

INDEPENDENT BILLING REVIEW FINAL DETERMINATION

July 28, 2015

[Redacted]
[Redacted]
[Redacted]

IBR Case Number:	CB15-0000850	Date of Injury:	11/05/2013
Claim Number:	[Redacted]	Application Received:	05/26/2015
Claims Administrator:	[Redacted]		
Assigned Date:	06/26/2015		
Provider Name:	[Redacted]		
Employee Name:	[Redacted]		
Disputed Codes:	29884		

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 \$249.17 in additional reimbursement for a total of \$444.70. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of **\$444.70** 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, M.D., M.P.H.
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

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 seeking remuneration for CPT code 29884, “Arthroscopy, knee, surgical; with lysis of adhesions, with or without manipulation (separate procedure)” performed on 11/11/2014.**
- The Claims Administrator denied the **29884** service with the following rationale: “We cannot review this service without necessary documentation. The service was not identified in the report.”
- The provider submitted an amended operative report for the date of service at issue.
- The provider originally billed CPT codes 29884, described above, 29785, “Arthroscopy, knee, surgical; synovectomy, limited (e.g. plica or shelf resection) (separate procedure)”, and HCPCS code G0289, “Arthroscopy, knee, surgical; for removal of loose body, foreign body, debridement/shaving of articular cartilage (chondroplasty) at the time of other surgical knee arthroscopy in a different compartment of the same knee”.
- The procedure performed on the date of service at issue was ‘Lysis of intraarticular adhesions in the suprapatellar nodules; limited synovectomy of the suprapatellar region and retropatellar region; and chondroplasty of the undersurface of the patella’. All procedures, according to the report, were performed in the patellofemoral compartment of the left knee.
- AMA CPT indicates if a CPT code descriptor includes the term “separate procedure”, the CPT code may not be reported separately with a related procedure. CMS interprets this designation to prohibit the separate reporting of a “separate procedure” when performed with another procedure in an anatomically related region often through the same skin incision, orifice or surgical approach.
- Chapter IV of the National Correct Coding Initiative Policy Manual for Medicare Services states CPT code 29875 should never be reported with another arthroscopic knee procedure on the ipsilateral knee; in this case, it is a Column II code to Column I code 29884.

