

INDEPENDENT BILLING REVIEW FINAL DETERMINATION

April 13, 2016

[REDACTED]
[REDACTED]
[REDACTED] [REDACTED] [REDACTED]
[REDACTED]

IBR Case Number:	CB16-0000483	Date of Injury:	07/01/2013
Claim Number:	[REDACTED]	Application Received:	03/22/2016
Claims Administrator:	[REDACTED]		
Date(s) of service:	03/10/2015		
Provider Name:	[REDACTED]		
Employee Name:	[REDACTED]		
Disputed Codes:	64415-XP		

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, M.D., M.P.H.
Medical Director

[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
- NCCI Policy Manual for Medicare Services, Chapter 1, 4
- MLN Matters Number MM8863

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 remuneration for 64415, for post-operative pain management submitted for date of service 03/10/2015.**
- **Authorization** for services not submitted for review.
- The Medicare National Correct Coding Initiative (NCCI) has Procedure to Procedure (PTP) edits to prevent unbundling of services, and the consequent overpayment to physicians and outpatient facilities.
- NCCI Edits indicate the following with Modifier indicator of 1:

▢ short description for column 1 code

Column 1	Column 2	CCI Edit	Description
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▢ short description for column 2 code

▢ SHOULDER ARTHROSCOPY/SURGERY

29824 **64415** Misuse of column two code with column one code

▢ N BLOCK INJ BRACHIAL PLEXUS

- Although the Modifier indicator is “1,” NCCI Manual refers to the shoulder joint as one anatomical site. Additionally, the modifier submitted and reflected on the UB-04 is Modifier – XP. Modifier XP, Separate Practitioner, A Service That Is Distinct Because It Was Performed By A Different Practitioner, and is not the appropriate modifier to unbundle a coded surgical pair.

- MLN Matters Number MM8863: a particular NCCI PTP code pair may be identified as payable only with the -XE separate encounter modifier but not the -59 or other -X{EPSU} modifiers.
- Medicare Global Surgery Rules prevent separate payment for postoperative pain management when provided by the physician performing an operative procedure. CPT codes 36000, 36410, 37202, 62310-62319, 64400-64489, and 96360-96376 describe some services that may be utilized for postoperative pain management. The services described by these codes may be reported by the physician performing the operative procedure only if provided for purposes unrelated to the postoperative pain management, the operative procedure, or anesthesia for the procedure.
- If two procedures are performed at the same anatomic site and same patient encounter, one procedure may be bundled into the other (e.g., one procedure may be integral to the other). However, if the two procedures are performed at separate anatomic sites or at separate patient encounters, they may be separately reportable.
- **Medicare Billing Manual, Chapter 1, page I-6, paragraph 1:** 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.
 - Final EOR reflects Column 1 CPT 29824 reimbursement with denial of Column 2 CPT 64415
- Based on the aforementioned documentation and guidelines, reimbursement is not indicated for CPT 64415.

DETERMINATION OF ISSUE IN DISPUTE: 64415

Date of Service: 03/10/2015							
HOPPS							
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Assist Surgeon	Units	Workers' Comp Allowed Amt.	Notes
64415	\$5987.00	\$0.00	\$236.92	NA	1	\$0.00	Refer to Analysis

[REDACTED]
 [REDACTED]
 [REDACTED]
 [REDACTED]

 [REDACTED]
 [REDACTED]
 [REDACTED]
 [REDACTED]