

**MAXIMUS FEDERAL SERVICES, INC.**

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



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**INDEPENDENT BILLING REVIEW FINAL DETERMINATION**

May 12, 2016

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

IBR Case Number:	CB16-0000653	Date of Injury:	02/26/2015
Claim Number:	[REDACTED]	Application Received:	04/20/2016
Claims Administrator:	[REDACTED]		
Date(s) of service:	09/23/2015		
Provider Name:	[REDACTED]		
Employee Name:	[REDACTED]		
Disputed Codes:	64447-XPRT		

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]  
[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: N/A
- National Correct Coding Initiatives

## 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 code 64447-XPRT performed on 09/23/2015.
- Claims Administrator denied 64447-XPRT indicating on the Explanation of Review “Service/item included in the value of other services per CCI edits. Related service could be on a separate bill.”
- Provider billed code 64447-XPRT along with code 29888 on a UB-04 with Bill Type 131 for Outpatient service.
- As a pair code exists between 29888 and 64447 stating standards of medical/surgical practice, services integral to HCPCS/CPT code defined procedures are included in those procedures based on the standards of medical/surgical practice. It is inappropriate to separately report services that are integral to another procedure with that procedure.
- Although the modifier indicator column shows ‘1’ which states that if an approved modifier is appended to the column ‘2’ code, and **documentation is submitted to support billed code**, then the edit may be overridden.
- Provider billed code 64447 with modifier –**XP**, “Separate Practitioner, A service that is distinct because it was performed by a different practitioner”
- Documentation submitted for review included Provider’s Operative Report which details the injured worker’s ACL repair with allograft of the right knee, the Anesthesia Record and

Nursing Intra-OP Record which documents “Procedure(s): Reconstruction, ACL with Triple Arthroscopy: Right Knee”

- Documentation submitted does not support a femoral nerve block performed by a separate practitioner, 64447-XP.
- Based on information reviewed, lack of supporting documentation and guidelines, reimbursement of code 64447-XPRT is not indicated.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Reimbursement of codes 64447-XPRT

<b>Date of Service:</b> 09/23/2015							
<b>Outpatient Services</b>							
<b>Service Code</b>	<b>Provider Billed</b>	<b>Plan Allowed</b>	<b>Dispute Amount</b>	<b>Units</b>	<b>Multiple Surgery</b>	<b>Workers’ Comp Allowed Amt.</b>	<b>Notes</b>
64447-XPRT	\$9,528.00	\$0.00	\$245.92	1	Yes	\$0.00	<b>Refer to Analysis</b>

National Correct Coding Initiative information:

<b>File</b>	<b>Column 1</b>	<b>Column 2</b>	<b>Modifier</b>
Hospital APC Version 21.2	29888	64447	Yes

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