

**MAXIMUS FEDERAL SERVICES, INC.**

Independent Bill Review  
P.O. Box 138006  
Sacramento, CA 95813-8006  
Fax: (916) 605-4280



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**INDEPENDENT BILLING REVIEW FINAL DETERMINATION**

December 12, 2014

[Redacted]  
[Redacted]  
[Redacted]

<b>IBR Case Number:</b>	CB14-0001274	<b>Date of Injury:</b>	05/11/2013
<b>Claim Number:</b>	[Redacted]	<b>Application Received:</b>	09/05/2014
<b>Claims Administrator:</b>	[Redacted]	<b>Assignment Date:</b>	10/06/2014
<b>Provider Name:</b>	[Redacted]		
<b>Employee Name:</b>	[Redacted]		
<b>Disputed Codes:</b>	29823, 29823-51, 29824-59 and 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.

**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,

[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: none
- 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:** Denial of CPT codes 29823, 29823-51, and 20610 and underpayment of CPT code 29824-59.
- Based on the NCCI edits there are three suspect code sets (see below). Code 20610 is suspect when submitted with codes 29823 and 29824, and code 29823 is suspect when submitted with CPT code 29824.
- The provider did not append a modifier to code 20610 indicating that the service was separate and distinct and therefore this service was appropriately denied.
- The operative report indicates debridement but does not indicate that it was extensive or distinct from the more extensive procedure reported with CPT code 29824 (per the NCCI edits). Furthermore the provider did not submit a modifier (such as -59) to indicate that code 29823 should be considered for reimbursement. Therefore the denial of CPT codes 29823 and 29823-51 is upheld.
- Reimbursement was calculated accurately for CPT code 29824 as follows:  
Adjusted CF \$80.58 x APC RW 29.6106 x WC Multi., .82 = \$1956.54
- The APC RW is based on the Calendar Year 2013 OPPS Addendum B (not CY 2014 Addendum B).

The table below describes the pertinent claim line information.

**DETERMINATION OF ISSUE IN DISPUTE: No additional reimbursement warranted.**

Date of Service: 1/16/2014						
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Multi Surg.	Workers' Comp Allowed Amt.	Notes
29823	\$ 9975.82	\$ 0	\$ 3872.42		\$ 0	<b>DISPUTED SERVICE:</b> Deny per NCCI edits. No modifier used.
29823-51	\$ 9975.82	\$ 0	\$ 1936.21		\$ 0	<b>DISPUTED SERVICE:</b> Deny per NCCI edits. No modifier used.
29824	\$ 5200.00	\$ 1956.54	\$ 1936.21	100%	\$1956.54	<b>DISPUTED SERVICE:</b> No additional reimbursement warranted.
20610	\$ 914.08	\$ 0	\$ 183.86		\$0	<b>DISPUTED SERVICE:</b> Deny per NCCI edits. No modifier used.

National Correct Coding Initiative information:

File	Column 1	Column 2	Modifier
Hospital APC Version 19.3	29823	20610	Allowed
Hospital APC Version 19.3	29824	20610	Allowed
Hospital APC Version 19.3	29824	29823	Allowed

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