

**MAXIMUS FEDERAL SERVICES, INC.**

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

April 13, 2015

[Redacted]  
[Redacted]  
[Redacted]

IBR Case Number:	CB15-0000115	Date of Injury:	02/22/2013
Claim Number:	[Redacted]	Application Received:	01/27/2015
Claims Administrator:	[Redacted]		
Assigned Date:	2/13/2015		
Provider Name:	[Redacted]		
Employee Name:	[Redacted]		
Disputed Codes:	29826-59 and 29999		

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, MD, MPH  
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
- Official Medical Fee Schedule
- Negotiated contracted rates:
- National Correct Coding Initiatives
- Other: CPT Assistant May 2001

## 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 codes 29826-59 and 29999.
- Claims administrator denied codes indicating on the Explanation of Review “No separate payment was made because the value of the service is included within the value of another service performed on the same day.”
- Provider billed codes 29826-59 and 29999 along with code 23412.
- Procedures that are often performed in sequence have been identified and the less extensive procedure is not separately reportable with the more extensive procedure. When the procedures corresponding to CPT code 23412 and CPT code 29826 are performed in sequence at the same patient encounter, only CPT code 23412 should be reported. It is not appropriate to report the codes 23412 and 29826 together unless these two procedures were performed at separate patient encounters or on different sites (contra-lateral shoulders) during the same session.
- Provider also billed code 29999, unlisted procedure, arthroscopy. Provider states that code 29999 is comparable to billed code 29826. Documentation submitted states “Then with the bur in the lateral portal approximately 5-8 mm of bone was resected from the posterior aspect of the distal clavicle”.
- *CPT Assistant*, May 2001, indicates that a bursectomy is a component of service code 29826. The article does not indicate that code 29999 should be used for the arthroscopic removal of the bursa but does indicate that a bursectomy is included with the

