

MAXIMUS FEDERAL SERVICES, INC.

Independent Bill Review
P.O. Box 138006
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Fax: (916) 605-4280



INDEPENDENT BILLING REVIEW FINAL DETERMINATION

July 2, 2015

[Redacted]
[Redacted]
[Redacted]

IBR Case Number:	CB15-0000656	Date of Injury:	08/29/2012
Claim Number:	[Redacted]	Application Received:	04/27/2015
Claims Administrator:	[Redacted]		
Date Assigned:	5/22/2015		
Provider Name:	[Redacted]		
Employee Name:	[Redacted]		
Disputed Codes:	64450-RT-51, 29870-RT-59, 29876-RT-22		

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 \$991.87 in additional reimbursement for a total of \$1186.87. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of \$1186.87 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: [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
- 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 denial of codes 64450-RT-51, 29870-RT-59, 29876-RT-22
- Claims Administrator denied codes indicating on the Explanation of Review “No separate payment was made because the value of the service is included within the value of another service performed on the same day”
- Provider billed codes 64450 and 29870 along with code 29881 which was reimbursed.
- As pair codes exist between 64450 and 29881 along with 29870 and 29881, generally these pairs are not billed together. However, modifier indicator column shows ‘1’ which states if an approved modifier is appended to the column 2 code and documentation submitted supports the use of billed code then the edit may be overridden.
- Provider did bill column 2 codes with an approved modifier.
- 64450 - Injection, anesthetic agent; other peripheral nerve or branch; 29870 - Arthroscopy, knee, diagnostic, with or without synovial biopsy (separate procedure)
- Operative Report submitted documents “...injected Marcaine with epinephrine for postoperative pain management.” Documentation does not specify nerve or branch as needed to bill code 64450. Report also does not document a separate procedure for billed code 29870.

- Based on report submitted, documentation does not support billed codes 64450 or 29870 and therefore reimbursement of two codes 64450 and 29870 is not warranted.
- Report submitted does document billed code 29876, “We did a partial lateral and medial meniscectomies, chondroplasty, and synovectomy since quite a bit of extensive synovitis of the synovium was present”
- Reimbursement of 29876 is warranted.
- Provider billed modifier -22 for increased procedural services. However, documentation does not indicate the service went above and beyond the normal procedure and therefore does not warrant the increased reimbursement.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Reimbursement of code 29876-RT-51

Date of Service: 11/7/2014						
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Multiple Surgery	Workers' Comp Allowed Amt.	Notes
29876	\$4750.00	\$0.00	\$991.87	50%	\$991.87	DISPUTED SERVICE: Allow reimbursement \$991.87

National Correct Coding Initiative information:

File	Column 1	Column 2	Modifier
Hospital APC Version 20.3	29881	29870	Allowed
Hospital APC Version 20.3	29881	64450	Allowed

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