

MAXIMUS FEDERAL SERVICES, INC.

Independent Bill Review
P.O. Box 138006
Sacramento, CA 95813-8006
Fax: (916) 605-4280



INDEPENDENT BILLING REVIEW FINAL DETERMINATION

November 5, 2014

[Redacted]
[Redacted]
[Redacted]
[Redacted]

| | | | |
|------------------------------|----------------------|------------------------------|------------|
| IBR Case Number: | CB13-0000895 | Date of Injury: | 04/20/1999 |
| Claim Number: | [Redacted] | Application Received: | 12/18/2013 |
| Claims Administrator: | [Redacted] | | |
| Provider Name: | [Redacted] | | |
| Employee Name: | [Redacted] | | |
| Disputed Codes: | 29826-80, & 23700-80 | | |

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: 06/09/2014

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 \$296.51 in additional reimbursement for a total of \$631.51. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of \$631.51 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 General Instructions, 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 codes 29826-80 & 23700-80
- 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.
- Operative Report documents procedures done on the right shoulder: manipulation under anesthesia; arthroscopic glenohumeral synovectomy and debridement, extensive; subacromial bursectomy and decompression with revision anterior acromionectomy; partial excision of lateral clavicle (modified Mumford procedure).
- 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); 29823 Arthroscopy, shoulder, surgical; debridement, extensive; 23700 Manipulation under anesthesia, shoulder joint, including application of fixation apparatus (dislocation excluded)
- Claims Administrator denied code 29826 indicating on the Explanation of Review "No separate payment was made because the value of the service is included within the value of another service performed on the same day." 29826 is a "List Separately" code: Pursuant OMFS Guidelines for surgery; "All add-on codes found in CPT are exempt from the multiple procedure concept, rule number 7, and are reimbursed at 100% of their value. Add-on codes in CPT can be readily identified by specific descriptor nomenclature which includes phrases such as "each additional" or "(list separately in addition to primary procedure)", therefore, CPT 29826-80

should be paid at 100% Official Medical Fee Schedule. Assistant Surgeon is reimbursed at 20% of the listed value.

- 23700-80 was also denied as “No separate payment was made because the value of the service is included within the value of another service performed on the same day.” Per coding guidelines, procedure codes 23700 and 29823 generally cannot be reported together except under special circumstances. Code 23700-80 is bundled in CPT code 29823-80 which was reimbursed at 100% OMFS and therefore Claims Administrator was correct to deny code 23700-80.

DETERMINATION OF ISSUE IN DISPUTE: Based on documentation received, reimbursement of code 29826-80 is warranted in the amount listed below.

The table below describes the pertinent claim line information.

| Date of Service: 3/14/2013 | | | | | | |
|-----------------------------------|------------------------|---------------------|-----------------------|--|-----------------------------------|--|
| Physician Services | | | | | | |
| Service Code | Provider Billed | Plan Allowed | Dispute Amount | Assist Surgeon Multiple Surgery | Workers' Comp Allowed Amt. | Notes |
| 29826-80 | \$296.51 | \$0.00 | \$296.51 | N/A | \$296.51 | DISPUTED SERVICE: Allow reimbursement of \$296.51 |
| 23700-80 | \$49.42 | \$0.00 | \$49.42 | N/A | \$0.00 | DISPUTED SERVICE: No reimbursement recommended |

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