MAXIMUS FEDERAL SERVICES, INC.
Independent Bill Review
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MAXIMUS Federal Services

INDEPENDENT BILLING REVIEW FINAL DETERMINATION

November 7, 2014

[redacted]

IBR Case Number:	CB14-0001042	**Date of Injury:**	10/17/2013
Claim Number:	[redacted]	**Application Received:**	07/24/2014
Claims Administrator:	[redacted]	**Assignment Date:**	08/29/2014
Provider Name:	[redacted]		
Employee Name:	[redacted]		
Disputed Codes:	29880-51, 29888 ,99070, 29880-59, & 29876-59		

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 $3808.42 in additional reimbursement for a total of $4058.42. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of $4058.42 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]
Chief Coding Reviewer

cc: [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: none
- 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**: Denial of codes 29876-59, 29880-51 and 99070. Payment less than expected for CPT codes 29888 and 29880-51.
- Based on the NCCI edits codes 29876-59 is suspect when submitted with code 29880 and 29888.
- Based on review of the operative report 29876-59 should be denied due to standards of medical practice/surgical practice and most extensive procedure. This was not a separate and distinct service.
- Based on the Medically Unlikely Edits (MUE) only 1 unit of code 29880 is allowed. Therefore allowance for one line of service is appropriate and the other should be denied.
- Code 99070 has a status indicator of "B" indicating that the service is not payable under the Outpatient Prospective Payment System.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Denial upheld for codes 99070, 29880-51 and 29876. Additional reimbursement warranted for codes 29888 and 29880-59 ($3808.42).

Date of Service: 1/10/2014						
Service	**Provider**	**Plan**	**Dispute**	**Mult**	**Workers'**	**Notes**

Code	Billed	Allowed	Amount	Surg	Comp Allowed Amt.	
29888	$8773.00	$ 1646.40	$ 18985.19	100%	$5423.17	**DISPUTED SERVICE:** Additional reimbursement of $3776.77 warranted. 82.2078*80.45*.82 = $5423.17
99070	$2663.63	$0	Included in above	N/A	$0	**DISPUTED SERVICE:** Deny based on status indicator B.
29880-59	$3380.00	$ 945.04	Included in above	50%	$ 976.69	**DISPUTED SERVICE:** Additional reimbursement of $31.65 warranted. 29.6106 * 80.45 * .82 * .5 = $976.69.
29880-51	$3380.00	$0	Included in above	N/A	$0	**DISPUTED SERVICE:** Deny based on MUE edits. Only 1 unit allowed for this service.
29876-59	$3380.00	$0	Included in above	N/A	$0	**DISPUTED SERVICE:** Deny based on NCCI edits

National Correct Coding Initiative information:

File	Column 1	Column 2	Modifier
Hospital APC Version 20.0	29888	29876	Allowed
Hospital APC Version 20.0	29880	29876	Allowed

Copy to:

[redacted]

Copy to:

[redacted]