

INDEPENDENT BILLING REVIEW FINAL DETERMINATION

April 20, 2015

[REDACTED]
[REDACTED]
[REDACTED]

IBR Case Number:	CB14-0001513	Date of Injury:	05/12/2008
Claim Numbers:	[REDACTED]	Application Received:	10/09/2014
Claims Administrator:	[REDACTED]	Assignment Date:	02/16/2015
Provider Name:	[REDACTED]		
Employee Names:	[REDACTED]		
Disputed Codes:	29085, 23105-59, 29823-59, 29999-59, 23130-59, and 23125-59		

[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: UPHOLD. MAXIMUS Federal Services has determined that no additional reimbursement is warranted. The Claims Administrator’s determination is upheld and the Claim Administrator does not owe the Provider additional reimbursement. A detailed explanation of the decision is provided later in this letter.

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,

Paul Manchester, M.D., M.P.H.
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

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 seeking remuneration for 29085, 23105-59, 29823-59, 29999-59, 23130-59, and 23125-59 ASC services performed on 12/14/2013.**
- **UB-04, Bill Type 831, DOS 12/14/2013 reflect the following “amended claim 07/21/2014” codes:**
 - **29805 Arthroscopy Shoulder**
 - **23105 -59 Glenohumeral Joint** (23106 Incision of Collar Bone Reflected on EOR)
 - **29823 -59 Arthroscopy Shoulder Debridement Extensive** (29807 Arthroscopy Repair of SLAP Reflected on EOR)
 - **29999 -59 Bursectomy**
 - **23130 -59 Acromioplasty**
 - **23125 -59 Claviclectomy Total** (23120 Partial Reflected on EOR)
- **Original UB-04** not available for IBR review.
- **EOR 9/8/2014** (Post Date) reflects 29807 (29823) Arthroscopy Shoulder, 23130 Partial Removal of Shoulder Bone, & 23120 (23125) Partial Remover of Collar Bone as reimbursed per OMFS and MPPR.
- Claims Administrator denied 29805, 23106 (23105) & 29999 with the following rational: “Modifier -59 is not appropriate for services billed. Documentation does not support criteria required by NCCI edit/part of Comprehensive Code.
- Modifier -59 Code Description: “Used to support a different session, a different procedure or surgery, a different site or organ system, a separate incision or excision, a

separate lesion, or a separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same individual.” (CPT Assist)

- Operative report 12/14/2014 indicates: “A posterior portal was utilized for introduction of the scope to superior for evacuation purposes and third portal to establish inferiorly. The portal was switched over as it was felt necessary. Lateral portal was utilized for lateral entry if felt necessary.”
- Operative note does not indicate which procedures were utilized with the aforementioned portals. As such, the criteria for Modifier -59 has not been met.
- UB-04 reflects CPT 29999-59: Unlisted Procedure e as “Bursectomy.”
- 2013 CPT reflects add-on code 29826 is utilized for Bursectomy procedure (29999-59) UB-04 does not reflect the correct code.
- UB04 Reflects CPT 23105-59, EOR Reflects CPT 23106. CPT 23105 is a column one code and is paired code to billed procedure 29805 and has been paired since 2010. UB-04 submitted for IBR does not reflect modifier -59 on column 2 code 29805.
- CPT 23125 Total Claviclectomy reflected on UB-04.
- Operative Note and EOR reflect CPT 23120 Partial Claviclectomy.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: 29085, 23105-59, 29823-59, 29999-59, 23130-59, and 23125-59

Date of Service: 12/14/2014							
Ambulatory Services							
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Assist Surgeon	Units	Workers' Comp Allowed Amt.	Notes
29805	\$3,565.00	\$0.00	\$3,565.00	N/A	1	\$0.00	Refer to Analysis
23105-59 (23106)	\$3,461.30	\$0.00	\$3,461.30	N/A	1	\$0.00	Refer to Analysis
29823-59 (29807)	\$3,649.00	\$3,589.45	\$69.23	N/A	1	\$3,589.49	Refer to Analysis
29999-59	\$3,259.55	\$0.00	\$3,249.55	N/A	1	\$0.00	Refer to Analysis
23130-59	\$5000.00	\$1589.99	\$3410.01	N/A	1	\$1589.99	Refer to Analysis
23125-59 (21320)	\$3461.30	\$2133.91	\$1327.39	N/A	1	\$2133.91	Refer to Analysis

Copy to:

[REDACTED]
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[REDACTED]

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