

INDEPENDENT BILLING REVIEW FINAL DETERMINATION

December 11, 2014

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

IBR Case Number:	CB14-0001100	Date of Injury:	09/03/2013
Claim Number:	[Redacted]	Application Received:	08/07/2014
Claims Administrator:	[Redacted]	Assignment Date:	09/18/2014
Provider Name:	[Redacted]		
Employee Name:	[Redacted]		
Disputed Codes:	29823-59		

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 \$250.00 for the review cost and \$498.78 in additional reimbursement for a total of \$748.78. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of \$748.78 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]
Medical Director

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: PPO Discount of 5%
- National Correct Coding Initiatives
- Other: OMFS Physician Fee Schedule

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 denial of CPT code 29823-59
- Claims Administrator denied CPT 29823-59 indicating on the Explanation of Benefits “Included in 29824 per Medicare CCI Edits. Mod 59 not supported since procedures were rendered on the same anatomical location and session.”
- Based on NCCI Edits found on CPT 29823, generally this code is not reported with 29824. However, Modifier Indicator ‘1’ does state that a modifier -59 is allowed as long as documentation supports the use of the modifier -59.
- 29823 - Arthroscopy, shoulder, surgical; debridement, extensive; 29824 - Arthroscopy, shoulder, surgical; distal claviclectomy including distal articular surface (Mumford procedure)
- Based on review of the operative report, the procedure was performed on the shoulder for a rotator cuff repair. Documentation stated by Provider “The long head of the biceps tendon had ruptured and there was a small stump of long head of biceps tendon remaining and this was debrided from the superior rim of the glenoid.” Provider clearly documents distal clavicle excision in report as well “large osteophytic projections coming from the joint and 10 mm of the distal clavicle was excised/resected using a motorized bur entering from the exterior mediolateral portal while viewing from the posterior portal.” 29823 was billed for extensive debridement of rotator cuff tendons, labrum and long head

of the biceps. 29824 was billed for distal clavicle excision. These procedures would not be in the same shoulder region and would consider this billed appropriately.

- Based on documentation reviewed, reimbursement of CPT 29823 is warranted. Provider states a PPO Discount of 5% is to be applied.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Based on information reviewed, reimbursement of CPT code 29823-59 is recommended.

Date of Service: 3/18/2014							
Physician Services							
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Assist Surgeon	Multiple Surgery	Workers' Comp Allowed Amt.	Notes
29823-59	\$1050.05	\$0.00	\$1050.05	N/A	50%	\$498.78	DISPUTED SERVICE: Allow reimbursement \$498.78

National Correct Coding Initiative information:

File	Column 1	Column 2	Modifier
Physician Version Number:	29824	29823	Allowed

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