

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:
- National Correct Coding Initiatives

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 is dissatisfied with denial of code 0232T-RT
- Claims Administrator denied code indicating on the Explanation of Review “This charge is not normally billed separately”
- Provider did not submit a Request for Authorization.
- Provider submitted documentation “Certification Recommendation” from Claims Administrator. Certified on this document shows “Right Shoulder Arthroscopy w/ Decompression & Possible Rotator Cuff Repair”, “Post-op Physical Therapy”, “Polar Care Unit”, “Shoulder Sling” and “Pre Op Medical Clearance TBD”.
- Certification for Platelet Rich Plasma or code 0232T is not indicated.
- A partial reimbursement by the Claims Administrator would indicate acceptance of procedure; partial payment is not reflected on the EOR’s. As such, Correct Coding rational and/or Contractual Obligations would dictate the level of reimbursement.
- PPO contract submitted, specific reimbursement for CPT 0232T not indicated.
- As code 0232T was not authorized by Claims Administrator, reimbursement of 0232T-RT is not warranted.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Reimbursement of code 0232T-RT

Date of Service: 04/17/2015						
Physician Services						
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Units	Workers' Comp Allowed Amt.	Notes
0232T-RT	\$2,000.00	\$0.00	\$2,000.00	1	\$0.00	DISPUTED SERVICE: Reimbursement not recommended.

Copy to:

[REDACTED]
[REDACTED]
[REDACTED]

Copy to:

[REDACTED]
[REDACTED]
[REDACTED]