

**INDEPENDENT BILLING REVIEW FINAL DETERMINATION**

December 15, 2014

[Redacted]  
[Redacted]  
[Redacted]

<b>IBR Case Number:</b>	CB13-0000612	<b>Date of Injury:</b>	09/21/2012
<b>Claim Number:</b>	[Redacted]	<b>Application Received:</b>	10/15/2013
<b>Claims Administrator:</b>	[Redacted]	<b>Assignment Date:</b>	10/06/2014
<b>Provider Name:</b>	[Redacted]		
<b>Employee Name:</b>	[Redacted]		
<b>Disputed Codes:</b>	29826, 29824 and 29822		

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 \$335.00 for the review cost and \$936.75 in additional reimbursement for a total of \$1271.75. A detailed explanation of the decision is provided later in this letter.**

The Claim Administrator is required to reimburse the Provider a total of \$1271.75 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,

[Redacted]  
[Redacted]

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: none
- National Correct Coding Initiatives, Hospital APC versions 18.3 and 19.0
- 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:** Denial of CPT codes 29826, 29822, and 29824.
- The Provider did not append modifiers to any of the CPT codes listed above.
- Based on the NCCI edits 29826 and 29822 would require use of modifiers to indicate that the services were separate and distinct if they were.
- The operative report does not substantiate use of CPT code 29822. There was no documentation of debridement in the operative report. Therefore code 29822 should not have been assigned and was appropriately denied.
- Code 29826 is suspect when submitted with CPT code 23412 (noted as paid at \$2998.59 on the EOR). The Provider did not append a modifier indicating a separate and distinct service and the operative report does not indicate a separate and distinct service from the open rotator cuff repair (which was billed with CPT code 23412 and reimbursed). Therefore code 29826 was also appropriately denied.
- There are no NCCI edit conflicts with CPT code 29824. The operative report indicates that the distal 1 cm of the clavicle was resected.
- Reimbursement for CPT code 29824 is calculated as follows:  
Adjusted CF \$77.04 x APC RW 29.6568 x WC Multi. .82 \* .5 = \$936.75

The table below describes the pertinent claim line information.

**DETERMINATION OF ISSUE IN DISPUTE: Reimbursement of \$936.75 for CPT code 29824. Deny reimbursement of 29826 and 29822.**

Date of Service: 1/9/2013						
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Multi Surg.	Workers' Comp Allowed Amt.	Notes
29826	\$4000.00	\$0	\$10581.82		\$0	<b>DISPUTED SERVICE:</b> Denial of CPT code 29826 appropriate.
29822	\$4000.00	\$0	Included in above		\$0	<b>DISPUTED SERVICE:</b> Denial of CPT code 29822 appropriate.
29824	\$16000.00	\$0	Included in above	50%	\$936.75	<b>DISPUTED SERVICE:</b> Allow reimbursement of \$936.75 for CPT code 29824.
23412	\$4500.00	\$2998.59	Not in dispute	100%	Not in Dispute	<b>Service not in dispute</b>

National Correct Coding Initiative information:

File	Column 1	Column 2	Modifier
Hospital APC Version 19.0	29824	29822	Allowed
Hospital APC Version 19.0	23412	29826	Allowed

Copy to:

[REDACTED]  
[REDACTED]  
[REDACTED]

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