

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 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: Reimbursement of CPT 29888-LT, 29881-LT, 64445-59, 64450-59, and 29876-LT59 performed on 06/30/2015.**
- Provider billed the disputed CPT codes on a UB04, bill type 131 for date of service 6/30/2015.
- Claims Administrator reimbursement rationale: "This bill has been repriced according to your PPO contract"
- A PPO contract was not submitted for this review.
- Based on the provider type, the reimbursement for services is calculated on the Centers for Medicare and Medicaid Services (CMS) Outpatient Prospective Payment System (OPPS). Procedures are assigned APC weights and "Proposed Payment Status Indicators." The surgical HCPCS code 29888, 29876, 29881, 64445 and 64450 have an assigned indicator of "T". The "T" indicator definition is "Significant procedure, multiple procedure reduction applies" and qualifies for separate APC payment.
- The Operative Report documented services performed on 6/30/2015.
- Based on the aforementioned documentation and guidelines, additional reimbursement is indicated.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Recommended reimbursement of disputed codes 29888-LT, 29881-LT, 64445-59, 64450-59 and 29876-LT59

Date of Service: 6/30/2015						
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Multiple Surgery	Workers' Comp Allowed Amt.	Notes
29888	\$2288.00	\$2288.00	\$8607.21	100%	\$8607.21	\$6319.21 Due to Provider
29876	\$2288.00	\$2288.00	\$1464.46	50%	\$1464.46	\$823.54 Overpaid
29881	\$2288.00	\$2288.00	\$1464.46	50%	\$1464.46	\$823.54 Overpaid
64445	\$2288.00	\$957.15	\$457.44	50%	\$457.44	\$499.43 Overpaid
64450	\$2288.00	\$252.88	\$253.72	50%	\$253.72	\$0.84 Due to Provider

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