

MAXIMUS FEDERAL SERVICES, INC.

Independent Bill Review
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Independent Bill Review Final Determination Reversed

9/25/2014

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|-----------------------|-------------------------|-----------------------|------------|
| IBR Case Number: | CB14-0000186 | Date of Injury: | 06/20/2013 |
| Claim Number: | ██████████ | Application Received: | 02/13/2014 |
| Claims Administrator: | ██████████ | | |
| Date(s) of service: | 10/23/2013 – 10/23/2013 | | |
| Provider Name: | ██████████ | | |
| Employee Name: | ██████████████████ | | |
| Disputed Codes: | 29823 | | |

Dear ██████████:

Determination:

A Request for Independent Bill Review (IBR) was assigned to MAXIMUS Federal Services on 03/27/2014, by the Administrative Director of the California Division of Workers' Compensation pursuant to California Labor Code section 4603.6. MAXIMUS Federal Services has determined that the **Claims Administrator's determination is reversed. The Claims Administrator is required to reimburse you the IBR fee of \$335.00 and the amount found owing of \$1,482.57, for a total of \$1,817.57.**

Pertinent Records and Other Appropriate Information Relevant to the Determination Reviewed - The following evidence was used to support the decision:

- 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
- AMA CPT, 1997 & 2013

Supporting Analysis:

Pursuant to Labor Code section 4603.5 and 5307.1, the Administrative Director of the Division of Workers' Compensation has adopted the Official Medical Fee Schedule as the Basis for billing and payment of medical services provided injured employees under the Workers' Compensation Laws of the State of California, utilizing the American Medical Association 1997 Current Procedural Terminology codes and definitions.

The dispute regards the denial of surgical services performed by the Provider on 10/23/2013. The Claims Administrator denied the reimbursement for a single surgical service for the following reason:

- Charge for a "separate procedure? That does not meet the criteria for payment. See the OMFS General Instructions Separate Procedure Rule."

For purposes of a clear discussion, all of the codes relative to this case will be discussed and defined.

The American Medical Association (AMA) Current Procedural Terminology 1997 code descriptions for the CPT codes in question are as follows:

- **CPT 29823:** Arthroscopy, shoulder, surgical; debridement, extensive.
- **CPT 29826 -51:** Arthroscopy, shoulder, surgical; decompression of subacromial space with partial acromioplasty, with coracoacromial ligament (ie, arch) release, when performed (List separately in addition to code for primary procedure)
- ***CPT 29827 :** arthroscopy, shoulder, surgical; with rotator cuff repair
- ***CPT 29824:** Claviclectomy; partial
- **Modifier 51:** Multiple Procedures
- **Modifier 59:** Distinct Procedural Service

***Note:** CPT codes 29827 & 29824 were assigned by the Claims Administrator to replace billed CPT Code 29909, an unlisted arthroscopy code. The source for these definitions is AMA CPT 2013.

On 01/07/2014, the CPT service in question was reviewed a second time by the Claims Administrator and again denied for the following reasons:

- Charge for a "separate procedure? That does not meet the criteria for payment. See the OMFS General Instructions Separate Procedure Rule."
- No additional reimbursement allowed after review of appeal/reconsideration.

It appears that the Claims Administrator bundled CPT Code 29823 into CPT Code 29824 as these are typically considered "paired codes."

Upon review of the documents provided, a letter dated 9/23/2013 addressed to the Provider, authorized the following surgical services:

1. Right shoulder arthroscopy
2. Arthroscopic rotator cuff repair
3. Subacromial decompression (SAD) full thickness rotator cuff tear.
4. Authorization No: CUOU-036651-003

It is important to note that the letter authorization treatment does not indicate the type of CPT codes that are authorized.

Documentation for CPT 29824 and 29827, reference the acromioclavicular joint and the subacromial bursal space; regions or areas. The Provider references the glenohumeral joint for CPT 29823. For example, on page 1 of the report, the Provider clearly states, "Upon entering the **glenohumeral joint**...There was **extensive** degeneration of the anterior labrum and the superior labrum. An anterior portal was immediately established in the rotator interval and the **extensive** intraarticular debridement was performed." Specifically, the Arthroscopy Debridement was performed independently of the other procedures on the same day of service.

Although the CPT in question 29823 is typically paired with similar codes and a modifier is required to identify the code as a separate procedure, it is important to realize that the guidelines for this case must abide by the 1997 American Medical Association Guidelines and not the year of the date of service in question, 2013. CPT 29823 was not paired with CPT Code 29824 (or 29827) in 1997. Since the documentation and the letter of authorization independently support Right Shoulder Arthroscopy, reimbursement is warranted for CPT Code 29823 and the OMFS reimbursement of \$1,482.57 is recommended.

The chart below provides a comparison of billed charges and reimbursement rates for the codes and date of services at issue.

| Validated Code | Validated Units | Dispute Amount | Total Fee Schedule Allowance | Provider Paid Amount | Allowed Recommended Reimbursement | Fee Schedule Utilized |
|----------------|-----------------|----------------|------------------------------|----------------------|-----------------------------------|-----------------------|
| 29823 | 1 | \$1,482.57 | \$1,482.57 | \$0.00 | \$1,482.57 | OMFS |

MAXIMUS Federal Services, as the Independent Bill Review Organization, has determined the Claims Administrator owes the Provider additional reimbursement. The Claims Administrator is required to reimburse the Provider for the IBR application fee (**\$335.00**) and the OMFS amount for CPT code 29823 (**\$1482.57**) for a total of **\$1,817.57**.

