

**MAXIMUS FEDERAL SERVICES, INC.**

Independent Bill Review  
P.O. Box 138006  
Sacramento, CA 95813-8006



Fax: (916) 605-4280

**INDEPENDENT BILLING REVIEW FINAL DETERMINATION**

September 14, 2015



IBR Case Number:	CB15-0001352	Date of Injury:	11/27/2013
Claim Number:	[REDACTED]	Application Received:	08/17/2015
Claims Administrator:	[REDACTED]		
Assigned Date:	9/3/2015		
Provider Name:	[REDACTED]		
Employee Name:	[REDACTED]		
Disputed Codes:	29822-59, 23440, 29822-AS, and 23440-AS		

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]

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**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
- National Correct Coding Initiatives
- Other: OMFS Physician's 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:** The denial of CPT 23440-59-LT, 23440 AS-59-LT, 29822-59-LT and 29822-AS-59-LT for date of service 9/17/2014. Provider billed and is disputing the denial for both the surgeon and assistant surgeon.
- The disputed codes were denied with the following rationale: No separate payment was made because the value of the service is included in the value of another service performed on the same day.
- The medical record did not substantiate the billed code 23440. The biceps tendon release was performed arthroscopically not as an open procedure.
- The arthroscopic bicep tendon release was performed at the same time as the arthroscopic debridement (29822); therefore, only the debridement should be reported. Reimbursement is not recommended for CPT 23440.
- The Provider was reimbursed for CPT 23412-LT and 23120-LT
- Per NCCI edits CPT 23120 is the more extensive procedure and includes 29822.

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- **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.
- CMS considers the shoulder joint to be a single anatomic structure. An NCCI procedure to procedure edit code pair consisting of two codes describing two shoulder joint procedures should never be bypassed with an NCCI-associated modifier when performed on the ipsilateral shoulder joint. This type of edit may be bypassed only if the two procedures are performed on contralateral joints.
- Reimbursement is not recommended for CPT 29822.

The table below describes the pertinent claim line information.

**DETERMINATION OF ISSUE IN DISPUTE:** Reimbursement of code 23440, 23440-AS, 29822 and 29822-AS.

<b>Date of Service 9/17/2014</b>							
<b>Physician Services</b>							
<b>Service Code</b>	<b>Provider Billed</b>	<b>Plan Allowed</b>	<b>Dispute Amount</b>	<b>Assist Surgeon</b>	<b>Multiple Surgery</b>	<b>Workers' Comp Allowed Amt.</b>	<b>Notes</b>
23440-59-LT	\$ 2400.00	\$ 0.00	\$ 2400.00	N/A	N/A	\$0.00	<b>DISPUTED SERVICE:</b> See Analysis.
23440-AS-59-LT	\$720.00	\$0.00	\$720.00	Allowed	N/A	\$0.00	<b>DISPUTED SERVICE:</b> See Analysis.
29822-59-LT	\$3900.00	\$0.00	\$3900.00	N/A	N/A	\$0.00	<b>DISPUTED SERVICE:</b> See Analysis.
29822-AS-59-LT	\$1170.00	\$0.00	\$1170.00	Allowed	N/A	\$0.00	<b>DISPUTED SERVICE:</b> See Analysis.

National Correct Coding Initiative information:

<b>File</b>	<b>Column 1</b>	<b>Column 2</b>	<b>Modifier</b>
Provider Version 20.2	23120	29822	Allowed

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