

MAXIMUS FEDERAL SERVICES, INC.

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



INDEPENDENT BILLING REVIEW FINAL DETERMINATION

January 13, 2015

[Redacted]
[Redacted]
[Redacted]

IBR Case Number:	CB14-0001598	Date of Injury:	12/22/2013
Claim Number:	[Redacted]	Application Received:	10/23/2014
Claims Administrator:	[Redacted]		
Date(s) of service:	[Redacted]		
Provider Name:	[Redacted]		
Employee Name:	[Redacted]		
Disputed Codes:	29823-59 and 29999		

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 \$3145.37 in additional reimbursement for a total of 3395.37. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of \$3395.37 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:
- National Correct Coding Initiatives
- Medicare and Medicaid Services (CMS) Outpatient Prospective Payment System (OPPS)

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 code 29823 and the reimbursement of code 29999.
- Claims administrator denied code 29823 indicating on the Explanation of Review “Service/item included in the value of other services per CCI edits. Related service could be on separate bill.” Claims administrator reimbursed \$1175.80 for code 29999 indicating “Priced according to state regulations out-patient facility schedule.”
- Based on the NCCI edits, generally codes 29824 and 29823 are not reported together. However, Modifier Indicator column shows ‘1’ which states that if an approved modifier is appended to the appropriate CPT code, and documentation is submitted to support the code, then the edit may be overridden. 29823 - Arthroscopy, shoulder, surgical; debridement, extensive
- Provider appended a -59 to 29823 and included documentation in the Operative Report describing the debrided portion of the procedure.
- Based on review of the operative report and the appropriate billing of code 29823-59, reimbursement is warranted of code 29823. Provider reimbursed code 29824 at 100% as the main procedure. CPT 29823 has a higher weight and should be the primary

procedure. Therefore, amount already reimbursed for 29824 will be applied per the multiple surgery rule reduction.

- Provider also states code 29999 was not reimbursed properly per fee schedule. Claims administrator reimbursed according to out-patient facility schedule. Provider wanted reimbursement of code 29999 paid according to CPT 23405. Provider does document biceps tenotomy was performed, however, was not submitted as one of the billed codes. Therefore, additional reimbursement of code 29999 compared as 23405 is not warranted.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Reimbursement of code 29823 is warranted and code 29999 is not warranted.

Date of Service: 07/23/2014						
Surgical Services						
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Multiple Surgery	Workers' Comp Allowed Amt.	Notes
29823	\$7000.00	\$0.00	\$4321.17	100%	\$4321.17 - 1175.80 =	DISPUTED SERVICE: Allow reimbursement \$3145.37
29999	\$6372.38	\$1175.80	\$108.66	50%	\$0.00	DISPUTED SERVICE: No reimbursement recommended.

National Correct Coding Initiative information:

File	Column 1	Column 2	Modifier
Hospital APC Version 20.2 07/01/2014-09/30/2014	29824	29823	Allow Modifier

Copy to:

York

[REDACTED]
[REDACTED]
[REDACTED]

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