

**INDEPENDENT BILLING REVIEW FINAL DETERMINATION**

November 12, 2014

[Redacted]  
[Redacted]  
[Redacted]  
[Redacted]

<b>IBR Case Number:</b>	CB14-0000679	<b>Date of Injury:</b>	03/28/2013
<b>Claim Number:</b>	[Redacted]	<b>Application Received:</b>	05/15/2014
<b>Claims Administrator:</b>	[Redacted]	<b>Assignment Date:</b>	07/02/2014
<b>Provider Name:</b>	[Redacted]		
<b>Employee Name:</b>	[Redacted]		
<b>Disputed Codes:</b>	29826-51		

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: OVERTURN. MAXIMUS Federal Services has determined that additional reimbursement is warranted. The Claims Administrator’s determination is reversed and the Claim Administrator owes the Provider additional reimbursement of \$250.00 for the review cost and \$749.29 in additional reimbursement for a total of \$999.29. A detailed explanation of the decision is provided later in this letter.**

The Claim Administrator is required to reimburse the Provider a total of \$999.29 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
- National Correct Coding Initiatives
- Other: Physician Fee Schedule

## 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:** The Provider is dissatisfied with the reimbursement of \$0.00 for CPT 29826-51.
- The Claims Administrator denied the CPT 29826-51 with the following explanations: In accordance with clinical based coding edits (National Correct Coding Initiative/Outpatient Code Editor) component codes of comprehensive surgery: Musculoskeletal System Procedure (20000-29999) has been allowed.
- 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.
- Operative report documented a left shoulder arthroscopy with subacromial decompression.
- Based on date of service and guidelines in effect, coding edits are not applicable for the billed CPT codes 29826-51, 29823, 23412-51 and 23430-51.
- Reimbursement warranted for the billed CPT 29826.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Reimbursement of code 29826-51.

<b>Date of Service:</b> 12/12/2013							
<b>Physician Services</b>							
<b>Service Code</b>	<b>Provider Billed</b>	<b>Plan Allowed</b>	<b>Dispute Amount</b>	<b>Assist Surgeon</b>	<b>Multiple Surgery</b>	<b>Workers' Comp Allowed Amt.</b>	<b>Notes</b>
29826-51	\$ 1485.57	\$ 0.00	\$ 741.29	N/A	Percent reduction 50%	\$ 741.29	<b>DISPUTED SERVICE:</b> Additional reimbursement of \$741.29 warranted.

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