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,

[Redacted]

Chief Coding Reviewer

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: CPT Assistant, may 2012, Volume 20, Issue 5

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**: Reimbursement less than expected for CPT code 29824 and denial of service reported with CPT code 86999.
- There are no suspect code sets based on the NCCI edits.
- Based on review of the operative report CPT code 29824 is substantiated.
- The operative report does substantiate the injection of platelet-rich plasma. However based on CPT Assistant, May 2012, Volume 22, Issue 5, code 86999 is not to be assigned for this service. Rather the Provider should have submitted code 0232T for the service. Therefore the denial of CPT code 86999 is correct.
- Per contract, 8% discount to be applied to allowed amount.
- Reimbursement of CPT code 29824 calculated as follows:
  Adjusted CF $80.58 x APC RW 29.6106 x WC Mult. .82 * .92 * .5 = $900.01
- Reimbursement for CPT code 29824 made correctly by the Claim Administrator.

The table below describes the pertinent claim line information.

**DETERMINATION OF ISSUE IN DISPUTE**: Reimbursement was made correctly for CPT code 29824 and denial of CPT code 86999 correct as proper code not submitted.

<table>
<thead>
<tr>
<th>Date of Service: 5-14-2014</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Service Code</strong></td>
</tr>
<tr>
<td>-----------------</td>
</tr>
<tr>
<td>29824</td>
</tr>
<tr>
<td>86999</td>
</tr>
</tbody>
</table>

Copy to:

[Redacted]

Copy to:

[Redacted]