
INDEPENDENT BILLING REVIEW FINAL DETERMINATION

May 25, 2016

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

IBR Case Number:	CB16-0000741	Date of Injury:	10/01/1998
Claim Number:	[REDACTED]	Application Received:	05/02/2016
Claims Administrator:	[REDACTED]		
Date(s) of service:	11/25/2015		
Provider Name:	[REDACTED]		
Employee Name:	[REDACTED]		
Disputed Codes:	52000		

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,

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 remuneration of CPT 52000 performed on date of service 11/25/2015.
- Claims Administrator denied code with rationale “This procedure is an integral part of total service performed and does not warrant separate procedure charge”
- Provider billed code 52000, Cystourethroscopy (**separate procedure**), along with 51725, Insertion of device into bladder to measure pressure of urine flow, on the same CMS 1500 form for date of service 11/25/2015.
- Provider submitted a QME in Urology report for date of service 11/25/2015. Documentation states “I wanted to perform a cystometrogram and cystoscopy but the patient was having too much pain to allow me to do diagnostic studies. So instead, I asked her to do some homework for me and have her return for a cystometrogram and cystoscopy which she did on 11/25/2015.”
- **Pursuant Medicare Correct Coding Policy on “Separate Procedure”** - Exposure and exploration of the surgical field is integral to an operative procedure and is not separately reportable. A procedure designated by the CPT code descriptor as a “separate procedure” **is not separately reportable if performed in a region anatomically related to the other procedure(s) through the same skin incision, orifice, or surgical approach.**
- **Chapter 7 Revision Date (Medicare): 1/1/2016 VII-19- 15.** A cystourethroscopy (CPT code 52000) performed near the termination of an intra-abdominal, intra-pelvic, or

retroperitoneal surgical procedure to assure that there was no intraoperative injury to the ureters or urinary bladder and that they are functioning properly is not separately reportable with the surgical procedure.

- Based on aforementioned documentation and guidelines, reimbursement of 52000 is not warranted.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Reimbursement of code 52000

Date of Service: 11/25/2015					
Provider Services					
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Workers' Comp Allowed Amt.	Notes
52000	\$331.00	\$0.00	\$331.00	\$0.00	Refer to Analysis

Copy to:

[REDACTED]
[REDACTED]
[REDACTED]

Copy to:

[REDACTED]
[REDACTED]
[REDACTED]