

MAXIMUS FEDERAL SERVICES, INC.

Independent Bill Review
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INDEPENDENT BILLING REVIEW FINAL DETERMINATION

July 17, 2015

[Redacted]
[Redacted]
[Redacted]

IBR Case Number:	CB15-0000964	Date of Injury:	09/20/2011
Claim Number:	[Redacted]	Application Received:	06/12/2015
Claims Administrator:	[Redacted]		
Date(s) of service:	10/23/2014		
Provider Name:	[Redacted]		
Employee Name:	[Redacted]		
Disputed Codes:	29870, 29880 and 29876		

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 \$978.42 in additional reimbursement for a total of \$1173.42. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of \$1173.42 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 29870, 29880 and 29876
- Claims Administrator denied code 29870 indicating on the Explanation of Review “According to the Official Medical Fee Schedule this service has a relative value of zero and therefore no payment is due”
- Provider billed code 29870 along with 27442 which was reimbursed.
- As a code pair exists with codes 29870 and 27442, these two codes are generally not billed together. However, Modifier Indicator shows ‘1’ which states that if an approved modifier is attached to the column two code and documentation is submitted to support the use of the code then the edit may be overridden.
- Provider did not bill with any modifier on column 2 code 29870. As coding guidelines were not met, reimbursement of code 29870 is not warranted.
- Provider also denied code 29876 - **Arthroscopy, knee, surgical; synovectomy, major, 2 or more compartments (eg, medial or lateral)**, indicating on the Explanation of Review “This service is included in primary or more extensive procedure”
- Documentation reviewed on the Provider’s report submitted shows synovectomies performed on the intercondylar notch and patellofemoral joint. These are not considered two separate compartments of the knee joint.

- Documentation does not support billed code 29876 and therefore, reimbursement of this code is not warranted.
- Claims Administrator also denied code 29880 - Arthroscopy, knee, surgical; with meniscectomy (medial AND lateral, including any meniscal shaving) including debridement/shaving of articular cartilage (chondroplasty), same or separate compartment(s), when performed, indicating on the Explanation of Review “This service is included in primary or more extensive procedure”
- Report submitted documents both medial and lateral meniscectomies along with a chondroplasty of the medial femoral condyle.
- A pair code exists between reimbursed code 27442 and 29880, however, Provider did bill column 2 code with an approved modifier and documentation does support the service performed.
- Based on information reviewed, reimbursement of 29880 is warranted.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Reimbursement of code 29880

Date of Service: 10/23/2014						
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Multiple Surgery	Workers' Comp Allowed Amt.	Notes
29880	\$3,380.00	\$0.00	\$3,380.00	50%	\$978.42	DISPUTED SERVICE: Allow reimbursement \$978.42

National Correct Coding Initiative information:

File	Column 1	Column 2	Modifier
Hospital APC Version: 20.3	27442	29870	Allowed

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