

**MAXIMUS FEDERAL SERVICES, INC.**

Independent Bill Review  
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**INDEPENDENT BILLING REVIEW FINAL DETERMINATION**

April 12, 2016

[Redacted]  
[Redacted]  
[Redacted]

IBR Case Number:	CB16-0000410	Date of Injury:	04/25/2014
Claim Number:	[Redacted]	Application Received:	03/11/2016
Assignment Date:	12/11/2015		
Claims Administrator:	[Redacted]		
Date(s) of service:	12/11/2015 – 12/11/2015		
Provider Name:	[Redacted]		
Employee Name:	[Redacted]		
Disputed Codes:	29828-51 LT and 0232T LT		

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 \$688.12 in additional reimbursement for a total of \$883.12. A detailed explanation of the decision is provided later in this letter.**

The Claim Administrator is required to reimburse the Provider a total of **\$883.12** 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

[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
- 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 29828 and 0232T submitted for date of service 12/11/2015.**
- The Claims Administrator's denied 29828 as a "bundled" service.
- Bill Type, Physician Services.
- **CCR § 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**.
- **All services performed on 12/11/2015 were considered.** NCCI Edits indicate the following code pairs with Modifier indicator of 1 (\* indicates reimbursed procedures reflected on EORs):

▭ short description for column 1 code

Column 1	Column 2	CCI Edit Description	Modifier Indicator	Effective Date
		└ short description for column 2 code		
		└ SHOULDER ARTHROSCOPY/SURGERY		
<u>*29820</u>	<u>**29805**</u>	CPT Manual or CMS manual coding instructions	1	1/1/2002
		└ SHOULDER ARTHROSCOPY DX		
		└ SHOULDER ARTHROSCOPY/SURGERY		
<u>*29822</u>	<u>**29805**</u>	CPT Manual or CMS manual coding instructions	1	1/1/2002
		└ SHOULDER ARTHROSCOPY DX		
<u>*29822</u>	<u>**29820**</u>	More extensive procedure	1	1/1/1996
		└ SHOULDER ARTHROSCOPY/SURGERY		
		└ SHOULDER ARTHROSCOPY/SURGERY		
<u>*29826</u>	<u>**29805**</u>	CPT Manual or CMS manual coding instructions	1	1/1/2002
		└ SHOULDER ARTHROSCOPY DX		
		└ ARTHROSCOP ROTATOR CUFF REPR		
<u>*29827</u>	<u>**29805**</u>	CPT Manual or CMS manual coding instructions	1	1/1/2003
		└ SHOULDER ARTHROSCOPY DX		
<u>*29827</u>	<u>**29820**</u>	More extensive procedure	1	7/1/2003
		└ SHOULDER ARTHROSCOPY/SURGERY		
<u>*29827</u>	<u>**29822**</u>	Standards of medical / surgical practice	1	7/1/2003
		└ SHOULDER ARTHROSCOPY/SURGERY		
		└ ARTHROSCOPY BICEPS TENODESIS		
<u>29828</u>	<u>**29805**</u>	CPT Manual or CMS manual coding instructions	1	1/1/2008
		└ SHOULDER ARTHROSCOPY DX		
<u>29828</u>	<u>**29820**</u>	CPT Manual or CMS manual coding instructions	1	1/1/2008
		└ SHOULDER ARTHROSCOPY/SURGERY		
<u>29828</u>	<u>**29822**</u>	CPT Manual or CMS manual coding instructions	1	1/1/2008

- §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.
- **CPT Assist:** Do not report 29828 in conjunction with 29805\*\*, 29820\*\*, 29822\*\*  
**However,** Authorization dated **12/07/2015** indicates surgical services were “**Approved**” for “Possible biceps tenodesis, left shoulder.”
  - Authorization does not indicate reimbursement subject to NCCI edits.
- **CCR § 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 pursuant to Section 1250 of the Health and Safety Code, and a contracting agent, employer, or carrier contract for reimbursement rates **different from those in the fee schedule**, the medical fee schedule for that health care provider or health facility licensed pursuant to Section 1250 of the Health and Safety Code.

