

MAXIMUS FEDERAL SERVICES, INC.

Independent Bill Review
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INDEPENDENT BILLING REVIEW FINAL DETERMINATION

February 27, 2015

[REDACTED]
[REDACTED]
[REDACTED]

IBR Case Number:	CB14-0001764	Date of Injury:	05/04/2012
Claim Number:	[REDACTED]	Application Received:	11/19/2014
Claims Administrator:	[REDACTED]		
Assigned Date:	12/30/2014		
Provider Name:	[REDACTED]		
Employee Name:	[REDACTED]		
Disputed Codes:	29870, 29881-59, 29877-59, 29877-51, 29879-59		

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: UPHOLD. MAXIMUS Federal Services has determined that no additional reimbursement is warranted. The Claims Administrator’s determination is upheld and the Claim Administrator does not owe the Provider additional reimbursement. A detailed explanation of the decision is provided later in this letter.

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 – CMS 2014 NCCI Policy Manual
- 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 reimbursement of codes 29870, 29881-59, 29877-59, 29877-51 and 29879-59
- Claims administrator reimbursed codes 29879 and 29881 \$2930.07 and denied codes 29870, 29877-59 and 29877-59.
- Based on the NCCI edits codes 29870, 29877-59 and 29877-59 should not be reported with codes 29870 and 29881.
- CMS 2014 NCCI Policy Manual states: 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).
- Claims administrator was correct to deny code 29877.
- NCCI Edits show that code 29870 may be payable if submitted with the proper modifier and there is documentation to support the use of the code.
- The original claim form submitted for this review does not show CPT 29870 with modifier -59 and documentation does not support this code. Therefore, reimbursement of code 29870 is not warranted.
- Codes 29879 and 29881 were reimbursed by claims administrator and require no further reimbursement.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Based on information reviewed, reimbursement of codes 29877-59, 29877-59 and 29870 is not recommended.

Date of Service: 5/1/2014						
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Multiple Surgery	Workers' Comp Allowed Amt.	Notes
29879-59	\$3675.00	\$1953.38	\$1721.62	100%	\$1807.14	DISPUTED SERVICE: No reimbursement recommended
29881-59	\$3800.00	\$976.69	\$976.69	50%	\$903.57	DISPUTED SERVICE: No reimbursement recommended
29877-59	\$3800.00	\$0.00	\$3800.00	N/A	\$0.00	DISPUTED SERVICE: No reimbursement recommended
29877-59	\$3800.00	\$0.00	\$3800.00	N/A	\$0.00	DISPUTED SERVICE: No reimbursement recommended
29870	\$3800.00	\$0.00	\$3800.00	N/A	\$0.00	DISPUTED SERVICE: No reimbursement recommended

National Correct Coding Initiative information:

File	Column 1	Column 2	Modifier Allowed
Hospital APC Version 20.1 4/1/2014-6/30/2014	29877	29870	Yes
Hospital APC Version 20.1 4/1/2014-6/30/2014	29879	29870	Yes
Hospital APC Version 20.1 4/1/2014-6/30/2014	29879	29877	No
Hospital APC Version 20.1 4/1/2014-6/30/2014	29881	29870	Yes
Hospital APC Version 20.1 4/1/2014-6/30/2014	29881	29877	No

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