

MAXIMUS FEDERAL SERVICES, INC.

Independent Bill Review
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INDEPENDENT BILLING REVIEW FINAL DETERMINATION

June 22, 2015

██████████
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IBR Case Number:	CB15-0000406	Date of Injury:	04/23/2015
Claim Number:	██████████	Application Received:	03/20/2015
Claims Administrator:	██████████		
Date Assigned:	5/4/2015		
Provider Name:	████████████████████		
Employee Name:	██████████████████		
Disputed Codes:	29877, 29874, 29875, 20610 & A4550		

Dear ██████████
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 \$589.15 in additional reimbursement for a total of \$784.15. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of \$784.15 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: ██████████
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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: PPO Discount 15%
- National Correct Coding Initiatives

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 29877, 29874, 29875, 20610 & A4550
- HCPCS code A4550 has a status code ‘B’ which is a bundled code and included in another service rendered. Therefore, a separate reimbursement for A4550 is not warranted.
- CPT codes 29874 and 29877 were also denied due to CCI edits that exist.
- Based on NCCI edits that do exist between two pair codes 29874 and 29877 with billed code 29875, Modifier Indicator column shows ‘0’ which states: 0 = modifier not appropriate; services represented by code combination not paid separately. Therefore, reimbursement of these two codes is not warranted.
- The Multiple Procedure (“Mult Proc”) column of the National Physician Fee Schedule Relative Value File contains a “3” to indicate procedures that are subject to special rules for multiple endoscopic procedures. For each endoscopic procedure with an indicator of “3”, the Endoscopic Base Code (“Endo Base”) column indicates the related base endoscopy code. Those codes that share a base code are in the same “family” and are “related.”
- Multiple Related Endoscopic procedures billed: If Multiple Procedure column contains an indicator of “3,” and multiple endoscopies are billed, **pay the full value of the highest**

valued endoscopy, plus the difference between the next highest and the base endoscopy. Access the Endo Base column to determine the base endoscopy.

- There may be instances in which two or more physicians each perform distinctly different, unrelated surgeries on the same patient on the same day (e.g., in some multiple trauma cases). When this occurs, the payment adjustment rules for multiple surgeries may not be appropriate. In such cases, the physician does not use modifier “-51” unless one of the surgeons individually performs multiple surgeries. (c) Determining Maximum Payment for Multiple Surgeries: The Multiple Procedure (“Mult Proc”) column of the National Physician Fee Schedule Relative Value File contains a “2” to indicate procedures that are subject to the surgery multiple procedure payment reduction.
- If a procedure is performed on the same day as another procedure, base the payment on the lower of (a) the actual charge, or (b) the fee schedule amount for the procedure reduced by the applicable percentage. Rank the procedures subject to the multiple surgery rule (indicator “2”) in descending order by fee schedule amount and apply the appropriate reduction to this code:
 - (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
 - Provider billed codes 29875 and 20610. Per OMFS, CPT 29875 Multiple Procedure column shows ‘3’ and for 20610 it shows ‘2’. Based on information reviewed, additional reimbursement is warranted.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Reimbursement of codes 29875 and 20610.

Date of Service: 9/15/2014							
Physician Services							
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Assist Surgeon	Multiple Surgery	Workers’ Comp Allowed Amt.	Notes
29875	\$830.48	\$116.76	\$713.71	N/A	100%	\$705.91	DISPUTED SERVICE: Allow reimbursement \$589.15
20610	\$50.40	\$42.84	\$50.40	N/A	50%	\$42.84	DISPUTED SERVICE: No further reimbursement is recommended.

National Correct Coding Initiative information:

File	Column 1	Column 2	Modifier
Physician Version Number: 20.2	29875	29874	Not Allowed
Physician Version Number: 20.2	29875	29877	Not Allowed

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