

**MAXIMUS FEDERAL SERVICES, INC.**

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



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**INDEPENDENT BILLING REVIEW FINAL DETERMINATION**

August 20, 2015

[REDACTED]  
[REDACTED]  
[REDACTED]

IBR Case Number:	CB15-0001190	Date of Injury:	10/25/2014
Claim Number:	[REDACTED]	Application Received:	07/23/2015
Assignment Date:	08/11/2015		
Claims Administrator:	[REDACTED]		
Date(s) of service:	03/04/2015 – 03/04/2015		
Provider Name:	[REDACTED]		
Employee Name:	[REDACTED]		
Disputed Codes:	29822-LT-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: 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, 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
- NCCI Policy Manual for Medicare Services, Chapter 4
- OMFS

## 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 23823 Arthroscopy, shoulder, surgical; debridement, extensive, performed on the R. shoulder of Injured Worker on 03/04/2015.**
- Claims Administrator denied reimbursement for 23823 services with the following rationale: “No separate payment was made because the value of the service is included in the value of another service.
- **§ 9789.12.13** Correct Coding Initiative  
(a) The National Correct Coding Initiative Edits (“NCCI”) adopted by the CMS shall apply to payments for medical services under the Physician Fee Schedule. Except where payment ground rules differ from the Medicare ground rules, claims administrators shall apply the NCCI physician coding edits and medically unlikely edits to bills to determine appropriate payment. Claims Administrators shall utilize the **National Correct Coding Initiative Coding Policy Manual for Medicare Services**. If a billing is reduced or denied reimbursement because of application of the NCCI, the claims administrator must notify the physician or qualified non-physician practitioner of the basis for the denial, including the fact that the determination was made in accordance with the NCCI.
- NCCI Policy Manual for Medicare Services - Effective January 1, 2014, Chapter 4, (E) Arthroscopy;
  - **Paragraph 4** States the following: “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. For knee joint arthroscopic debridement see the following paragraph.”

- Operative report and CMS 1500 and reflects CPT 29827 Arthroscopy, shoulder, surgical; with rotator cuff repair performed on same anatomical site as 29822-LT-59. As such, CPT 29822-LT-59 is not separately reportable.

The table below describes the pertinent claim line information.

**DETERMINATION OF ISSUE IN DISPUTE: Based on the aforementioned documentation and guidelines, reimbursement is not indicated for 29822-LT-59.**

<b>Date of Service:</b> 03/04/2015							
<b>HOPPS</b>							
<b>Service Code</b>	<b>Provider Billed</b>	<b>Plan Allowed</b>	<b>Dispute Amount</b>	<b>Assist Surgeon</b>	<b>Units</b>	<b>Workers' Comp Allowed Amt.</b>	<b>Notes</b>
29822 LT-59	\$1,736.39	\$0.00	\$1,499.90	N/A	1	\$0.00	<b>Refer to Analysis</b>

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