

INDEPENDENT BILLING REVIEW FINAL DETERMINATION

March 31, 2016

██████████
██████████
██████████

IBR Case Number:	CB16-0000375* *Corrected from CB16-0000374	Date of Injury:	11/04/2013
Claim Number:	██████████	Application Received:	03/03/2016
Claims Administrator:	██████████		
Date(s) of service:	08/21/2015		
Provider Name:	████████████████████		
Employee Name:	██████████		
Disputed Codes:	29870-59RT, 29881-RT, 29875-59RT, and 20610-RT		

Dear ██████████

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 \$861.97 in additional reimbursement for a total of \$1,056.97. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of \$1,056.97 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

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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: N/A
- National Correct Coding Initiatives

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 billed codes 29870-59RT, 29881-RT, 29875-59RT, and 20610-RT performed on date of service 08/21/2015.
- Claims Administrator denied codes with indication “The service(s) is for a condition(s) which is not related to the covered work related injury”
- Communication dated July 10, 2015 from Claims Administrator to Provider documents “Procedure/Treatment Certified: Outpatient Arthroscopy/Partial Meniscectomy of the Right Knee”
- § 5307.11: A health care provider or health facility licensed pursuant to Section 1250 of the Health and Safety Code, and a contracting agent, employer, or carrier may contract for reimbursement rates different from those in the fee schedule adopted and revised pursuant to Section 5307.1. When a health care provider or health facility licensed pursuant to Section 1250 of the Health and Safety Code, and a contracting agent, employer, or carrier contract for reimbursement rates different from those in the fee schedule, the medical fee schedule for that health care provider or health facility licensed pursuant to Section 1250 of the Health and Safety Code shall not apply to the contracted reimbursement rates.
- Provider billed codes on a CMS 1500 form with Place of Service 22.

- Provider’s Operative Report documents “Right knee arthroscopic partial medical meniscectomy”
- As CCI Edits do exist:
 - KNEE ARTHROSCOPY/SURGERY
29881/20610 **Misuse of column two code with column one code**
 - DRAIN/INJ JOINT/BURSA W/O US
29881/29870 "CPT ""separate procedure"" definition"
 - KNEE ARTHROSCOPY DX
29881/29875 **More extensive procedure**
KNEE ARTHROSCOPY/SURGERY
- National Correct Coding Initiative Policy Manual for Medicare Services:
 - **Separate Procedure:** Definition: 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.
 - Reimbursement of 29870 is not warranted.
 - **More Extensive Procedure:** The CPT Manual often describes groups of similar codes differing in the complexity of the service. Unless services are performed at separate patient encounters or at separate anatomic sites, the less complex service is included in the more complex service and is not separately reportable.
 - Reimbursement of 29875 is not warranted.
 - **Misuse of Column Two Code with Column One Code:** Three or more HCPCS/CPT codes may be reported on the same date of service. Although the column two code is misused if reported as a service associated with the column one code.
 - Reimbursement of 20610 is not warranted.
- Based on aforementioned guidelines, reimbursement of 29881 is warranted.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Reimbursement of codes 29870-59RT, 29881-RT, 29875-59RT, and 20610-RT

Date of Service: 08/21/2015					
Physician Services					
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Workers’ Comp Allowed Amt.	Notes
29881	\$1,120.72	\$0.00	\$1,120.72	\$861.97	\$861.97 Due to Provider

National Correct Coding Initiative information:

File	Column 1	Column 2	Modifier
Physician Version Number: 21.2	29881	20610	Allowed
Physician Version Number: 21.2	29881	29870	Allowed
Physician Version Number: 21.2	29881	29875	Allowed

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

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