

MAXIMUS FEDERAL SERVICES, INC.

Independent Bill Review
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INDEPENDENT BILLING REVIEW FINAL DETERMINATION

November 6, 2014

██████████
██████████
██████████

IBR Case Number:	CB14-0000500	Date of Injury:	08/02/2012
Claim Number:	██████████	Application Received:	03/28/2014
Claims Administrator:	██████████	Assignment Date:	06/09/2014
Provider Name:	████████████████████		
Employee Name:	██████████		
Disputed Codes:	99081 and 20610		

Dear ██████████:

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 \$335.00 for the review cost and \$52.98 in additional reimbursement for a total of \$387.98. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of \$387.98 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,

██████████
Chief Coding Reviewer

cc: ██████████
████████████████████

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 Contract
- National Correct Coding Initiatives
- Other: OMFS General Information and Instructions

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 CPT codes 20610 & 99081.
- Pursuant to Labor Code section 4603.5 and 5307.1, the Administrative Director of the Division of Workers' Compensation has adopted the Official Medical Fee Schedule as the Basis for billing and payment of medical services provided injured employees under the Workers' Compensation Laws of the State of California, utilizing the American Medical Association 1997 Current Procedural Terminology codes and definitions.
- Primary Treating Physician's Progress Report (PR-2) reviewed documents the injured worker's "sharp pain in the left knee." Patient has had left knee medial and lateral meniscectomy and loose body removal with trochlear chondroplasty on 01/29/2013. Patient presents now with "Mild patellafemoral chondromalacia with grade 2 chondrosis in the trochlea." Treatment option agreed between Provider and patient was Orthovise injection to help relieve left knee pain.
- Provider billed CPT 20610, Arthrocentesis, aspiration and/or injection; major joint or bursa (e.g., shoulder, hip, knee joint, subacromial bursa), J7324 (59676036001) and 99081 By Report.
- Claims Administrator denied codes 20610 & 99081 indicating on the Explanation of Review "The charge exceeds the Official Medical Fee Schedule allowance. The charge has been adjusted to the scheduled allowance."

- Title 8, California Code of Regulations, Division 1, Chapter 4.5, Subchapter 1 Administrator Director, “Administer” means the direct application of a drug or device to the body of a patient by injection, inhalation, ingestion, or other means. The aspiration and/or injection procedure code may be billed in addition to the drug and therefore reimbursement of 20610 is recommended.
- Based on a review of the OMFS General Information and Instructions, Primary Treating Physician's Progress Reports (PR-2) are reported when there is any significant change in the treatment plan reported in the Doctor's First Report including but not limited to, an extension of duration or frequency of treatment, a new need for hospitalization or surgery, a new need for referral to or consultation by another physician, a change in methods of treatment or in required physical medicine services, a need for rental or purchase of durable medical equipment or orthotic devices. Provider’s PR-2 contains new treatment plan for the patient and therefore meets the criteria for a PR-2. Reimbursement for 99081 is recommended.
- PPO Contract was received and an 8% discount is to be applied.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Reimbursement of code

Date of Service: 8/26/2013						
Physician Services						
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Units	Workers’ Comp Allowed Amt.	Notes
20610	\$239.79	\$ 0.00	\$ 239.79	1	\$ 42.23	DISPUTED SERVICE: Allow reimbursement \$42.23
99081	\$12.30	\$ 0.00	\$ 12.30	1	\$10.75	DISPUTED SERVICE: Allow reimbursement \$10.75

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