

**INDEPENDENT BILLING REVIEW FINAL DETERMINATION**

December 17, 2014

[Redacted]  
[Redacted]  
[Redacted]  
[Redacted]

<b>IBR Case Number:</b>	CB14-0001267	<b>Date of Injury:</b>	1/3/2012
<b>Claim Number:</b>	[Redacted]	<b>Application Received:</b>	9/4/2014
<b>Claims Administrator:</b>	[Redacted]	<b>Assignment Date:</b>	10/6/2014
<b>Provider Name:</b>	[Redacted]		
<b>Employee Name:</b>	[Redacted]		
<b>Disputed Codes:</b>	28234-T7, 28234-T8, 28285-T6, 28234-T9		

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 \$3343.52 in additional reimbursement for a total of \$3593.52. A detailed explanation of the decision is provided later in this letter.**

The Claim Administrator is required to reimburse the Provider a total of \$3593.52 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]  
[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: [REDACTED]
- 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 CPT codes 28285-T6, 28234-T7 28234-T8, and 28234-T9.
- The case file does not indicate the CPT codes 28296-RT, 28270-59-RT, and L8699 are to be considered in the independent bill review.
- Based on the NCCI edits, there are five suspect code sets however the services that are suspect were performed on different digits and therefore the edits do not apply.
- The operative report substantiates the use of the all of the service codes assigned.
- Based on review of the operative report all the above codes (except L8699 which was denied correctly were done on different sites and with use of modifiers; these services can be coded and reimbursed.
- The provider between the Provider and [REDACTED] indicates that reimbursement is to be set at 95% of the allowed amount.
- Reimbursement for the codes in dispute is as follows: (they all of the same APC)  
Adjusted CF \$96.62 x APC RW 22.2111 x WC Mult. .82 \* Mult .5 \* .95 = \$835.88

The table below describes the pertinent claim line information.

**DETERMINATION OF ISSUE IN DISPUTE: Reimbursement of \$3343.52 to be made to the Provider for CPT codes 28285-T6, 28234-T7, 28234-T8, 28234-T9.**

Date of Service: 3/26/2014						
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Mult Surg	Workers' Comp Allowed Amt.	Notes
28285-T6	\$879.88	\$ 0	\$879.88	50%	\$835.88	<b>DISPUTED SERVICE:</b> Allow \$835.88
28234-T7	\$879.88	\$ 0	\$879.88	50%	\$835.88	<b>DISPUTED SERVICE:</b> Allow \$835.88
28234-T8	\$879.88	\$ 0	\$879.88	50%	\$835.88	<b>DISPUTED SERVICE:</b> Allow \$835.88
28234-T9	\$879.88	\$0	\$879.88	50%	\$835.88	<b>DISPUTED SERVICE:</b> Allow \$835.88

National Correct Coding Initiative information:

File	Column 1	Column 2	Modifier
Hospital APC Version 19.3	28270	28234	Allowed
Hospital APC Version 19.3	28270	28234	Allowed
Hospital APC Version 19.3	28296	28234	Allowed
Hospital APC Version 19.3	28296	28270	Allowed
Hospital APC Version 19.3	28296	28285	Allowed

Copy to:

[REDACTED]  
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