

**MAXIMUS FEDERAL SERVICES, INC.**

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

March 25, 2015

[REDACTED]  
[REDACTED]  
[REDACTED]  
[REDACTED]

IBR Case Number:	CB14-0001947	Date of Injury:	10/10/2011
Claim Number:	[REDACTED]	Application Received:	12/19/2014
Claims Administrator:	[REDACTED]		
Assigned Date:	1/22/2014		
Provider Name:	[REDACTED]		
Employee Name:	[REDACTED]		
Disputed Codes:	29807, 29827, 23430, 29826		

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 \$0.00 additional reimbursement as provider has already been reimbursed for a total of \$250.00. A detailed explanation of the decision is provided later in this letter.**

The Claim Administrator is required to reimburse the Provider a total of \$250.00 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, 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
- 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 reimbursement of codes 29807, 29827, 23430, 29826
- Claims administrator reimbursed codes indicating on the Explanation of Review “The charges have been priced in accordance to a PPO owned contract.”
- Claim had been reimbursed according to OPSS guidelines. However, reimbursement was based on the ASC multiplier .82 instead to Hospital Outpatient of 1.22. [REDACTED] is categorized as a Hospital.
- Documentation was received from the claims administrator that they made an additional payment of \$4690.92 after this dispute had been filed by the provider.
- Additional payment was calculated using the multiplier 1.22 as the provider had disputed. Reimbursement was also calculated based upon a PPO owned contract. No contract was submitted for this review and therefore any additional payment cannot be determined.
- As provider had filed the IBR prior to the additional payment made by the claims administrator, the claims administrator is now responsible for the IBR fee of \$250.00

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Additional reimbursement of codes 29807, 29827, 23430, 29826 is recommended. Provider has already been reimbursed and claims administrator is only responsible to reimburse the IBR review fee of \$250.00.

<b>Date of Service:</b> 7/1/2014						
<b>Service Code</b>	<b>Provider Billed</b>	<b>Plan Allowed</b>	<b>Dispute Amount</b>	<b>Multiple Surgery</b>	<b>Workers' Comp Allowed Amt.</b>	<b>Notes</b>
29807, 29827, 23430, 29826	\$58937.13	\$14289.18	\$49338.87	N/A	\$14289.18	<b>DISPUTED SERVICE:</b> No further reimbursement is recommended for codes 29807, 29827, 23430, 29826

Copy to:

[REDACTED]

Copy to:

[REDACTED]