

**INDEPENDENT BILLING REVIEW FINAL DETERMINATION**

November 24, 2014

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

<b>IBR Case Number:</b>	CB14-0000531	<b>Date of Injury:</b>	03/20/2006
<b>Claim Number:</b>	[REDACTED]	<b>Application Received:</b>	04/03/2014
<b>Claims Administrator:</b>	[REDACTED]	<b>Assignment Date:</b>	06/20/2014
<b>Provider Name:</b>	[REDACTED]		
<b>Employee Name:</b>	[REDACTED]		
<b>Disputed Codes:</b>	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 \$1519.60 in additional reimbursement for a total of \$1769.60. A detailed explanation of the decision is provided later in this letter.**

The Claim Administrator is required to reimburse the Provider a total of \$1769.60 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]  
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: None
- National Correct Coding Initiatives
- Medicare and Medicaid Services (CMS) Outpatient Prospective Payment System (OPPS)
- Other: HOPPS Addendum B, January 2013

## 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 29826.
- Claims Administrator denied code indicating on the Explanation of Review “No payment is being made as none is necessarily owed.”
- Pursuant to Labor Code section 5307.1(g)(2), the Acting Administrative Director of the Division of Workers’ Compensation orders that Title 8, California Code of Regulations, sections 9789.30 through 9789.39, pertaining to Hospital Outpatient Departments and Ambulatory Surgical Centers Fee Schedule in the Official Medical Fee Schedule, are adjusted to conform to the hospital outpatient prospective payment system (HOPPS) final rule of November 15, 2012, the wage index values in the hospital inpatient prospective payment system (IPPS) final rule of August 31, 2012, and corrections to the IPPS final rule published on October 3, 2012 and October 29, 2012 in the Federal Register which change the Medicare payment system. For services rendered on or after January 1, 2013: APC relative weight x adjusted conversion factor x 1.22 workers’ compensation multiplier for hospital outpatient departments and 0.82 workers’ compensation multiplier for ambulatory surgical centers, pursuant to Section 9789.30(x).
- Code 29826 has a status indicator of T for 2013. Status indicator T - Significant procedure, multiple reduction applies paid under OPPS.

- Payment is based on Hospital Outpatient Department (HOD) – 84.13 Adjusted CF x 29.6106 APC RW x 1.22 = 3039.19. Multiple surgery cascade is applied at 50% of allowed amount. Reimbursement is allowed in the amount \$1519.60.

The table below describes the pertinent claim line information.

**DETERMINATION OF ISSUE IN DISPUTE: Based on Outpatient Prospective Payment System, reimbursement of code 29826 is warranted.**

Date of Service: 11/19/2013						
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Multiple Surgery	Workers' Comp Allowed Amt.	Notes
29826	\$37151.50	\$5702.18	\$1519.60	50%	\$ 1519.60	<b>DISPUTED SERVICE:</b> Allow reimbursement \$1519.60

Copy to:

  
  
  


Copy to:

  
  
