

**INDEPENDENT BILLING REVIEW FINAL DETERMINATION**

January 13, 2015

[Redacted]  
[Redacted]  
[Redacted]

<b>IBR Case Number:</b>	CB14-0001595	<b>Date of Injury:</b>	02/20/2014
<b>Claim Number:</b>	[Redacted]	<b>Application Received:</b>	10/23/2014
<b>Claims Administrator:</b>	[Redacted]	<b>Assignment Date:</b>	12/03/2014
<b>Provider Name:</b>	[Redacted]		
<b>Employee Name:</b>	[Redacted]		
<b>Disputed Codes:</b>	28924-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 \$250.00 for the review cost and \$1117.01 in additional reimbursement for a total of \$1367.01. A detailed explanation of the decision is provided later in this letter.**

The Claim Administrator is required to reimburse the Provider a total of \$1367.01 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,

[Redacted]  
[Redacted]

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
- Negotiated contracted rates: PPO Discount 5%
- National Correct Coding Initiatives
- Medicare and Medicaid Services (CMS) Outpatient Prospective Payment System (OPPS)

## 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 29824.
- Claims administrator denied code 29824 indicating on the Explanation of Review “The submitted documentation does not support the service being billed for. We will re-evaluate this upon receipt of clarifying information.” Claims administrator also states “CPT 29824 was denied based on AMA coding tips, to qualify for the reimbursement of the distal claviclectomy, documentation should support the removal of 8-10 mm from the distal clavicle/joint. Your report indicated the size of 6-7 mm; therefore we did not recommend an additional payment for CPT 29824 as documentation does not support CPT 29824”
- 29824 - Arthroscopy, shoulder, surgical; distal claviclectomy including distal articular surface (Mumford procedure).
- AMA CPT 29824 does not describe an amount for removal. No evidence was submitted by claims administrator to support the information they state was the reason for denial of code 29824.
- On review of the operative report submitted, Provider documents “Then, using an anterior working portal, distal clavicle resection arthroplasty was carried out removing approximately 6 mm to 7 mm of distal clavicle to a flat clavicular surface.”

- Based on information reviewed, Provider does document procedure 29824 having been performed. Therefore, reimbursement of code 29824 is warranted.

The table below describes the pertinent claim line information.

**DETERMINATION OF ISSUE IN DISPUTE: Reimbursement of code 29824 is recommended.**

Date of Service: 07/15/2014						
Surgical Services						
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Units	Workers' Comp Allowed Amt.	Notes
29824	\$8000.00	\$0.00	\$1117.01	1	\$1117.01	<b>DISPUTED SERVICE:</b> Allow reimbursement \$1117.01

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