

MAXIMUS FEDERAL SERVICES, INC.

Independent Bill Review
P.O. Box 138006
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Fax: (916) 605-4280



INDEPENDENT BILLING REVIEW FINAL DETERMINATION

May 18, 2015

[Redacted]
[Redacted]
[Redacted]

IBR Case Number:	CB15-0000223	Date of Injury:	10/01/2013
Claim Number:	[Redacted]	Application Received:	02/23/2015
Claims Administrator:	[Redacted]		
Date Assigned:	3/18/2015		
Provider Name:	[Redacted]		
Employee Name:	[Redacted]		
Disputed Codes:	29881		

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 \$195.00 for the review cost and \$205.90 in additional reimbursement for a total of \$400.90. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of \$400.90 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: PPO Discount 5%
- National Correct Coding Initiatives
- Other: §9789.16.5. Surgery - Multiple Surgeries and Endoscopies.

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 29881. Provider billed code 29881 along with 29876.
- Claims Administrator denied code indicating on the Explanation of Review “The endoscopy/arthroscopy code has been repriced in accordance with the endoscopy methodology labor code 5307.1”
- §9789.16.5 Surgery – Multiple Surgeries and Endoscopies
 - (d) Determining Maximum Payment for Endoscopies
 - The Multiple Procedure (“Mult Proc”) column of the National Physician Fee Schedule Relative Value File contains a “3” to indicate procedures that are subject to special rules for multiple endoscopic procedures. For each endoscopic procedure with an indicator of “3”, the Endoscopic Base Code (“Endo Base”) column indicates the related base endoscopy code. Those codes that share a base code are in the same “family” and are “related.”
 - Two codes billed: Endoscopic procedure and related base endoscopic procedure billed
 - If an endoscopic procedure is reported with only its base procedure, the base procedure is not separately payable. Payment for the base procedure is included in the payment for the other endoscopy.

- Multiple Related Endoscopic procedures billed: If Multiple Procedure column contains an indicator of “3,” and multiple endoscopies are billed, pay the full value of the highest valued endoscopy, plus the difference between the next highest and the base endoscopy. Access the Endo Base column to determine the base endoscopy.
- Billed procedures have a based base endoscopy code of 29870, and multiple procedure status indicator of “3.”
- The Claims Administrator did not reimburse the Provider based on the Multiple Endoscopy guidelines as described in the OMFS Physician Fee Schedule Regulation effective January 1, 2014. Therefore, reimbursement of code 29881 is warranted.
- Documentation submitted states a 5% PPO discount is to be applied.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Reimbursement of code 29881 is recommended.

Date of Service:							
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Endo Based Code	Multiple Surgery	Workers' Comp Allowed Amt.	Notes
29881	\$216.74	\$0.00	\$205.90	29870 - \$693.11	N/A	\$205.90	DISPUTED SERVICE: allow reimbursement \$205.90
29876	\$1098.45	\$1043.53	N/A	29870	N/A	N/A	Service not in dispute

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