

INDEPENDENT BILLING REVIEW FINAL DETERMINATION

May 25, 2016

[REDACTED]
[REDACTED]
[REDACTED]

IBR Case Number:	CB16-0000701	Date of Injury:	05/08/2014
Claim Number:	[REDACTED]	Application Received:	04/27/2016
Claims Administrator:	[REDACTED]		
Date(s) of service:	02/01/2016		
Provider Name:	[REDACTED]		
Employee Name:	[REDACTED]		
Disputed Codes:	27425, 29877-59, 29874-59, 29875-59, and 20610-59		

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: 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 \$591.91 in additional reimbursement for a total of \$786.91. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of \$786.91 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,

Maximus

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 seeking reimbursement of codes 27425, 29877-59, 29874-59 and 20610-59 performed on date of service 02/01/2016.
- Claims Administrator reimbursed CPT code 29875 in the amount \$191.11 and denied all other services billed.
- Submitted authorization dated December 23, 2015 verifies “Left knee lateral release has been CERTIFIED upon peer review report”
- Provider’s Operative Report submitted documents procedure performed:
 1. Left knee arthroscopy, arthroscopic patellar chondroplasty
 2. Arthroscopic synovectomy
 3. Percutaneous lateral retinacular release
 4. Injection Marcaine 25%, 20 ml, plus Toradol 30 mg.
- Further in the Provider’s Operative Report states “Through a standard anterolateral portal, the Storz 5-mm, 30-degree arthroscope was inserted.” Under Operative Arthroscopy, Provider documents “a percutaneous lateral release was then performed using Metzenbaum scissors. A 90-degree patellar tile test was possible post-release, and flexion-extension tracking demonstrated centralization in the trochlea.”
- Billed code 27425: Lateral retinacular release, open
- Documentation does not support an “open” procedure was performed.

- Parenthetical Guidelines specific to 27425: **For arthroscopic lateral release, use 29873.**
- NCCI edits exist between procedure performed code 29873 and all other billed codes 29877, 29874, 29875 and 20610 which are not separately reimbursable per Medicare correct coding guidelines.
- Based on aforementioned documentation and guidelines, additional reimbursement is recommended for CPT 29873 only.
- PPO contract not submitted for IBR.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Reimbursement of code 29873

Date of Service: 02/01/2016						
Physician Services						
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Multiple Surgery	Workers' Comp Allowed Amt.	Notes
29873	\$3,559.34	\$191.11	\$3,368.23	100%	\$783.02	\$783.02 - \$191.11 = \$591.91 Due to Provider

National Correct Coding Initiative information:

File	Column 1	Column 2	Modifier
Physician Version Number: 22.0	29873	29874	More extensive procedure
Physician Version Number: 22.0	29873	29877	Misuse of column two code
Physician Version Number: 22.0	29873	20610	Misuse of column two code
Physician Version Number: 22.0	29873	29875	"Separate Procedure" definition

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