

MAXIMUS FEDERAL SERVICES, INC.

Independent Bill Review
P.O. Box 138006
Sacramento, CA 95813-8006
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Independent Bill Review Final Determination Reversed

12/31/2013

[REDACTED]
[REDACTED]
[REDACTED]

Re: Claim Number: [REDACTED]
Claims Administrator name: [REDACTED]
Date of Disputed Services: 3/4/2013 – 3/4/2013
MAXIMUS IBR Case: CB13-0000382

Dear [REDACTED], MD:

Determination:

A Request for Independent Bill Review (IBR) was assigned to MAXIMUS Federal Services on 9/12/2013, 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 reversed. The Claims Administrator is required to reimburse you the IBR fee of \$335.00 and the amount found owing of \$247.61, for a total of \$582.61.**

Pertinent Records and Other Appropriate Information Relevant to the Determination Reviewed:

The following evidence was used to support the 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: OMFS
- Other: OMFS Surgery Groundrules and Guidelines

Supporting Analysis:

The dispute regards surgical services billed for date of service 3/4/2013. The Provider billed CPT 29880, 29877, 29874, 29875 and 20610, was reimbursed \$2,699.93 and is requesting additional reimbursement of \$1,490.17. The Claims Administrator reimbursed \$1,444.20 for the billed procedure code 29880 indicating "FS Allowance = FS AllowedFee -(FS AllowedFee*(Fee Schedule Discount Percent/100.0))= 1569.78 - (1,569.78 * 0.08) = 1,444.20." The Claims Administrator reimbursed \$98.96 for the billed procedure code 29875 indicating " 107.56 - (107.56 * 0.08) = \$98.96." The Claims Administrator denied reimbursement for 29877 indicating "Chondroplasty of the knee joint, same or separate compartment(s) when performed at the same operative session is included in CPT 29880 per AMA CPT guidelines." The Claims Administrator denied reimbursement of the billed procedure codes 29874 and 20610 indicating "This procedure is included in the 29880 per Medicare CCI edits. No additional allowance recommended."

CPT 29880 - Arthroscopy, knee, surgical; for infection, lavage and drainage with meniscectomy (medial and lateral, including any any meniscal shaving).

CPT 29877 - Arthroscopy, knee, surgical; for infection, lavage and drainage debridement/shaving of articular cartilage (chondroplasty).

CPT 29874 - Arthroscopy, knee, surgical; for infection, lavage and drainage for removal of loose body or foreign body.

CPT 29875 - Arthroscopy, knee, surgical; for infection, lavage and drainage synovectomy, limited.

CPT 20610 - Arthrocentesis, aspiration and/or injection; major joint or bursa.

The Provider submitted an Operative Report for date of service 3/4/2013. Per the report the following procedures were performed: right knee arthroscopy, arthroscopic partial medial and lateral meniscectomy; arthroscopic chondroplasty, patellofemoral joint; arthroscopic removal of chondral loose bodies; arthroscopic tricompartmental synovectomy; and injection Depo-Medrol and Marcaine, intra-articular.

The billed procedure codes 29877 and 29880 are reported together when performed in separate compartments of the knee during the same session. There are three compartments of the knee commonly visualized during arthroscopic surgery: medial, lateral, and patellofemoral. The operative report documented an "arthroscopic partial medial and lateral meniscectomy" and "arthroscopic chondroplasty, patellafemoral joint." The medical record reported the procedures were performed in separate compartments of the knee. The denial of CPT 29877 by the Claims Administrator was not correct.

The billed procedure code 20610 is not a separately reimbursable service when performed on the same day as 29880, 29874, 29875 and/or 29877. The billed procedure code 20610 is considered part of the surgical package.

The billed procedure code 29874 is not separately reported when performed in the same knee compartment as procedures in the code range of 29875-29881. The billed procedure code 29874 is considered to be an inclusive component of codes 29875-29881. The operative report did not document a different or separate knee compartment as the billed knee arthroscopy procedure codes 29877 and 29880.

Per the OMFS Surgery Multiple or Bilateral Procedures ground rules, when multiple arthroscopic procedures are performed on the same joint during the same operative session, the primary

procedure should be reimbursed at 100% of the unit value, the second and subsequent arthroscopic procedures should be reimbursed at 10% of their schedule value. The allowance for the primary procedure (29880) was based on 100% of the OMFS allowance and the subsequent procedures (29875 and 29877) were based on 10% of the OMFS allowance.

MAXIMUS requested a copy of the PPO contract. A copy of the PPO contract was not received. The procedure code allowances and recommended reimbursement amounts were based on the Official Medical Fee Schedule.

The additional reimbursement of \$247.61 is warranted per the Official Medical Fee Schedule codes 29880, 29877 and 29875.

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
29880		1	\$125.58	\$1,569.78	\$1,444.20	\$125.58	OMFS
29877		1	\$1,133.73	\$113.37	\$0.00	\$113.37	OMFS
29874		1	\$109.01	\$0.00	\$0.00	\$0.00	OMFS
29875		1	\$98.90	\$107.56	\$98.90	\$8.66	OMFS
20610		1	\$22.95	\$0.00	\$0.00	\$0.00	OMFS

MAXIMUS Federal Services, as the Independent Bill Review Organization, has determined the Claims Administrator owes the Provider additional reimbursement. The Claims Administrator is required to reimburse the Provider for the IBR application fee (**\$335.00**) and the OMFS amount for CPT codes 29880, 29877 and 29875 (\$247.61) for a total of \$582.61.

The Claims Administrator is required to reimburse the provider \$582.61 within 45 days of date on this notice per section 4603.2 (2a). 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,

[REDACTED], RHIT

Copy to:

[REDACTED]
[REDACTED]
[REDACTED]

Copy to:

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