

**INDEPENDENT BILLING REVIEW FINAL DETERMINATION**

March 4, 2016

[REDACTED]  
[REDACTED]  
[REDACTED]

IBR Case Number:	CB16-0000164	Date of Injury:	04/06/2015
Claim Number:	[REDACTED]	Application Received:	02/09/2016
Claims Administrator:	[REDACTED]		
Date(s) of service:	05/21/2015		
Provider Name:	[REDACTED]		
Employee Name:	[REDACTED]		
Disputed Codes:	29823-51		

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 \$491.71 in additional reimbursement for a total of \$686.71. A detailed explanation of the decision is provided later in this letter.**

The Claim Administrator is required to reimburse the Provider a total of \$686.71 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

[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

## 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 denied CPT 29823, Arthroscopy, and shoulder, surgical; debridement, extensive performed on 05/21/2015.
- Claims Administrator denied code indicating “do not report arthroscopy procedure when it proceeds an arthrotomy in the same session or compartment. Service denied”
- Provider billed code 29823 along with codes 23412 - Repair of ruptured musculotendinous cuff (eg, rotator cuff) open; chronic on a CMS 1500 form.
- NATIONAL CORRECT CODING INITIATIVE POLICY MANUAL FOR MEDICARE SERVICES: Debridement of tissue in the surgical field integral to the completion of another musculoskeletal procedure is not separately reportable.
- RFA dated 05/12/2015 shows “**Procedure Requested: Surgery/Procedure, A-scope R should debridement/SAD, MINI OPEN RCR**” bottom of RFA has signature of the Authorized Agent, dated 5/12/15 showing services as “Approved” A separate email communication between Claims Administrator and Provider confirming authorized services for surgery also submitted for this review.
- § 5307.11: A health care provider or health facility licensed pursuant to Section 1250 of the Health and Safety Code, and a contracting agent, employer, or carrier may contract for reimbursement rates different from those in the fee schedule adopted and revised pursuant to Section 5307.1. When a health care provider or health facility licensed

