MAXIMUS FEDERAL SERVICES, INC.
Independent Bill Review
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Fax: (916) 605-4280

INDEPENDENT BILLING REVIEW FINAL DETERMINATION

July 21, 2015

[redacted]

IBR Case Number:	CB15-0000986	Date of Injury:	06/04/2013
Claim Number:	[redacted]	Application Received:	06/16/2015
Claims Administrator:	[redacted]		
Date(s) of service:	06/27/2014		
Provider Name:	[redacted]		
Employee Name:	[redacted]		
Disputed Codes:	20605-LT, 29840-LT, 29844-LT		

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 $991.87 in additional reimbursement for a total of $1186.87. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of $1186.87 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]

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: NCCI Policy Manual CHAP4-CPTcodes20000-29999_final10312013.doc Revision Date: 1/1/2014

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 20605-LT, 29840-LT, 29844-LT
- Claims Administrator denied codes indicating on the Explanation of Review "The charge exceeds the APC rate for this service."
- Provider billed code 20605, Arthrocentesis, aspiration and/or injection, intermediate joint or bursa, along with reimbursed code 29846, Arthroscopy, wrist, surgical; excision and/or repair of triangular fibrocartilage and/or joint debridement.
- Pursuant CHAPTER IV SURGERY: MUSCULOSKELETAL SYSTEM CPT CODES 20000-29999 FOR NATIONAL CORRECT CODING INITIATIVE POLICY MANUAL FOR MEDICARE SERVICES: H. General Policy Statements: 20. Arthrocentesis procedures (e.g., CPT codes 20600, 20605, 20610) should not be reported separately with an open or arthroscopic joint procedure when performed on the same joint. However, if an arthrocentesis procedure is performed on one joint and an open or

arthroscopic procedure is performed on a different joint, the arthrocentesis procedure may be reported separately.

- Provider's Operative Report submitted does not show a separate joint for the service billed.
- Reimbursement of 20605 is not warranted.
- Provider also billed code 29840, Arthroscopy, wrist, diagnostic, with or without synovial biopsy (separate procedure)
- NCCI Policy - Surgical arthroscopy includes diagnostic arthroscopy which is not separately reportable. If a diagnostic arthroscopy leads to a surgical arthroscopy at the same patient encounter, only the surgical arthroscopy may be reported.
- Reimbursement of 29840 is not warranted.
- §9789.16.5. Surgery - Multiple Surgeries and Endoscopies. Multiple surgeries are separate procedures performed by a single physician or physicians in the same group practice on the same patient at the same operative session or on the same day for which separate payment may be allowed. Multiple surgeries are distinguished from procedures that are components of or incidental to a primary procedure. These intra-operative services, incidental surgeries, or components of more major surgeries are not separately billable.
- 29844 is the final code in dispute.
- 29844, Arthroscopy, wrist, surgical; synovectomy, partial.
- As a pair code exists between reimbursed code 29846 and 29840, modifier indicator column shows '1' which states that if an approved modifier is appended to the column 2 code, and documentation shows support for the billed service, then the edit maybe overridden.
- Provider did append an approved modifier and documentation does support the service performed.
- Based on documentation reviewed, reimbursement of code 29844 is warranted.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Reimbursement of code 29844-LT-51-59

Date of Service: 06/27/2014						
Service Code	**Provider Billed**	**Plan Allowed**	**Dispute Amount**	**Multiple Surgery**	**Workers' Comp Allowed Amt.**	**Notes**
29844-LT-51-59	$4750.00	$0.00	$991.87	50%	$991.87	**DISPUTED SERVICE**: Allow reimbursement $991.87

National Correct Coding Initiative information:

File	**Column 1**	**Column 2**	**Modifier**
Hospital APC Version 20.1	29846	29844	Yes

Copy to:

[redacted]

Copy to:

[redacted]