

INDEPENDENT BILLING REVIEW FINAL DETERMINATION

November 3, 2014

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

IBR Case Number:	CB14-0000313	Date of Injury:	06/21/2011
Claim Number:	[REDACTED]	Application Received:	03/05/2014
Claims Administrator:	[REDACTED]		
Provider Name:	[REDACTED]		
Employee Name:	[REDACTED]		
Disputed Codes:	29805, 29823, 29820, 29827, 29826, 29824 & 99070		

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.

IBR Assigned: 04/25/2014

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,

[REDACTED]
Chief Coding Reviewer

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: non
- 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:** Denial of CPT codes 29805, 29820, 99070 and low reimbursement rates of CPT codes 29827, 29826, 29823 and 29824.
- Based on the NCCI edits there are several suspect codes sets (see below).
- The Provider did not append modifiers to any of the codes indicating separate and distinct services.
- Code 29827 should be considered the primary procedure and reimbursed at 100% of the fee schedule amount all other allowable services to be reimbursed at 50% of the fee schedule amount based on status indicator “T”
- Codes 29826, 29824 and 29823 should be reimbursed as already reimbursed by the Claim Administrator. Note that code 29823 requires a modifier to be reimbursed per the NCCI edits but the service was allowed by the Claim Administrator.
- Codes 29805 and 29820 are to be denied based on lack of appended modifier and based on review of operative report.
- Code 99070 to be denied based on OPSS status indicator of “B” that indicates the services are bundled into reimbursement for primary services.
- Reimbursement for all services not denied have been reimbursed appropriately by the Claim Administrator.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Deny reimbursement of CPT codes 99070, 29805 and 29820. Reimbursement by the Claim Administrator correct no additional reimbursement warranted.

Date of Service: 8/14/2013						
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Mult Surg	Workers' Comp Allowed Amt.	Notes
29827	\$ 6500	\$3589.43	\$ 2910.57	100%	\$ 3589.43	DISPUTED SERVICE: Paid appropriately by the Claim Administrator.
29826	\$ 6118	\$ 979.68	\$ 5138.32	50%	\$ 976.68	DISPUTED SERVICE: Paid appropriately by the Claim Administrator.
29824	\$ 2025	\$976.69	\$ 1048.31	50%	\$ 976.69	DISPUTED SERVICE: Paid appropriately by the Claim Administrator.
29823	\$ 5318.35	\$ 1794.72	\$ 3523.63	50%	\$ 1794.72	DISPUTED SERVICE: Paid appropriately by the Claim Administrator.
29805	\$ 3565	\$ 0	\$ 3565	50%	\$ 0	DISPUTED SERVICE: Deny based on NCCI edits
29820	\$ 2037	\$ 0	\$ 2037	50%	\$ 0	DISPUTED SERVICE: Deny based on NCCI edits
99070	\$ 1655.58	\$ 0	\$ 1655.58	50%	\$ 0	DISPUTED SERVICE: Deny based on status indicator of "B".

National Correct Coding Initiative information:

File	Column 1	Column 2	Modifier
Hospital APC Version 19.2	29820	29805	Allowed
Hospital APC Version 19.2	29823	29805	Allowed
Hospital APC Version 19.2	29823	29820	Allowed
Hospital APC Version 19.2	29824	29805	Allowed
Hospital APC Version 19.2	29824	29820	Allowed
Hospital APC Version 19.2	29824	29823	Allowed
Hospital APC Version 19.2	29826	29805	Allowed
Hospital APC Version 19.2	29827	29805	Allowed
Hospital APC Version 19.2	29827	29820	Allowed

Copy to:

[REDACTED]
[REDACTED]
[REDACTED]

Copy to:

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