

INDEPENDENT BILLING REVIEW FINAL DETERMINATION

December 11, 2014

[Redacted]
[Redacted]
[Redacted]
[Redacted]

IBR Case Number:	CB14-0000747	Date of Injury:	05/04/2013
Claim Number:	[Redacted]	Application Received:	05/15/2014
Claims Administrator:	[Redacted]	Assignment Date:	07/29/2014
Provider Name:	[Redacted]		
Employee Name:	[Redacted]		
Disputed Codes:	29879-59		

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: 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]

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:
- National Correct Coding Initiatives
- Other: CPT Coding Guidelines

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 CPT code 29879-59.
- Claims Administrator denied code 29879-59 and indicated on the Explanation of Review “The value of this procedure is included in the value of another procedure performed on this date.”
- Provider submitted an Operative report that was reviewed. Based on the report submitted, the following was found: Codes billed: 29879-51, 29879-59, 29880 & 29875-59. There was debridement with partial synovectomy in all 3 compartments including the patellofemoral joint. (The provider billed 29875 -59 for this). There was a chondroplasty in all 3 compartments including the patellofemoral joint. (Provider billed 29879 -51 for this). There was a microfracture of the intracondylar notch and medial tibial plateau. (Provider billed 29879 -59 for this). There was also partial medial and lateral meniscectomies and removal of a large loose body of the left knee. (Billed as 29880). CPT 29879 is defined as “abrasion arthroplasty (includes chondroplasty where necessary) or multiple drilling or microfracture. The duplicate billing of 29879 -51 and 29879 -59 is invalid. CPT 29879 -51 should be billed and 29879 -59 is billed in error. (Should have also been billed 29880 -51, 29875 -51).
- Based on review of Operative report, Claims Administrator was correct to deny code 29879-59. Therefore, no reimbursement is warranted.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Based on information received, reimbursement of code 29879-59 is not recommended.

Date of Service: 7/18/2013							
Physician Services							
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Assist Surgeon	Multiple Surgery	Workers' Comp Allowed Amt.	Notes
29879-59	\$1308.15	\$0.00	\$327.04	N/A	N/A	\$0.00	DISPUTED SERVICE: No reimbursement recommended.

Copy to:

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[REDACTED]
[REDACTED]
[REDACTED]

Copy to:

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