

INDEPENDENT BILLING REVIEW FINAL DETERMINATION

February 13, 2015

[REDACTED]
[REDACTED]
[REDACTED]

IBR Case Number:	CB14-0001772	Date of Injury:	10/21/2013
Claim Number:	[REDACTED]	Application Received:	11/20/2014
Claims Administrator:	[REDACTED]		
Provider Name:	[REDACTED]		
Employee Name:	[REDACTED]		
Disputed Codes:	29870, 29881, 29877 and 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,

Paul Manchester, M.D., M.P.H.
Chief Coding Reviewer

cc: [REDACTED]
Division of Workers’ Compensation (DWC) Medical Unit

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
- National Correct Coding Initiatives
- Medicare and Medicaid Services (CMS) Outpatient Prospective Payment System (OPPS)
- Other: OMFS Outpatient Hospital ASC Fee Schedule

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:** The reimbursement of 29881, 29877, and denial of CPT 29876 and 29870.
- Based on the NCCI edits, code pairs exist between the following billed codes: 29876 and 29870; 29876 and 29877; 29881 and 29870; and 29881 and 29877.
- CPT 29870 may be billed with CPT 29876, 29881 if justifiable and billed with an appropriate modifier. CPT 29870 is defined as a “separate procedure”, and was not billed with a modifier; therefore, reimbursement is not recommended.
- CPT 29877 when billed with 29876 and 29881 is defined as a misuse of column two code with column one code and is not billable together even with a modifier. Additional reimbursement is not recommended for CPT 29877.
- The documentation did not substantiate the billed CPT code 29876. The operative report did not document a major synovectomy, 2 or more compartments. The synovectomy services documented were included in the procedures performed (29881).
- CPT 29881 was reimbursed as the primary procedure code, and based on the Outpatient Hospital and ASC OMFS fee schedule. Additional reimbursement is not recommended.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Reimbursement of code 29870, 29881, 29877 and 29874 is not warranted.

Date of Service: 5/15/2014						
Hospital Outpatient and Ambulatory Surgery						
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Multiple Surgery	Workers' Comp Allowed Amt.	Notes
29881	\$ 3380.00	\$ 1953.37	\$ 2647.48	100%	\$ 1953.37	DISPUTED SERVICE: See Analysis.
29877	\$ 3380.00	\$ 976.69	\$2647.48	N/A	\$0.00	DISPUTED SERVICE: See Analysis
29876	\$ 3380.00	\$ 0.00	\$ 2647.48	N/A	\$0.00	DISPUTED SERVICE: See Analysis
29870	\$3380.00	\$0.00	\$2647.48	N/A	\$0.00	DISPUTED SERVICE: See Analysis

National Correct Coding Initiative information:

File	Column 1	Column 2	Modifier
Hospital APC Version 20.1	29881	29870	Allowed
Hospital APC Version 20.1	29881	29877	Not Allowed

Copy to:

[REDACTED]
[REDACTED]
[REDACTED]

Copy to:

Division of Workers' Compensation Medical Unit
1515 Clay Street, 18th Floor
Oakland, CA 94612

Copy to:

[REDACTED]
[REDACTED]
[REDACTED]