

MAXIMUS FEDERAL SERVICES, INC.

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



INDEPENDENT BILLING REVIEW FINAL DETERMINATION

November 18, 2015

[Redacted]
[Redacted]
[Redacted]

IBR Case Number:	CB15-0001951	Date of Injury:	11/22/2005
Claim Number:	[Redacted]	Application Received:	10/20/2015
Claims Administrator:	[Redacted]		
Date(s) of service:	01/08/2015		
Provider Name:	[Redacted]		
Employee Name:	[Redacted]		
Disputed Codes:	2805, 29821, 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,

Paul Manchester, MD, MPH
Medical Director

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: N/A
- 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:** Provider seeking remuneration for codes 29805, 29821, 29823 and 29826 on date of service 01/08/2015
- Claims Administrator reimbursed \$3,945.52 of the \$20,129.35 billed.
- CPT codes 29805 and 29826 were both denied any reimbursement by Claims Administrator.
- Code 29826 has a status indicator 'N1' – Packaged service/item; no separate payment made.
- Reimbursement of 29826 is not warranted.
- Code 29805 - Arthroscopy, shoulder, diagnostic, with or without synovial biopsy (separate procedure).
- Pursuant General Information and Instructions, Separate Procedures: some of the listed procedures are commonly carried out as an integral part of a total service, and as such do not warrant a separate reimbursement. When however, such a procedure is performed independent of and is not immediately related to other services, it may be listed as a “separate procedure.” Thus, when a procedure is performed alone for a specific purpose it may be considered to be a separate procedure.
- Documentation submitted does not support a separate procedure for the diagnostic arthroscopy. Therefore, reimbursement of 29805 is not warranted.

- Claims Administrator reimbursed code 29823 - Arthroscopy, shoulder, surgical; debridement, extensive
- Pursuant NCCI Policy Manual for Medicare Services, codes 20000-29999, Arthroscopy: With the exception of the knee joint, arthroscopic debridement should not be reported separately with a surgical arthroscopy procedure when performed on the same joint at the same patient encounter.
- Therefore, reimbursement of 29823 is not warranted.
- Per HOPPS reimbursement for 29821: $58.6059 \times 83.31 \times 80.81\% = 3,945.52$.
- As Claims Administrator reimbursed a total of \$3,945.52, per HOPPS reimbursement of code 29821, no further reimbursement is owed to Provider.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Reimbursement of code codes 29805, 29821, 29823 and 29826

Date of Service: 01/08/2015						
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Multiple Surgery	Workers' Comp Allowed Amt.	Notes
29805, 29821, 29823, 29826	\$20,129.35	\$3,945.52	\$16,183.83	N/A	\$ 3,945.52	Refer to Analysis

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