

## INDEPENDENT BILLING REVIEW FINAL DETERMINATION

June 16, 2016

[REDACTED]  
[REDACTED]  
[REDACTED] [REDACTED]  
[REDACTED]

IBR Case Number:	CB16-0000869	Date of Injury:	10/24/2014
Claim Number:	[REDACTED]	Application Received:	05/25/2016
Assignment Date:	06/14/2016		
Claims Administrator:	[REDACTED]		
Date(s) of service:	04/12/2016 – 04/12/2016		
Provider Name:	[REDACTED]		
Employee Name:	[REDACTED]		
Disputed Codes:	29846-RT, 29844-59 RT, and 20605-59 RT		

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 \$879.11 in additional reimbursement for a total of \$1,074.11. A detailed explanation of the decision is provided later in this letter.**

The Claim Administrator is required to reimburse the Provider a total of **\$1,074.11** 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,

MAXIMUS

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 seeking remuneration for 29846-RT, 29844-59RT, and 20605-59 RT, submitted for date of service 04/12/2016.**
- Claims Administrator denied codes indicating “not an appropriate charge for medical provider to submit”
- Opportunity to Dispute Eligibility communicated with the Claims Administrator on 05/26/2016; response not yet received.
- Contractual Agreement not submitted for review.
- CMS 1500, Bill Type, Physician.
  - EORs indicate “not an appropriate charge for medical provider to submit.” To decrease the possibility of future claim rejections with this rationale, Box 33 of the HCFA should reflect the Surgeon performing the surgical service and not group practice. Additionally, the service location NPI, box 32a, should reflect the place of service, in this case, the surgical center, and not the billing Provider’s NPI. The Billing Provider’s Location is not an ASC surgical center. These services may only be performed at ASC locations.

- **§ 9789.12.13 Correct Coding Initiative** (a) The National Correct Coding Initiative Edits (“NCCI”) adopted by the CMS shall apply to payments for medical services under the Physician Fee Schedule. Except where payment ground rules differ from the Medicare ground rules, claims administrators shall apply the NCCI physician coding edits and medically unlikely edits to bills to determine appropriate payment.
- **NCCI Medicare Billing Guidelines, Chapter 4, page 20, paragraph 31** states the following: The existence of the NCCI edit indicates that the two codes generally should not be reported together unless the two corresponding procedures are performed at two separate patient encounters or two separate **anatomic sites**. (Emphasis added)
- Chapter IV Surgery: musculoskeletal system cpt codes 20000-29999 for National Correct Coding Initiative Policy Manual: H. General Policy Statements: 20. Arthrocentesis procedures should not be reported separately with an open or arthroscopic joint procedure when performed on the same joint.
- Submitted Operative Report reflects services performed by Orthopedic Surgeon. Documentation does not reflect a separate joint for the various services billed; services performed on right wrist.
- 3 code pairs found in Physician Version 22.1 (4/1/2016-6/30/2016):

▭ short description for column 1 code

<b>Column 1</b>	<b>Column 2</b>	<b>CCI Edit Description</b>	<b>Modifier Indicator</b>	<b>Effective Date</b>
	▭ short description for column 2 code			
	▭ WRIST ARTHROSCOPY/SURGERY			
<u>29844</u>	<u>20605</u>	Misuse of column two code with column one code	1	1/1/2011
	▭ DRAIN/INJ JOINT/BURSA W/O US			
	▭ WRIST ARTHROSCOPY/SURGERY			
<u>29846</u>	<u>20605</u>	Misuse of column two code with column one code	1	1/1/2011
	▭ DRAIN/INJ JOINT/BURSA W/O US			
<u>29846</u>	<u>29844</u>	More extensive procedure	1	1/1/1996
	▭ WRIST ARTHROSCOPY/SURGERY			

- Medicare Billing Manual, Page I6, paragraph 1: Each edit table contains edits which are pairs of HCPCS/CPT codes that in general should not be reported together. Each edit has a column one and column two HCPCS/CPT code. If a provider reports the two codes of an edit pair, the column two code is denied, and **the column one code is eligible for payment. (Emphasis added)**
- **Based on the aforementioned documentation and guidelines, reimbursement is indicated for 29846 RT and is not indicated for 29844 RT and 20605 RT.**

The table on page 5 describes the pertinent claim line information.

**DETERMINATION OF ISSUE IN DISPUTE: 29846-RT, 29844-59RT, 20605-59 RT**

<b>Date of Service:</b> 04/12/2016						
Provider Services						
<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>
29846-RT	\$1,541.46	\$0.00	\$1,541.46	N/A	\$879.11	<b>OMFS Refer to Analysis</b>
29844-RT	\$1,471.56	\$0.00	\$1,471.56	N/A	\$0.00	<b>Refer to Analysis</b>
20605-RT	\$108.66	\$0.00	\$108.66	N/A	\$0.00	<b>Refer to Analysis</b>

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