

INDEPENDENT BILLING REVIEW FINAL DETERMINATION

December 16, 2014

[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]

IBR Case Number:	CB14-0000960	Date of Injury:	02/05/2013
Claim Number:	[REDACTED]	Application Received:	07/02/2014
Claims Administrator:	[REDACTED]	Assignment Date:	09/08/2014
Provider Name:	[REDACTED]		
Employee Name:	[REDACTED]		
Disputed Codes:	29822-59, 29826-59		

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 \$452.35 in additional reimbursement for a total of \$702.35. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of \$702.35 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: PPO Discount 6%
- 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 codes 29822-59 and 29826-59
- Based on the NCCI edits, generally code 29824 and 29822 are generally not reported together either. However, Modifier Indicator column shows '1', there may be occasions where both codes are payable. Provider billed 29822-59, which is an appropriate override modifier for the NCCI edit.
- Based on review of the operative report, Provider documents 29822-59, Arthroscopy, shoulder, surgical; debridement, limited, as a distinct procedure. Therefore, reimbursement for CPT 29822-59 is warranted.
- CPT 29826-59 was also denied after having been approved by Claims Administrator's Utilization Review as documented in the Certification Recommendation letter received. CPTs approved in the letter from the Utilization Review include: 29826, 29827, 29807, 23430 and 29424. Claims Administrator approved 29826 prior to the procedure and then denied it as bundled with 23412 which was reimbursed. Since CPT 23412 was reimbursed, no reimbursement for 29826 is recommended.
- PPO Contract reviewed shows a 6% discount is to be applied to the reimbursement.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Based on information reviewed, reimbursement of code 29822-59 is warranted.

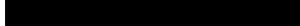
Date of Service: 1/23/2014							
Physician Services							
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Assist Surgeon	Multiple Surgery	Workers' Comp Allowed Amt.	Notes
29822-59	\$1742.91	\$0.00	\$1742.91	N/A	50%	\$481.22	DISPUTED SERVICE: Allow reimbursement \$452.35 per PPO Contract
29826-59	\$2030.49	\$0.00	\$2030.49	N/A	50%	\$0.00	DISPUTED SERVICE: No reimbursement recommended.

National Correct Coding Initiative information:

File	Column 1	Column 2	Modifier
Physician Version Number: 20.0 1/1/2014-3/31/2014	23412	29826	Allow Modifier
Physician Version Number: 20.0 1/1/2014-3/31/2014	29824	29822	Allow Modifier

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