

INDEPENDENT BILLING REVIEW FINAL DETERMINATION

April 26, 2015

[REDACTED]
[REDACTED]
[REDACTED]

IBR Case Number:	CB15-0000131	Date of Injury:	04/02/2014
Claim Number:	[REDACTED]	Application Received:	01/30/2015
Claims Administrator:	[REDACTED]	Assignment Date:	02/25/2014
Provider Name:	[REDACTED]		
Employee Name:	[REDACTED]		
Disputed Codes:	29826-59, L3960-LT		

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: 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
- Medicare Manual Modifier -59, Chapter 1
- OMFS

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 29826-59-LT Arthroscopy, shoulder, surgical and L3960-LT Shoulder Elbow Wrist Orthosis for date of service 09/10/2014.**
- Claims Administrator denied reimbursement for 29826-59-LT services with the following rationale: “guidelines for multiple or bi-lateral surgical services within the value of another service on the same day is not separately reimbursable.”
- CMS 1500 and Operative Report dated 09/10/2014 indicates an arthroscopic procedure was performed on the left shoulder, in addition to 29826-59-LT.
- **Modifier -59** Code Description: Distinct Procedural Service.
- Pursuant Title 8 CCR Physician Fee Schedule 1/1/2014, § 9789.12.13 Correct Coding Initiative: (a) The National Correct Coding Initiative Edits (“NCCI”) adopted by the CMS shall apply to payments for medical services under the Physician Fee Schedule. Except where payment ground rules differ from the Medicare ground rules, claims administrators shall apply the NCCI physician coding edits and medically unlikely edits to bills to determine appropriate payment. Claims Administrators shall utilize the National Correct Coding Initiative Coding Policy Manual for Medicare Services. If a billing is reduced or denied reimbursement because of application of the NCCI, the claims administrator must notify the physician or qualified non-physician practitioner of the basis for the denial, including the fact that the determination was made in accordance with the NCCI.

- Medicare Billing Manual Modifier – 59, Chapter 1, Page 26, states the following:
“Arthroscopic treatment of a shoulder injury in adjoining areas of the ipsilateral shoulder constitutes treatment of a single anatomic site.”
- **DME L3960-LT** denied by the Claims Administrator with the following rational:
 “Documentation on the CMS1500 or UB04 is not supported by the information in the medical record.”
- Four Page Operative Report Dated 09/10/2014 reviewed for DME L3960-LT. Provider states in letter to CA DME provided to Injured Worker in “recovery room.” Page 3, last paragraph, line 1, of Operative Report states the following: “The patient was awakened from anesthesia and taken to the recovery room in stable condition.” Report does not indicate DME dispensed to Injured Worker
- Additional documentation, i.e., Discharge and/or Recover Room Report not submitted for IBR.
- Documentation provided does not support DME L3960.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Based on the aforementioned documentation and guidelines, reimbursement is not supported for 29826-59-LT & L3960-LT.

Date of Service: 09/10/2014							
Med-Legal Services							
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Assist Surgeon	Units	Workers' Comp Allowed Amt.	Notes
29826-59-LT	\$3,640.00	\$0.00	\$3,640.00	N/A	1	\$0.00	Refer to Analysis
L3960-LT	\$2,302.00	\$0.00	\$2,302.00	NA	1	\$0.00	Refer to Analysis

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