- **The 12/07/2015** Authorization is contractual in nature. As such, the contractual obligations apply pursuant to **LC § 5307.11**.
- **Administrative Rules § 9789.16.5 Surgery – Multiple Surgeries and Endoscopies (d)** Determining Maximum Payment for Endoscopies, The Multiple Procedure (“Mult Proc”) column of the National Physician Fee Schedule Relative Value File contains a “3” to indicate procedures that are subject to special rules for multiple endoscopic procedures. For each endoscopic procedure with an indicator of “3”, the Endoscopic Base Code (“Endo Base”) column indicates the related base endoscopy code. Those codes that share a base code are in the same “family” and are “related.”
- EOR’s indicate surgical procedures 29827, 29822, and 29822 were reimbursed in accordance with **§ 9789.16.5** with CPT 29805 as the base code. Disputed CPT 29828 is part of the family of codes subject to reimbursement as determined by the Authorization dated 12/07/2015.
- **HCPCS 0232T Injection(s), platelet rich plasma, any site, including image guidance, harvesting and preparation when performed, Status indicator “C,”** denied by the Claims Administrator due to “global” period.
- HCPCS 0232T, Status Indicator ‘C’ does not have a listed value under the OMFS and is a By Report Code.
- **Administrative Rules § 9789.12.4. “By Report” - Reimbursement for Unlisted Procedures/Procedures Lacking RBRVUs.** (b)(1) In accordance with section 9789.12.3, when procedures with status indicator codes C, N, or R, do not have RVUs assigned under the CMS' National Physician Fee Schedule Relative Value File, these services shall be billed by report, **justifying that the service was reasonable and necessary to cure or relieve from the effects of the industrial injury or illness.** Pertinent information should include an adequate definition or description of the nature, extent, and need for the procedure, and the time, effort and equipment necessary to provide the service.
- **§ 9792.6. Utilization Review Standards – Definition** (a) “Authorization” means assurance that appropriate reimbursement will be made for an **approved specific course of proposed medical treatment to cure or relieve the effects of the industrial injury pursuant to section 4600 of the Labor Code**, subject to the provisions of section 5402 of the Labor Code, based on either a completed “Request for Authorization,” DWC Form RFA, as contained in California Code of Regulations, title 8, section 9785.5, or a request for authorization of medical treatment accepted as complete by the claims administrator under section 9792.9.1(c)(2), that has been transmitted by the treating physician to the claims administrator. Authorization shall be given pursuant to the timeframe, procedure, and notice requirements of California Code of Regulations, title 8, section 9792.9.1, and may be provided by utilizing the indicated response section of the **“Request for Authorization,”** DWC Form RFA if that form was initially submitted by the treating physician.
- **Authorization dated 12/07/2015**, requested Items 1 – 7, **does not reflect a request** for Autologous Products or Procedures.
- **Authorization dated 12/07/2015 does not indicate approval** for Autologous Products or Procedures.
- Without an authorization signed by the Claims Administrator for 0232T services, IBR unable to determine reimbursement pursuant to **§ 9789.12.4 & § 9792.6.**
- **Based on the aforementioned documentations and guidelines, reimbursement indicated for 29828 and is not indicated for 0232T.**

The table on the page 5 describes the pertinent claim line information.

**DETERMINATION OF ISSUE IN DISPUTE: 29828 & 0232T**

<b>Date of Service: 12/11/2015</b>							
<b>Physician</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>
29828	\$1,871.86	\$0.00	\$1,871.86	N/A	1	\$688.12	Refer to Analysis
0232T	\$2,000.00	\$0.00	\$309.03	NA	1	\$0.00	Refer to Analysis

[REDACTED]

[REDACTED]