

INDEPENDENT BILLING REVIEW FINAL DETERMINATION

June 24, 2015

[Redacted]
[Redacted]
[Redacted]

IBR Case Number:	CB15-0000351	Date of Injury:	02/14/2014
Claim Number:	[Redacted]	Application Received:	03/12/2015
Assignment Date:	05/07/2015		
Claims Administrator:	[Redacted]		
Date(s) of service:	08/29/2014 – 08/29/2014		
Provider Name:	[Redacted]		
Employee Name:	[Redacted]		
Disputed Codes:	29824, 23130, 29821, 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 \$195.00 for the review cost and \$1953.38 in additional reimbursement for a total of \$2,148.38. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of **\$2,148.38** 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,

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
- NCCI Policy Manual for Medicare Services, Chapter 4
- 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 29824, Distal Claviclectomy, 23130 Acromioplasty, 29821 Arthroscopy, Shoulder, & 29999 Bursectomy performed in Ambulatory Setting on 08/29/2014.**
- Claims Administrator denied reimbursement for 29821 services with the following rational: “value of this service included in the value of another service.”
- CPT 29824, 23130 & 29999 reimbursement rational based on “Fee Schedule Allowance.”
- CMS 1500 indicates Physician Services.
- CPT 29821 is included in 23130 and 29824 and there is no additional value applied.
- For Services After April 1, 2014, 42 C.F.R. § 419.44 (a) Multiple surgical procedures. When more than one surgical procedure for which payment is made under the hospital outpatient prospective payment system is performed during a single surgical encounter, the Medicare program payment amount and the beneficiary copayment amount are based on --(1) The full amounts for the procedure with the highest APC payment rate; and (2) One-half of the full program and the beneficiary payment amounts for all other covered procedures.
- CPT 29824 and 29999 are status indicator “T” codes and MPPR applies.
- Contractual Agreement not available for IBR.
- **Based on the aforementioned documentation and guidelines, additional reimbursement is warranted for Primary Procedure 23130, and Tertiary Procedure 29999.**

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: 29824, 23130, 29821, 29999

Date of Service: 08/29/2014							
Ambulatory Services							
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Assist Surgeon	Units	Workers' Comp Allowed Amt.	Notes
29824	\$2,025	\$976.69	\$1048.31	N/A	1	\$976.69	Refer to Analysis
23130	\$5,000	\$1,589.99	\$3,410.01	N/A	1	\$3,179.98	\$1,589.99 Due Provider
29821	\$5,128	\$0.00	\$5,128	NA	1	\$0.00	Refer to Analysis
29999	\$3,259.55	\$363.39	\$2,896.16	N/A	1	\$877.74	\$363.39 Due Provider

Copy to:

[REDACTED]
[REDACTED]
[REDACTED]

Copy to:

[REDACTED]
[REDACTED]
[REDACTED]