

**INDEPENDENT BILLING REVIEW FINAL DETERMINATION**

November 14, 2014

[REDACTED]  
[REDACTED]  
[REDACTED]

<b>IBR Case Number:</b>	CB13-0000982	<b>Date of Injury:</b>	7/25/2008
<b>Claim Number:</b>	[REDACTED]	<b>Application Received:</b>	12/27/2013
<b>Claims Administrator:</b>	[REDACTED]		
<b>Provider Name:</b>	[REDACTED]		
<b>Employee Name:</b>	[REDACTED]		
<b>Disputed Codes:</b>	29827, 29823, 20690, 23415, 29826, 20610		

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.

IBR assigned: 4/14/2014

**Final Determination: OVERTURN. MAXIMUS Federal Services has determined that additional reimbursement is warranted. The Claims Administrator’s determination is reversed and the Claims Administrator owes the Provider additional reimbursement of \$335.00 for the review cost and \$1033.73 in additional reimbursement for a total of \$1368.73. A detailed explanation of the decision is provided later in this letter.**

The Claim Administrator is required to reimburse the Provider a total of \$1368.73 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,

[REDACTED]

Chief Coding Reviewer

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: [REDACTED] Contract
- 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:** Reimbursement lower than expected for CPT codes 29827 and 29823 and reimbursement denied for service codes 20690, 29826, 23415 and 20610.
- Based on the NCCI edits codes 20610 and 29826 should be denied. These services are suspect in the NCCI edits and the provider did not submit a modifier indicating that the services were separate and distinct.
- Based on review of the operative report code 20690 is not substantiated and therefore should not be reimbursed.
- An 8% discount should be applied to all allowed amounts based on contract agreement.
- Based on review of the operative report the acromioplasty was an open service and therefore assignment of code 23415 is substantiated and reimbursement should be made as follows:  $23415 = (48.2042 * 80.58) * .82 * .92 * .5 = \$1465.16$
- Reimbursement for codes 29827 and 29823 as follows:  
 $29827 = 54.4111 * 80.58 * .82 * .92 = \$3307.63$  (less than already reimbursed)  
 $29823 = 54.4111 * 80.58 * .82 * .92 * .5 = \$1653.81$  (less than already reimbursed)

The table below describes the pertinent claim line information.

**DETERMINATION OF ISSUE IN DISPUTE:** Additional reimbursement of \$1033.73 to be made for code 23415-59 (which reflects change in reimbursement amount of codes 29827 and 29823).

<b>Date of Service: 7/11/2013</b>						
<b>Service Code</b>	<b>Provider Billed</b>	<b>Plan Allowed</b>	<b>Dispute Amount</b>	<b>Mult Surg</b>	<b>Workers' Comp Allowed Amt.</b>	<b>Notes</b>
29827	\$ 9975.82	\$ 3592.25	\$ 6380.57	100%	\$3307.63	<b>DISPUTED SERVICE:</b> Reimbursement less than original reimbursement. .
29823-51	\$ 9975.82	\$ 1797.62	\$ 8178.20	50%	\$1653.81	<b>DISPUTED SERVICE:</b> Reimbursement less than original reimbursement. .
23415-59	\$ 8305.62	\$ 0	\$ 8305.62	50%	\$1465.16	<b>DISPUTED SERVICE:</b> Additional reimbursement of \$1033.73 to be made.
20690	\$ 5670.30	\$ 0	\$ 6380.57	50%	\$0	<b>DISPUTED SERVICE:</b> Deny this service .
29826	\$ 5220.00	\$ 0	\$ 6380.57	50%	\$3307.63	<b>DISPUTED SERVICE:</b> Deny this service .
20610	\$ 914.08	\$ 0	\$ 6380.57	50%	\$3307.63	<b>DISPUTED SERVICE:</b> Deny this service .

National Correct Coding Initiative information:

<b>File</b>	<b>Column 1</b>	<b>Column 2</b>	<b>Modifier</b>
Hospital APC Version 19.2	23415	20610	Allowed
Hospital APC Version 19.2	23415	29826	Allowed
Hospital APC Version 19.2	29823	20610	Allowed
Hospital APC Version 19.2	29826	20610	Allowed
Hospital APC Version 19.2	29827	20610	Allowed

Copy to:

[REDACTED]  
[REDACTED]  
[REDACTED]

Copy to:

[REDACTED]  
[REDACTED]  
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