

**INDEPENDENT BILLING REVIEW FINAL DETERMINATION**

November 6, 2014

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

<b>IBR Case Number:</b>	CB14-0000333	<b>Date of Injury:</b>	04/05/2013
<b>Claim Number:</b>	[REDACTED]	<b>Application Received:</b>	03/07/2014
<b>Claims Administrator:</b>	[REDACTED]	<b>Assignment Date:</b>	04/28/2014
<b>Provider Name:</b>	[REDACTED]		
<b>Employee Name:</b>	[REDACTED]		
<b>Disputed Codes:</b>	29877 (3 units), 99070, & 29875		

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,

[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: none
- 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 29877 (3 units), 29875, and 99070.
- Based on review of the operative report 29880 is the primary procedure.
- CPT code 29877 (3 units) should be denied based on the NCCI edits. There are no situations when a modifier can be appended to allow reimbursement when submitted with CPT code 29870.
- CPT code 29875 is suspect when submitted with CPT code 29880. The provider should append a modifier indicating that this service is separate and distinct from the service reported with CPT code 29880. The provider did not append a modifier and therefore reimbursement is not considered and the service should be denied. Furthermore, the operative report does not substantiate the use of code 29857.
- Code 99070 should not be reimbursed separately. This CPT code has a status indicator of “B” which indicates that it is not paid under the Outpatient Prospective Payment System (OPPS).

The table below describes the pertinent claim line information.

**DETERMINATION OF ISSUE IN DISPUTE:** No additional reimbursement warranted. The services were appropriately denied.

<b>Date of Service:</b> 8/16/2013						
<b>Service Code</b>	<b>Provider Billed</b>	<b>Plan Allowed</b>	<b>Dispute Amount</b>	<b>Multiple Surgery</b>	<b>Workers' Comp Allowed Amt.</b>	<b>Notes</b>
29877	\$ 3380	\$ 0	\$ 3380	Na	\$0	<b>DISPUTED SERVICE:</b> Deny service based on NCCI edits.
29877-51	\$ 3380	\$ 0	\$ 3380	Na	\$0	<b>DISPUTED SERVICE:</b> Deny service based on NCCI edits.
29877-51	\$ 3380	\$ 0	\$ 3380	Na	\$0	<b>DISPUTED SERVICE:</b> Deny service based on NCCI edits.
29875	\$ 3380	\$ 0	\$ 3380	Na	\$0	<b>DISPUTED SERVICE:</b> Deny service based on NCCI edits.
99070	\$ 979.52	\$ 0	\$ 979.52	Na	\$0	<b>DISPUTED SERVICE:</b> Deny service based on NCCI edits.
29880	\$3380	\$1953.38	Not in dispute	100%	Not in dispute	Service not in dispute.

National Correct Coding Initiative information:

<b>File</b>	<b>Column 1</b>	<b>Column 2</b>	<b>Modifier</b>
Hospital APC Version 19.2	29880	29877	Not Allowed
Hospital APC Version 19.2	29880	29875	Allowed
Hospital APC Version 19.2	29875	29877	Not Allowed

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