

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 25, 2015

[Redacted]
[Redacted]
[Redacted]

IBR Case Number:	CB15-0000569	Date of Injury:	08/13/2014
Claim Number:	[Redacted]	Application Received:	04/14/2015
Claims Administrator:	[Redacted]		
Date Assigned:	5/14/2015		
Provider Name:	[Redacted]		
Employee Name:	[Redacted]		
Disputed Codes:	64450-RT51 and 29870-RT51		

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: OVERTURN. MAXIMUS Federal Services has determined that additional reimbursement is warranted. The Claims Administrator’s determination is reversed and the Claim Administrator owes the Provider additional reimbursement of \$195.00 for the review cost and \$835.37 in additional reimbursement for a total of \$.A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of \$835.37 within 45 days of the date on this letter per section 4603.2 (2a) of the California Labor Code. 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]
[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: PPO Discount 10%
- 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:** Provider is dissatisfied with denial of codes 64450-RT51 and 29870-RT51
- Claims Administrator denied code 64450 indicating on the Explanation of Review “NCCI comprehend/compt Edit for surgery codes 60000-69999
- Provider billed code 64450 along with 29881 which was reimbursed. Medicare’s NCCI policy does not mention these two codes not able to be billed together without the option for an override.
- As pair edits exist between codes 64450 and 29881, generally these two codes are not billed together. However, Modifier Indicator column shows ‘1’ which states if an approved modifier is appended to the appropriate CPT code and documentation supports the use of billed code, then the edit may be overridden.
- Modifiers that may be used under appropriate clinical circumstances to bypass an NCCI edit include: Anatomic modifiers: E1-E4, FA, F1-F9, TA, T1-T9, LT, RT, LC, LD, RC, LM, RI; Global surgery modifiers: 24, 25, 57, 58, 78, 79; Other modifiers: 27, 59, 91
- Provider’s documentation detail the procedure code 64450-RT performed and was billed with one of the approved modifiers.
- Based on information reviewed, reimbursement of 64450-RT is warranted.

- Claims Administrator also denied code 29870-RT indicating on the Explanation of Review “NCCI comprehend/componet edit for surgery codes 20000-29999”
- Medicare’s policy does not list these two codes as not to be billed together. And per NCCI edit that exists between billed code 29870-RT and 29881, modifier indicator column shows a ‘1’. Same rules for this pair code as already mentioned above apply. Provider does document code on the Operative Report the procedure was performed in a separate compartment and billed with an approved modifier.
- Based on information reviewed, reimbursement of 29870-RT is warranted.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Reimbursement of codes 64450-RT51 and 29870-RT51

Date of Service: 11/25/2014						
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Multiple Surgery	Workers’ Comp Allowed Amt.	Notes
64450-RT	\$375.00	\$0.00	\$45.00	50%	\$41.99	DISPUTED SERVICE: Allow reimbursement \$41.99
29870-RT	\$4750.00	\$0.00	\$991.87	50%	\$793.38	DISPUTED SERVICE: Allow reimbursement \$793.38

National Correct Coding Initiative information:

File	Column 1	Column 2	Modifier
Hospital APC Version 20.3	29881	29870	Allowed
Hospital APC Version 20.3	29881	64450	Allowed

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