

INDEPENDENT BILLING REVIEW FINAL DETERMINATION

November 24, 2014

[Redacted]

IBR Case Number:	CB14-0000936	Date of Injury:	06/24/2013
Claim Number:	[Redacted]	Application Received:	07/01/2014
Claims Administrator:	[Redacted]	Assignment Date:	08/11/2014
Provider Name:	[Redacted]		
Employee Name:	[Redacted]		
Disputed Codes:	29870, 29880-59, 29880-51, 29877-59, 29877-51, 29874-59 and 29875-59		

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 \$976.69 in additional reimbursement for a total of \$1226.69. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of \$1226.69 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,

[Redacted]

cc: [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: none
- 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:** Denial of codes 29870, 29880-51, 29877-59, 29877-51, 29874-59 and 29875-59 and low reimbursement for code 29880-59.
- Based on the NCCI edits codes 29877-59, 29877-51, and 29874-59 should be denied. Modifiers are not allowed to seek reimbursement as distinct services for these services. There are no situations when these codes can be reimbursed with the column 1 procedure (see NCCI table below).
- Although the use of code 29875 is suspect when submitted with CPT code 29880. The operative report indicates that the service was separate and distinct and should be reimbursed as a secondary service (50% reduction to be applied).
- Based on the Medically Unlikely Edits (MUE) only 1 unit of code 29880 is allowed. Therefore allowance for one line of service is appropriate and the other should be denied.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Reimbursement of codes 29877-59, 29877-51, 29877-51, 29874 and 29880-51 to be denied. CPT Code 29875 should be reimbursed \$976.69.

Date of Service: 1/23/2014						
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Multi Surg.	Workers' Comp Allowed Amt.	Notes
29870	\$3380.00	\$0	\$ 20923.62	N/A	\$0	DISPUTED SERVICE: Deny based on NCCI edits
29880-59	\$3380.00	\$ 1953.38	Included in above	100%	\$ 1953.38	DISPUTED SERVICE: No additional reimbursement warranted. 29.6106 * 80.45 * .82 = \$1953.38.
29880-51	\$3380.00	\$0	Included in above	N/A	\$0	DISPUTED SERVICE: Deny based on MUE edits. Only 1 unit allowed for this service.
29877-59	\$3380.00	\$0	Included in above	N/A	\$0	DISPUTED SERVICE: Deny based on NCCI edits
29877-51	\$3380.00	\$0	Included in above	N/A	\$0	DISPUTED SERVICE: Deny based on NCCI edits
29874-59	\$2597.00	\$0	Included in above	N/A	\$0	DISPUTED SERVICE: Deny based on NCCI edits
29875-59	\$3380.00	\$0	Included in above	50%	\$976.69	DISPUTED SERVICE: Additional reimbursement of \$31.65 warranted. 29.6106 * 80.45 * .82 * .5 = \$976.69.

National Correct Coding Initiative information:

File	Column 1	Column 2	Modifier
Hospital APC Version 20.0	29874	29870	Allowed
Hospital APC Version 20.0	29875	29870	Allowed
Hospital APC Version 20.0	29875	29874	Not allowed
Hospital APC Version 20.0	29875	29877	Not allowed
Hospital APC Version 20.0	29877	29870	Allowed
Hospital APC Version 20.0	29877	29874	Not allowed
Hospital APC Version 20.0	29880	29870	Allowed
Hospital APC Version 20.0	29880	29874	Not allowed
Hospital APC Version 20.0	29880	29875	Allowed
Hospital APC Version 20.0	29880	29877	Not allowed

Copy to:

[REDACTED]
[REDACTED]
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