

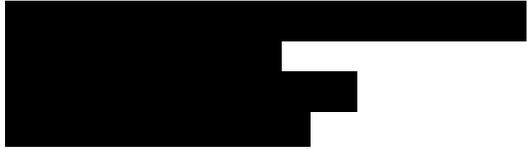
MAXIMUS FEDERAL SERVICES, INC.

Independent Bill Review
P.O. Box 138006
Sacramento, CA 95813-8006
Fax: (916) 605-4280



INDEPENDENT BILLING REVIEW FINAL DETERMINATION

July 10, 2015



IBR Case Number:	CB15-0000861	Date of Injury:	11/29/2011
Claim Number:	[REDACTED]	Application Received:	05/27/2015
Claims Administrator:	[REDACTED]		
Assigned Date:	6/26/2015		
Provider Name:	[REDACTED]		
Employee Name:	[REDACTED]		
Disputed Codes:	29870, 29876-LT-59, 29881-LT-51-59, 27442-LT-59, and 27442-LT-51-59		

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]

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
- OMFS Outpatient Hospital and ASC Fee Schedule

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:** The Provider is seeking reimbursement for CPT **29870, 29876-LT-59, 29881-LT-51-59, 27442-LT-59, and 27442-LT-51.**
- Additional reimbursement is not recommended based on the findings.
- Claims Administrator reimbursed the Provider for CPT 29881-LT-51-59 and CPT 29876-LT-59 based on the OMFS allowance, no additional payment was issued on the second bill review.
- HCPCS/CPT code 29870 is designated as a "separate procedure". Therefore, if it is reported with HCPCS/CPT codes 29876 and 29881, HCPCS/CPT code 29870 is bundled into HCPCS/CPT codes 29876 and 29881.
- The operative report did not substantiate the billed code CPT 27442 (2 units). The operative report described arthroscopic procedures performed on the left knee: left knee diagnostic arthroscopy; synovectomy; partial medial meniscectomy; and chondroplasty of the medial femoral condyle and patella.
- The arthroscopic procedures were performed in the medial and lateral compartments. The arthroscopic code for chondroplasty of the knee is CPT 29877. CPT code 29877 can be reported only once, regardless of how many compartments are affected.
- HCPCS/CPT codes have been written as precisely as possible to not only describe a specific procedure but to also avoid describing similar procedures which are already defined by other HCPCS/CPT codes. When the procedure described by HCPCS/CPT code 29877 is reported with the procedure described by HCPCS/CPT codes 29881 and

29876 reporting the former code represents a misuse of this code, and separate payment is not allowed.

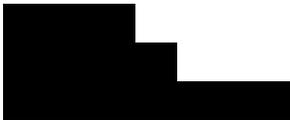
- The medical record did not support the reimbursement for CPT 27442, and the services performed were better described by CPT 29877, which is included in the primary procedures (29881 and 29876). Reimbursement not recommended.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Reimbursement is not recommended for CPT 29870, 29876-LT-59, 29881-LT-51-59, 27442-LT-59, and 27442-LT-51..

Date of Service: 10/9/2014						
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Multiple Surgery	Workers' Comp Allowed Amt.	Notes
29876-LT-59	\$ 3,380.00	\$1928.43	\$ 1822.60	100%	\$ 1928.43	DISPUTED SERVICE: See Analysis.
29881-LT-51-59	\$3,380.00	\$964.22	\$991.87	50%	\$964.22	DISPUTED SERVICE: See Analysis.
29870	\$3,380.00	\$0.00	\$3,380.00	N/A	\$0.00	DISPUTED SERVICE: See Analysis.
27442-LT-59	\$4,345.45	\$0.00	\$4,345.45	N/A	\$0.00	DISPUTED SERVICE: See Analysis.
27442-LT-51-59	\$4,345.45	\$1735.33	\$4345.45	N/A	\$0.00	DISPUTED CODE: See Analysis

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