

**MAXIMUS FEDERAL SERVICES, INC.**

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



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**INDEPENDENT BILLING REVIEW FINAL DETERMINATION**

June 30, 2015

[Redacted]  
[Redacted]  
[Redacted]

IBR Case Number:	CB15-0000570	Date of Injury:	06/26/2013
Claim Number:	[Redacted]	Application Received:	04/14/2015
Claims Administrator:	[Redacted]		
Date Assigned:	5/14/2015		
Provider Name:	[Redacted]		
Employee Name:	[Redacted]		
Disputed Codes:	29820-RT22, 29805-RT5159, and 23700 RT5951		

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 \$1785.20 in additional reimbursement for a total of \$1980.20. A detailed explanation of the decision is provided later in this letter.**

The Claim Administrator is required to reimburse the Provider a total of \$1980.20 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:
- 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 29820-RT22, 29805-RT5159, and 23700 RT5951
- Claims Administrator denied code 23700 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”
- CHAP4-CPTcodes 20000-29999\_final10312013.doc; Revision Date: 1/1/2014  
CHAPTER IV SURGERY: MUSCULOSKELETAL SYSTEM CPT CODES 20000-29999 FOR NATIONAL CORRECT CODING INITIATIVE POLICY MANUAL FOR MEDICARE SERVICES: When it is necessary to perform skeletal/joint manipulation under anesthesia to assess range of motion, reduce a fracture or for any other purpose during another procedure in an anatomically related area, the corresponding manipulation code (e.g., CPT codes 22505, **23700**, 27275, 27570, 27860) **is not separately reportable**. Reimbursement of 23700 is not warranted.
- Provider is requesting reimbursement for CPT code 29805-RT-51-59. Provider billed codes 29820, 29822, 29826, 23700, 64450, 99354, 99070 and 99070 on a UB-04 claim form. EORs received does not show CPT 29805 reviewed by Claims Administrator. As it appears CPT 29805 was not billed by Provider. Reimbursement of code 29805 is not warranted.

- Provider also billed code 29820 with modifiers –RT and -22 for increased procedural services.
- As a pair code exists between paid code 29822 and 29820, provider billed column two code with an approved modifier and submitted documentation that supports billed code.
- Documentation does not support an increased procedural service and therefore Provider will not be reimbursed for modifier -22.
- Based on information reviewed, reimbursement of CPT 29820-RT is warranted.

The table below describes the pertinent claim line information.

**DETERMINATION OF ISSUE IN DISPUTE: Reimbursement of code 29820-RT**

<b>Date of Service: 11/7/2014</b>						
<b>Service Code</b>	<b>Provider Billed</b>	<b>Plan Allowed</b>	<b>Dispute Amount</b>	<b>Multiple Surgery</b>	<b>Workers' Comp Allowed Amt.</b>	<b>Notes</b>
29820	\$9875.00	\$0.00	\$1822.66	50%	\$1785.20	<b>DISPUTED SERVICE:</b> Allow reimbursement \$1785.20

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