

MAXIMUS FEDERAL SERVICES, INC.

Independent Bill Review
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INDEPENDENT BILLING REVIEW FINAL DETERMINATION

November 5, 2014

[Redacted]
[Redacted]
[Redacted]

IBR Case Number:	CB13-0000654	Date of Injury:	12/05/2011
Claim Number:	[Redacted]	Application Received:	10/28/2013
Claims Administrator:	[Redacted]		
Provider Name:	[Redacted]		
Employee Name:	[Redacted]		
Disputed Codes:	29822-LT		

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.

IBR Case Assigned: 06/9/2014

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 \$1090.13 in additional reimbursement for a total of \$1425.13. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of \$1425.13 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]
Chief Coding Reviewer

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
- Other: OMFS, AMA CPT 1997 & 2013

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 zero reimbursement of CPT code 29822-LT
- Pursuant to Labor Code section 4603.5 and 5307.1, the Administrative Director of the Division of Workers' Compensation has adopted the Official Medical Fee Schedule as the Basis for billing and payment of medical services provided injured employees under the Workers' Compensation Laws of the State of California, utilizing the American Medical Association 1997 Current Procedural Terminology codes and definitions.
- Provider billed CPT codes 29826(Arthroscopy, shoulder, surgical; decompression of subacromial space with partial acromioplasty, with coracoacromial ligament (i.e., arch) release, when performed (list separately in addition to code for primary procedure); 29822(Arthroscopy, shoulder, surgical; debridement, limited) and 29909(unlisted procedure code)
- Claims Administrator reimbursed a partial payment to include code 29826 and changed code 29909 to 29806(Arthroscopy, shoulder surgical; capsulorrhaphy). Claims Administrator denied code 29822 and indicated on the Explanation of Review "Charge for a 'separate procedure' that does not meet the criteria for payment. See the OMFS General Instruction for Separate Procedure rule."
- Pursuant California Code of Regulations, Title 8, Section 9789.11.9789.12.4, "An unlisted procedure shall be billed using the appropriate unlisted procedure code from the CPT. The procedure shall be billed by report (report not separately reimbursable), justifying that the service was reasonable and necessary to cure or relieve from the effects of the industrial injury or illness. Pertinent information should include an adequate definition or description of the nature, extent, and need for the procedure, and the time, effort and equipment necessary to provide the service."
- American Medical Association CPT 1997 states "Separate Procedure: Some of the listed procedures are commonly carried out as an integral part of a total service, and as such do not

warrant separate identification... Thus, when a procedure that is ordinarily a component of a larger procedure is performed alone for a specific purpose, it may be considered to be a separate procedure.”

- Based on the OMFS 1997 Coding Guideline stipulates that for CPT 29806 and 29822, these codes were not bundled until 01/01/1998. Therefore, reimbursement for CPT code 29822 is warranted.

DETERMINATION OF ISSUE IN DISPUTE: Reimbursement of code 29822 is warranted in the amount listed below.

The table below describes the pertinent claim line information.

Date of Service: 05/7/2013						
Physician Services						
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Assist Surgeon Multiple Surgery	Workers' Comp Allowed Amt.	Notes
29822	\$2328.00	\$0.00	\$2328.00	N/A	\$1090.13	DISPUTED SERVICE: Allow reimbursement of \$1090.13

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