

MAXIMUS FEDERAL SERVICES, INC.

Independent Bill Review
P.O. Box 138006
Sacramento, CA 95813-8006
Fax: (916) 605-4280



INDEPENDENT BILLING REVIEW FINAL DETERMINATION

January 14, 2015

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

IBR Case Number:	CB14-0001637	Date of Injury:	04/16/2012
Claim Number:	[Redacted]	Application Received:	10/31/2014
Claims Administrator:	[Redacted]		
Date(s) of service:	[Redacted]		
Provider Name:	[Redacted]		
Employee Name:	[Redacted]		
Disputed Codes:	29880-LT		

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.

Case Assigned: 11/17/2014

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 \$1224.42 in additional reimbursement for a total of \$1474.42. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of \$1474.42 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]
[Redacted]

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 code 29880
- Claims administrator reimbursed \$2351.59 indicating on the Explanation of Review “Charge for this procedure exceeds the OPSS schedule allowance.”
- The Administrative Director incorporates by reference, the Centers for Medicare and Medicaid Services' (CMS) Hospital Outpatient Prospective Payment System (HOPPS) certain addenda published in the Federal Register notices announcing revisions in the Medicare payment rates. See Section 9789.39(b) for the adopted payment system addenda by date of service.
- (b) For services rendered on or after July 15, 2005, the Administrative Director incorporates by reference, the Centers for Medicare and Medicaid Services' (CMS) Hospital Inpatient Prospective Payment Systems (IPPS) certain tables published in the Federal Register notices announcing revisions in the Medicare payment rates. See Section 9789.39(b) for the adopted payment system tables by date of service
- For services rendered on or after January 1, 2013: APC relative weight x adjusted conversion factor x 1.22 workers' compensation multiplier for non-listed hospital outpatient departments and 0.82 workers' compensation multiplier for ambulatory surgical centers, pursuant to Section 9789.30(x).

- Provider billed charge on a UB04 form with provider number which is to be calculated as an outpatient facility not as an ambulatory surgery center.
- Based on information reviewed, additional reimbursement of code 29880 is warranted.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Additional reimbursement of code 29880 is recommended.

Date of Service: 12/3/2013						
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Multiple Surgery	Workers' Comp Allowed Amt.	Notes
29880	\$15555.00	\$2351.59	\$1224.42	N/A	\$3576.007	DISPUTED SERVICE: Allow reimbursement \$1224.42

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