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## INDEPENDENT BILLING REVIEW FINAL DETERMINATION

August 31, 2015

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

IBR Case Number:	CB15-0001284	Date of Injury:	01/16/2015
Claim Number:	[REDACTED]	Application Received:	08/06/2015
Claims Administrator:	[REDACTED]		
Date(s) of service:	02/26/2015 – 02/26/2015		
Provider Name:	[REDACTED]		
Employee Name:	[REDACTED]		
Disputed Codes:	29880-RT		

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
- 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 reimbursement of 29880-RT
- Claims Administrator reimbursed 29880-RT and denied billed code 29876
- OMFS Update for Hospital Outpatient and Ambulatory Surgical Center (ASC) Services Effective December 1, 2014
- CHAP4-CPTcodes20000-29999; Revision Date: 1/1/2014 CHAPTER IV SURGERY: MUSCULOSKELETAL SYSTEM CPT CODES 20000-29999 FOR NATIONAL CORRECT CODING INITIATIVE POLICY MANUAL FOR MEDICARE SERVICES
- Arthroscopic synovectomy of the knee may be reported with CPT codes 29875 (limited synovectomy, “separate procedure”) or 29876 (major synovectomy of two or three compartments). A synovectomy to “clean up” a joint on which another more extensive procedure is performed is not separately reportable. CPT code 29875 should never be reported with another arthroscopic knee procedure on the ipsilateral knee. CPT code 29876 may be reported for a medically reasonable and necessary synovectomy with another arthroscopic knee procedure on the ipsilateral knee if the synovectomy is performed in two compartments on which another arthroscopic procedure is not performed. For example, CPT code 29876 should never be reported for a major

synovectomy with CPT code 29880 (knee arthroscopy, medial AND lateral meniscectomy) on the ipsilateral knee since knee arthroscopic procedures other than synovectomy are performed in two of the three knee compartments

- Based on information reviewed, additional reimbursement for 29880 is not warranted.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Reimbursement of code 29880

Date of Service: 2/26/2015						
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Multiple Surgery	Workers' Comp Allowed Amt.	Notes
29880	\$4347.00	\$2999.80	\$1499.90	100%	\$2999.80	<b>DISPUTED SERVICE:</b> No further reimbursement is recommended

National Correct Coding Initiative information:

File	Column 1	Column 2	Modifier
Hospital APC Version 21.0	29880	29876	Allowed

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