

**MAXIMUS FEDERAL SERVICES, INC.**

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



---

**INDEPENDENT BILLING REVIEW FINAL DETERMINATION**

June 12, 2015

[Redacted]

|                       |              |                       |            |
|-----------------------|--------------|-----------------------|------------|
| IBR Case Number:      | CB15-0000443 | Date of Injury:       | 01/17/2103 |
| Claim Number:         | [Redacted]   | Application Received: | 03/28/2105 |
| Claims Administrator: | [Redacted]   |                       |            |
| Date Assigned:        | 4/15/2015    |                       |            |
| Provider Name:        | [Redacted]   |                       |            |
| Employee Name:        | [Redacted]   |                       |            |
| Disputed Codes:       | 29876-59     |                       |            |

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,

Paul Manchester, MD, MPH  
Medical Director

cc: [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
- Medicare and Medicaid Services (CMS) Outpatient Prospective Payment System (OPPS)
- Other:

## 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 29876
- Claims Administrator denied code indicating on the Explanation of Review “No separate payment was made because the value of the service is included within the value of another service performed on the same day”
- 29876 - Arthroscopy, knee, surgical; synovectomy, major, 2 or more compartments (eg, medial or lateral)
- According to National Correct Coding Initiative Policy Manual for Medicare Services 1/1/2014: *CPT code 29876 may be reported for a medically reasonable and necessary synovectomy with another arthroscopic knee procedure on the ipsilateral knee if the synovectomy is performed in two compartments on which another arthroscopic procedure is not performed. For example, CPT code 29876 should never be reported for a major synovectomy with CPT code 29880 (knee arthroscopy, medial AND lateral meniscectomy) on the ipsilateral knee since knee arthroscopic procedures other than synovectomy are performed in two of the three knee compartments.*
- Provider’s Operative Report documents synovectomy and chondroplasty of the suprapatellar pouch, medial and lateral compartments. The intercondylar notch required only synovectomy.

- Based on information reviewed, reimbursement for code 29876 is not warranted as documentation from Provider does not support reporting guidelines.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Reimbursement of code 29876 is not recommended.

| Date of Service: 11/20/2014 |                 |              |                |                  |                            |  |
|-----------------------------|-----------------|--------------|----------------|------------------|----------------------------|--|
| Service Code                | Provider Billed | Plan Allowed | Dispute Amount | Multiple Surgery | Workers' Comp Allowed Amt. | Notes  |
| 29876                       | \$5104.24       | \$0.00       | \$1445.93      | N/A              | \$0.00                     | <b>DISPUTED SERVICE:</b> No reimbursement recommended. |

National Correct Coding Initiative information:

| File                      | Column 1 | Column 2 | Modifier |
|---------------------------|----------|----------|----------|
| Hospital APC Version 20.3 | 29880    | 29876    | Allowed  |
|                           |          |          |          |

Copy to:

██████████  
 ██████████  
 ██████████

Copy to:

██  
 ██  
 ██