a relative value of zero and therefore no payment is due”
- CPT 29870 - Arthroscopy, knee, diagnostic, with or without synovial biopsy (separate procedure)
- As pair codes exist between 29870 and 29876, NCCI states “CPT ‘separate procedure’ definition”.
- Pursuant §9789.16.5. Surgery - Multiple Surgeries and Endoscopies, reimbursement of 29870 is not warranted.
- On review of the Explanation of Review, Both reimbursed codes 29880 and 29876 were reduced 50%. A primary procedure 29880 was not reimbursed at 100% Pursuant §9789.16.5. Surgery - Multiple Surgeries and Endoscopies (c) Determining Maximum Payment for Multiple Surgeries, procedures that are subject to the surgery multiple procedure payment reduction.
- (A) 100 percent of the fee schedule amount for the highest valued procedure; and
- (B) 50 percent of the fee schedule amount for the second through the fifth highest valued procedures
- Based on information reviewed, additional reimbursement of 29880 is warranted.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Reimbursement of code 29880

Date of Service: 10/25/2015						
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Multiple Surgery	Workers' Comp Allowed Amt.	Notes
29880	\$3800.00	\$962.52	\$962.52	100%	\$1925.04	DISPUTED SERVICE: Allow reimbursement \$962.52

National Correct Coding Initiative information:

File	Column 1	Column 2	Modifier
Hospital APC Version 20.3	29876	29877	Not Allowed
Hospital APC Version 20.3	29876	29871	Allowed
Hospital APC Version 20.3	29876	29870	Allowed

Copy to:

██████████
 ██████████
 ██████████

Copy to:

██
 ██
 ██