

INDEPENDENT BILLING REVIEW FINAL DETERMINATION

September 8, 2015

[REDACTED]
[REDACTED]
[REDACTED]

IBR Case Number:	CB15-0001270	Date of Injury:	08/31/2011
Claim Number:	[REDACTED]	Application Received:	08/05/2015
Claims Administrator:	[REDACTED]		
Date(s) of service:	01/27/2015		
Provider Name:	[REDACTED]		
Employee Name:	[REDACTED]		
Disputed Codes:	23412-RT, 29120-RT, 29822-59-RT, and 29826-RT		

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, MD, MPH
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: 10% PPO Discount
- 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 reimbursement of codes 23412-RT, 29120-RT, 29822-59-RT, and 29826-RT
- UB-04 submitted by Provider shows billed codes 23412, 23120, 29822 and 29826. Each 1 unit and all with modifier –RT.
- Provider billed code 23412, Repair of ruptured musculotendinous cuff (eg, rotator cuff) open; chronic, along with 29822, Arthroscopy, shoulder, surgical; debridement, limited.
- CHAPTER IV SURGERY: MUSCULOSKELETAL SYSTEM CPT CODES 20000-29999 FOR NATIONAL CORRECT CODING INITIATIVE POLICY MANUAL FOR MEDICARE SERVICES: (E) Arthroscopy: (3) If an arthroscopic procedure is converted to an open procedure, only the open procedure may be reported. Neither a surgical arthroscopy nor a diagnostic arthroscopy code should be reported with the open procedure code when a surgical arthroscopic procedure is converted to an open procedure.
- Reimbursement of 29822 is not warranted.
- Provider also billed code 29826 which has a status indicator of ‘N’ - Items and Services Packaged into APC Rates. Paid under OPPS; Payment is packaged into payment for other services. Therefore, there is no separate APC payment.
- Reimbursement of 29826 is not warranted.

- Partial PPO contract received shows the Lesser Of “75% of eligible billed charges or 90% of the amount payable under guidelines established under any State law or regulation pertaining to health care services rendered for occupationally ill/injured workers”
- Order of the Acting Administrative Director of the Division of Workers’ Compensation (OMFS Update for Hospital Outpatient and Ambulatory Surgical Center (ASC) Services Effective December 1, 2014): For services rendered on or after December 1, 2014, section 9789.30, subsections (a) adjusted conversion factor, (e) APC payment rate, (f) APC relative weight, (j) Facility Only Services, (q) labor-related share, (r) market basket inflation factor, and (z) wage index, are adjusted to conform to the Medicare hospital outpatient prospective payment system (HOPPS) final rule of December 10, 2013.
- Based on calculations per HOPPS guidelines, additional reimbursement is not warranted.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Reimbursement of codes 23412-RT, 29120-RT, 29822-59-RT, and 29826-RT

Date of Service: 01/27/2015						
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Multiple Surgery	Workers’ Comp Allowed Amt.	Notes
23412-RT, 29120-RT, 29822-59-RT, and 29826-RT	\$66,620.05	\$6480.26	\$2816.47	Yes	\$6339.42	DISPUTED SERVICE: No further reimbursement is recommended.

Copy to:

██████████
 ██████████
 ████████████████████

Copy to:

██
 ████████████████████████████████████
 ████████████████████