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**INDEPENDENT BILLING REVIEW FINAL DETERMINATION**

July 27, 2015

[REDACTED]  
[REDACTED]  
[REDACTED]

IBR Case Number:	CB15-0001068	Date of Injury:	10/30/2002
Claim Number:	[REDACTED]	Application Received:	07/01/2015
Claims Administrator:	[REDACTED]		
Date(s) of service:	12/01/2014		
Provider Name:	[REDACTED]		
Employee Name:	[REDACTED]		
Disputed Codes:	89051 and 20610		

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]  
[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 89051 and 20610
- Claims Administrator denied code 89051 indicating on the Explanation of Review “Per CCR 9789.32(a)(1) the item has a status code N, Q1, Q2, or Q3 and is packaged into the APC payment for the emergency room visit, surgical procedure, or Facility Only Service (in which case no additional fee is allowable).”
- In this case, Claims Administrator is correct as CPT code 89051 does have status indicator ‘N’ - Items and Services Packaged into APC Rates. Paid under OPSS; Payment is packaged into payment for other services. Therefore, there is no separate APC payment.
- Reimbursement of 89051 is not warranted.
- Provider billed code 26010 – RT x 2 units
- 20610 - Arthrocentesis, aspiration **and/or** injection, major joint or bursa (eg, shoulder, hip, knee, subacromial bursa); without ultrasound guidance.
- CPT 20610 may be billed as a bilateral procedure with modifier -50 to indicate a bilateral procedure. However, it is inappropriate of the Provider to bill code 20610-RT x 2 units according to CPT guidelines.
- Documentation submitted includes the Provider’s Procedure Notes which indicates the same knee joint aspiration and injection were performed.

- Based on information reviewed, reimbursement of CPT 20610 is not warranted.

The table below describes the pertinent claim line information.

**DETERMINATION OF ISSUE IN DISPUTE:** Reimbursement of codes 89051 & 20610

<b>Date of Service:</b> 12/1/2014						
<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>
89051	\$264.78	\$0.00	\$264.78	N/A	\$0.00	<b>DISPUTED SERVICE:</b> Reimbursement is not recommended.
20610	\$1585.70	\$0.00	\$1585.70	N/A	\$0.00	<b>DISPUTED SERVICE:</b> Reimbursement is not recommended

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