

MAXIMUS FEDERAL SERVICES, INC.

Independent Bill Review
P.O. Box 138006
Sacramento, CA 95813-8006
Fax: (916) 605-4280



INDEPENDENT BILLING REVIEW FINAL DETERMINATION

November 5, 2014

[Redacted]
[Redacted]
[Redacted]

IBR Case Number:	CB14-0000767	Date of Injury:	09/19/2013
Claim Number:	[Redacted]	Application Received:	05/22/2014
Claims Administrator:	[Redacted]		
Provider Name:	[Redacted]		
Employee Name:	[Redacted]		
Disputed Codes:	23020, 20610, 29823 and 23700		

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: no contract.
- 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 23700-59, and 20610 and underpayment of CPT codes 23823 and 23202-51.
- Based on the NCCI edits misuse of column 2 code with column 1 code and standards of medical/surgical practice
- Based on review of the operative report 29823 is the primary procedure and code 23700 is not separate and distinct from code 29823.
- Deny code 23020 because it was not done. This is an open procedure code. The entire operative report shows case done arthroscopically.
- Deny code 20610 due to misuse of column 2 code with column 1 code. No modifier appended indicating that it was separate and distinct from 29823.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Reimbursement of code 29823 is allowed at a higher amount that already paid however reimbursement for CPT codes 23020, 23700 and 20610 should be denied. Because the Claim Administrator already reimbursed more than the allowed for the disputed services, no additional reimbursement warranted.

Date of Service: 1/18/2014						
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Multi Surgery	Workers ' Comp Allowed Amt.	Notes
23700-59	\$ 2704.94	\$ 0	\$ 524.83	50%	\$0	DISPUTED SERVICE: Deny service as component of primary service performed and not separate and distinct.
23020	\$ 5670.30	\$ 983.19	\$ 193.85	50%	\$0	DISPUTED SERVICE: Deny service because it was never performed. (This is an open procedure code)
20610	\$ 914.08	\$ 0	\$ 91.93	50%	\$0	DISPUTED SERVICE: Deny service. Misuse of column 2 with column 1 code.
29823	\$ 9975.82	\$ 3307.63	\$ 564.79	100%	\$3595.25	DISPUTED SERVICE: Although additional reimbursement of \$287.62 allowed for this particular line of service the Claim Administrator paid more than this amount for code 23020 which should be denied.

National Correct Coding Initiative information:

File	Column 1	Column 2	Modifier
Hospital APC Version 20.0	29823	20610	Allowed
Hospital APC Version 20.0	29823	23700	Allowed
Hospital APC Version 20.0	23020	23700	Allowed
Hospital APC Version 20.0	23700	20610	Allowed

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