

MAXIMUS FEDERAL SERVICES, INC.

Independent Bill Review
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Fax: (916) 605-4280



INDEPENDENT BILLING REVIEW FINAL DETERMINATION

08/03/2015

[REDACTED]
[REDACTED]
[REDACTED]

IBR Case Number:	CB15-0000869	Date of Injury:	09/15/2014
Claim Number:	[REDACTED]	Application Received:	05/28/2015
Assignment Date:	06/30/2015		
Claims Administrator:	[REDACTED]		
Date(s) of service:	02/13/2015 – 02/13/2015		
Provider Name:	[REDACTED]		
Employee Name:	[REDACTED]		
Disputed Codes:	29823RT, 29726RT, and 64415-59		

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 \$3,670.05 in additional reimbursement for a total of \$3,865.05. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of **\$3,865.05** 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, M.D., M.P.H.
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

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 CPT add-on code 29826 RT “Arthroscopy, shoulder, surgical; decompression of subacromial space with partial acromioplasty, with coracoacromial ligament (i.e., arch) release, when performed (list separately in addition to code for primary procedure)” and OMFS reimbursement 29823 RT Shoulder Arthroscopy & 64415-59 Nerve Block Injection Brachial plexus, for date of service 02/13/2015.**
- The injured worker underwent right shoulder surgery on the date of service at issue for treatment of calcific tendinitis, adhesive capsulitis and synovitis.
- The procedure was documented as: 1) right shoulder arthroscopy with extensive arthroscopic glenohumeral debridement; 2) labral resection with synovectomy; 3) partial arthroscopic capsulectomy of the rotator cuff interval; 4) arthroscopic coracoacromial ligament release; 5) arthroscopic subacromial decompression; 6) manipulation of the right shoulder under general anesthesia.
- The Claims Administrator denied the **29826** service with the following rationale: “Items and/or services are packaged into the APC rate. Therefore, there is no separate APC payment. Service not paid under Outpatient Facility Fee Schedule.”
- Documentation from the operative report supports the performance of the 29826RT service as per the following: "Debridement of the subacromial space was initially less than 5mm and once the coracoacromial ligament was released and subacromial decompression was carried out, there appeared to be no further evidence of impingement. The subacromial space measured a centimeter in height".
- CPT 29826 is a status indicator “N” and is packaged into the payment for the main procedure and is not separately reimbursable and does not have a relative weight.

