

**INDEPENDENT BILLING REVIEW FINAL DETERMINATION**

December 19, 2014

[REDACTED]  
[REDACTED]  
[REDACTED]  
[REDACTED]

<b>IBR Case Number:</b>	CB14-0001431	<b>Date of Injury:</b>	07/21/2013
<b>Claim Number:</b>	[REDACTED]	<b>Application Received:</b>	09/26/2014
<b>Claims Administrator:</b>	[REDACTED]	<b>Assignment Date:</b>	10/16/2014
<b>Provider Name:</b>	[REDACTED]		
<b>Employee Name:</b>	[REDACTED]		
<b>Disputed Codes:</b>	29824, 29827, 29825, 29805, 2982, 29823, 29826		

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], RHIT, CCS  
Chief Coding Reviewer

cc: [REDACTED]  
Division of Workers’ Compensation (DWC) Medical Unit

## 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 29805, 29821-59, and 29825-59 and reimbursement less than expected for CPT codes 29823-59, 29824-59, 29826-59, and 29827-59.
- Based on the NCCI edits there are several suspect codes sets.
- The denial of CPT code 29805 is correct. A diagnostic arthroscopy is not coded when a surgical service is performed.
- Both CPT code 29821 (synovectomy) is a component of the distal clavicle excision and therefore should not be coded separately.
- CPT code 29825 (lysis of adhesions) is a component of the rotator cuff repair (29827) and should not be assigned separately.
- Codes 29821 and 29825 are mutually exclusive to other, more extensive services and therefore should not be coded and reimbursed separately.
- Per case documentation code 99070 is not in dispute.

The table below describes the pertinent claim line information.

**DETERMINATION OF ISSUE IN DISPUTE: Denial of CPT codes 29805, 29821-59, and 29825-59 and reimbursement of CPT codes 29823-59, 29824-59, 29826-59, and 29827-59 were made appropriately by the Claims Administrator and therefore additional reimbursement is not warranted.**

Date of Service: 3/6/14						
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Mult Surg	Workers' Comp Allowed Amt.	Notes
29805	\$3565.00	\$0	\$3565.00		\$0	DISPUTED SERVICE: Reimbursement not substantiated based on NCCI edits.
29821-59	\$5128.35	\$0	\$5128.35		\$0	DISPUTED SERVICE: Reimbursement not substantiated based on NCCI edits.
29823-59	\$5318.35	\$1794.72	\$3523.63	50%	\$1794.72	DISPUTED SERVICE: Reimbursement amount correct. No additional reimbursement due to the Provider.
29824-59	\$2025.00	\$976.69	\$1048.31	50%	\$976.69	DISPUTED SERVICE: Reimbursement amount correct. No additional reimbursement due to the Provider.
29825-59	\$4465.00	\$0	\$4465.00		\$0	DISPUTED SERVICE: Reimbursement not substantiated based on NCCI edits.
29826	\$6118.00	\$976.69	\$5141.31	50%	\$976.69	DISPUTED SERVICE: Reimbursement amount correct. No additional reimbursement due to the Provider.
29827-59	\$6500.00	\$3589.44	\$2910.56	100%	\$3589.44	DISPUTED SERVICE: Reimbursement amount correct. No additional reimbursement due to the Provider.

National Correct Coding Initiative information:

<b>File</b>	<b>Column 1</b>	<b>Column 2</b>	<b>Modifier</b>
Hospital APC Version 19.3	29821	29805	Allowed
Hospital APC Version 19.3	29823	29805	Allowed
Hospital APC Version 19.3	29823	29825	Allowed
Hospital APC Version 19.3	29824	29805	Allowed
Hospital APC Version 19.3	29824	29821	Allowed
Hospital APC Version 19.3	29824	29823	Allowed
Hospital APC Version 19.3	29824	29825	Allowed
Hospital APC Version 19.3	29825	29805	Allowed
Hospital APC Version 19.3	29825	29821	Allowed
Hospital APC Version 19.3	29826	29805	Allowed
Hospital APC Version 19.3	29826	29805	Allowed
Hospital APC Version 19.3	29827	29825	Allowed

Copy to:

[REDACTED]  
[REDACTED]  
[REDACTED]  
[REDACTED]

Copy to:

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