MAXIMUS FEDERAL SERVICES, INC.
Independent Bill Review
P.O. Box 138006
Sacramento, CA 95813-8006
Fax: (916) 605-4280

Independent Bill Review Final Determination Upheld

1/31/2014

Re: Claim Number: [Redacted]
Claims Administrator name: [Redacted]
MAXIMUS IBR Case: CB13-0000471

Dear [Redacted],

Determination:
A Request for Independent Bill Review (IBR) was assigned to MAXIMUS Federal Services on 10/7/2013, by the Administrative Director of the California Division of Workers’ Compensation pursuant to California Labor Code section 4603.6. MAXIMUS Federal Services has determined that the Claims Administrator's determination is upheld. This determination finds that the Claims Administrator does not owe the Provider additional reimbursement.

Pertinent Records and Other Appropriate Information Relevant to the Determination Reviewed:
The following evidence was used to support the decision:

- 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
- Other: Outpatient Hospital Fee Schedule
**Supporting Analysis:**
The dispute regards the payment for surgical facility services on date of service 5/29/2013. The facility services were billed on a UB-04/CMS1450 using revenue codes for services and supplies related to CPT 29888. The Provider was reimbursed $2,506.09, and is requesting additional reimbursement of $3,304.60. The Claims Administrator allowed reimbursement of $2,296.53 for CPT 29888 indicating “The charge for this procedure exceeds the fee schedule allowance. Recommendation of payment has been based on a procedure code which best describes services rendered.”

The Provider is disputing the reimbursement amount of the billed procedure code 29888.

CPT 29888 - Arthroscopically aided anterior cruciate ligament repair/augmentation or reconstruction.

Pursuant to Labor Code section 5307.1(g)(2), the Administrative Director of the Division of Workers’ Compensation orders that Title 8, California Code of Regulations, sections 9789.30 and 9789.31, pertaining to Hospital Outpatient Departments and Ambulatory Surgical Centers Fee Schedule in the Official Medical Fee Schedule, is amended to conform to CMS’ hospital outpatient prospective payment system (OPPS). The Administrative Director incorporates by reference, the Centers for Medicare and Medicaid Services’ (CMS) Hospital Outpatient Prospective Payment System (OPPS) certain addenda published in the Federal Register notices announcing revisions in the Medicare payment rates. The adopted payment system addenda by date of service are found in the Title 8, California Code of Regulations, Section 9789.39(b). Based on the adoption of the CMS hospital outpatient prospective payment system (OPPS), CMS coding guidelines and the hospital outpatient prospective payment system (OPPS) were referenced during the review of this Independent Bill Review (IBR) case.

The Provider submitted an operative report for the surgical procedure: Repair of the left patellar tendon. The operative report documented an open patellar tendon repair. The surgical approach was described as open. There was no mention of the use of an arthroscope during the procedure. Therefore, the billed procedure code 29888 was not supported by the documentation. The CPT 29888 describes an arthroscopically aided procedure. The recommended CPT code(s) for the described "open patellar tendon repair" is CPT code 27380. The description of CPT code 27380 is “Suture of infrapatellar tendon; primary.” The allowance based on the PPO contract and the OMFS Hospital Outpatient Fee Schedule for the CPT 27380 is less than the reimbursement of $2,296.53 by the Claims Administrator. A CPT code with an allowance higher than the Claims Administrator's reimbursement of $2,296.53 could not be recommended.

There is no additional reimbursement warranted for the outpatient surgical facility services billed for date of service 5/29/2013.

The chart below provides a comparison of billed charges and reimbursement rates for the codes and dates of services at issue.

<table>
<thead>
<tr>
<th>Validated Code</th>
<th>Validated Units</th>
<th>Dispute Amount</th>
<th>Total Fee Schedule Allowance</th>
<th>Provider Paid Amount</th>
<th>Allowed Recommended Reimbursement</th>
<th>Fee Schedule Utilized</th>
</tr>
</thead>
<tbody>
<tr>
<td>29888</td>
<td>1</td>
<td>$3,304.60</td>
<td>$2,296.53</td>
<td>$2,296.53</td>
<td>$0.00</td>
<td>PPO Contract</td>
</tr>
</tbody>
</table>

IBR Final Determination Upheld
Form Effective Date 7.23.13
Chief Coding Specialist Decision Rationale:
This decision was based on Outpatient Hospital Fee Schedule, PPO Contract and comparison with explanation of review (EOR). This was determined correctly by the Claims Administrator and the payment of $2,296.53 is upheld.

This decision constitutes the final determination of the Division of Workers’ Compensation Administrative Director, is binding on all parties, and is not subject to further appeal except as specified in Labor Code section 4603.6(f)

Sincerely,

[Signature], RHIT

Copy to:

[Redacted]

Copy to:

[Redacted]