

MAXIMUS FEDERAL SERVICES, INC.

Independent Bill Review
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INDEPENDENT BILLING REVIEW FINAL DETERMINATION

July 21, 2015

[Redacted]
[Redacted]
[Redacted]

IBR Case Number:	CB15-0000990	Date of Injury:	03/23/2015
Claim Number:	[Redacted]	Application Received:	06/17/2015
Claims Administrator:	[Redacted]		
Date(s) of service:	03/23/2015		
Provider Name:	[Redacted]		
Employee Name:	[Redacted]		
Disputed Codes:	20690-LT and 23412-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, 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:
- 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 codes 20690-LT and 23412-LT
- Claims Administrator denied codes indicating on the Explanation of Review “Services unsubstantiated by documentation”
- 23412 - Repair of ruptured musculotendinous cuff (eg, rotator cuff) open; chronic.
- Provider’s report submitted documents “Tendinopathy was identified digitally, the edges of which were ellipsed.”
- Provider submitted a printout of code description 23412 from EncoderPro.com Expert. The rotator cuff repair is described in detail.
- Provider’s Operative Report for date of service 3/23/2015 does not document which tendon edges were ellipsed or any details of repair of a rotator cuff. A rotator cuff repair is not described.
- Documentation submitted does not support code 23412 and therefore, reimbursement of code is not warranted.
- 20690 - Application of a uniplane (pins or wires in 1 plane), unilateral, external fixation system
- Provider’s Operative Report submitted documents “This then allowed an Opus anchor to be placed”

