

MAXIMUS FEDERAL SERVICES, INC.

Independent Bill Review
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Fax: (916) 605-4280



INDEPENDENT BILLING REVIEW FINAL DETERMINATION

June 22, 2015

[Redacted]
[Redacted]
[Redacted]

| | | | |
|-----------------------|-------------------------|-----------------------|------------|
| IBR Case Number: | CB15-0000472 | Date of Injury: | 02/15/2014 |
| Claim Number: | [Redacted] | Application Received: | 04/01/2015 |
| Assignment Date: | 04/274/2015 | | |
| Claims Administrator: | [Redacted] | | |
| Date(s) of service: | 02/09/2015 – 02/09/2015 | | |
| Provider Name: | [Redacted] | | |
| Employee Name: | [Redacted] | | |
| Disputed Codes: | 29877, 29874 & 29875 | | |

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 \$195.00 for the review cost and \$711.68 in additional reimbursement for a total of \$906.68. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of **\$906.68** 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, M.D., M.P.H.
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
- AMA CPT 2015
- NCCI Edits: APC Version 21.0 (1/1/2015-3/31/2015)

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 seeking full remuneration for Surgical Services 29877, 29874 & 29875 for date of service 02/09/2015.**
- The Claims Administrator denied the services stating, “No separate payment was made because the value of the service is included within the value of another service performed on the same day.”
- EOR’s indicate the following services submitted for reimbursement:
 - **29877**
 - **29874**
 - **29875 Reimbursed 118.78.**
 - **20610 Reimbursed 64.96**
- **NCCI edits reveal** The following code pairs generally cannot be reported together. Use the Column 1 code.
(If Modifier Indicator=1, there may be occasions where both codes are payable, see NCCI Chapter I Section E .)

▭ short description for column 1 code

| Column 1 | Column 2 | CCI Edit Description* |
|----------|----------|-----------------------|
|----------|----------|-----------------------|

▭ short description for column 2 code

| Modifier Indicator | Effective Date* |
|--------------------|-----------------|
|--------------------|-----------------|

| | | | | |
|--------------------------------|--------------|---|----------|-----------------|
| ⌊ KNEE ARTHROSCOPY/SURGERY | | | | |
| <u>29874</u> | <u>20610</u> | Misuse of column two code with column one code | 1 | 1/1/1996 |
| ⌋ DRAIN/INJ JOINT/BURSA W/O US | | | | |
| ⌊ KNEE ARTHROSCOPY/SURGERY | | | | |
| <u>29875</u> | <u>20610</u> | Misuse of column two code with column one code | 1 | 1/1/1996 |
| ⌋ DRAIN/INJ JOINT/BURSA W/O US | | | | |
| <u>29875</u> | <u>29874</u> | Misuse of column two code with column one code | 0 | 4/1/2003 |
| ⌋ KNEE ARTHROSCOPY/SURGERY | | | | |
| <u>29875</u> | <u>29877</u> | Misuse of column two code with column one code | 0 | 4/1/2003 |
| ⌋ KNEE ARTHROSCOPY/SURGERY | | | | |
| ⌊ KNEE ARTHROSCOPY/SURGERY | | | | |
| <u>29877</u> | <u>20610</u> | Misuse of column two code with column one code | 1 | 1/1/1996 |
| ⌋ DRAIN/INJ JOINT/BURSA W/O US | | | | |
| <u>29877</u> | <u>29874</u> | Misuse of column two code with column one code | 0 | 1/1/1996 |

- Medicare Manual, Chapter 1, Page 21, Paragraph 7: modifier be indicator of “0” indicates that NCCI-associated modifier **cannot be** used to bypass the edit.
- Medicare Manual, Chapter 1, Page 8, paragraph 2: Each edit table contains edits which are pairs of HCPCS/CPT codes that in general should not be reported together. Each edit has a column one and column two HCPCS/CPT code. If a provider **reports the two codes of an edit** pair, the column two code is denied, and **the column one code is eligible for payment.**
- Disputed Code 29877 reflects a modifier indicator of “0,” additional reimbursement is not indicated.
- Medicare Manual, Chapter 1, Page 21, Paragraph 7, A Modifier indicator or “1” indicates that NCCI-Associated modifiers may be used to bypass an edit under appropriate circumstances.
- Disputed Code 29874, reflects modifier -59 applied. However, the documentation does not support the use a separate code. The AAOS indicates, “To report both procedures, the surgeon should document the medical necessity and the performance of a “synovial resection” for pathology—not just cleaning up loose synovium that might be fibrillating in the joint.”
- For services rendered on or after September 1, 2014, APC relative weight x adjusted conversion factor x 0.808 workers’ compensation multiplier, pursuant to Section 9789.30(aa). See Section 9789.39(b) for the APC relative weight by date of service.
- CPT 29875 reimbursed \$118.78. 29875 accepted by the Claims Administrator for reimbursement and is considered the primary procedure. Additional reimbursement is warranted for 29875.

The table below describes the pertinent claim line information.

