

**MAXIMUS FEDERAL SERVICES, INC.**

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



**INDEPENDENT BILLING REVIEW FINAL DETERMINATION**

December 8, 2015

[Redacted]  
[Redacted]  
[Redacted]

IBR Case Number:	CB15-0002100	Date of Injury:	03/17/2015
Claim Number:	[Redacted]	Application Received:	11/13/2015
Claims Administrator:	[Redacted]		
Date(s) of service:	07/25/2015		
Provider Name:	[Redacted]		
Employee Name:	[Redacted]		
Disputed Codes:	29823 (downcoded to 29822)		

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 \$195.00 for the review cost and \$1,794.25 in additional reimbursement for a total of \$1,989.25. A detailed explanation of the decision is provided later in this letter.**

The Claim Administrator is required to reimburse the Provider a total of \$1,989.25 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,

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: 92% PPO Reimbursement
- 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 of 29823, Arthroscopy, shoulder, surgical; debridement, extensive for date of service 07/25/20105
- Claims Administrator down coded 29823 to 29822 indicating on the Explanation of Review “The procedure code billed does not accurately describe the services performed. Reimbursement was made for a code that is supported by the description and documentation submitted with the billing”
- Provider’s Operative Report documents “extensive debridement was performed, debriding all frayed portions of the labrum superiorly and anteriorly. We also debrided the frayed portion of the biceps and the undersurface of the rotator cuff”
- Documentation supports billed code 29823 and therefore, additional reimbursement is warranted.
- Title 8, CCR 9789.32((a) Sections 9789.30 through 9789.39 shall be applicable to the maximum allowable fees for emergency room visits and surgical procedures rendered on or after July 1, 2004 and before September 1, 2014. Sections 9789.30 through 9789.39 shall be applicable to the maximum allowable fees for emergency room visits, surgical procedures, and Facility Only Services rendered on or after September 1, 2014. For purposes of this section, emergency room visits and surgical procedures shall be defined by HCPCS codes set forth in section 9789.39(b) by date of service.

- PPO contract not submitted for review.
- EOR received reflects a 92% PPO reimbursement rate.

The table below describes the pertinent claim line information.

**DETERMINATION OF ISSUE IN DISPUTE: Reimbursement of code 29823**

<b>Date of Service: 07/25/20105</b>						
<b>Service Code</b>	<b>Provider Billed</b>	<b>Plan Allowed</b>	<b>Dispute Amount</b>	<b>Multiple Surgery</b>	<b>Workers' Comp Allowed Amt.</b>	<b>Notes</b>
29823	\$7902.00	\$1840.10	\$6061.90	N/A	\$3634.35	\$1,794.25 Due to Provider

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