

MAXIMUS FEDERAL SERVICES, INC.

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



INDEPENDENT BILLING REVIEW FINAL DETERMINATION

February 9, 2015

[Redacted]
[Redacted]
[Redacted]

IBR Case Number:	CB14-0001684	Date of Injury:	04/22/2014
Claim Number:	[Redacted]	Application Received:	11/10/2014
Claims Administrator:	[Redacted]		
Date(s) of service:	08/01/2014 – 08/01/2014		
Provider Name:	[Redacted]		
Employee Name:	[Redacted]		
Disputed Codes:	29827, 29821-51, 29826-51		

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 \$372.58 in additional reimbursement for a total of \$622.58. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of \$622.58 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, M.D., M.P.H.
Medical Director

cc: [Redacted]
Division of Workers’ Compensation (DWC) Medical Unit

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: 90% OMFS
- 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 seeking review of APC payment and Contractual Agreement rates for 29827 Arthroscopy, shoulder, with rotator cuff repair, 29821-51 Arthroscopy, shoulder, surgical; synovectomy complete & 29826-51 Arthroscopy, shoulder surgical decompression of subacromial space with partial acromioplasty with carocoacromial ligament release performed on 08/01/2014.
- EOR 10/24/2014 calculations appear to be based on Addendum B CY 2013 weights.
- Title 8, OMFS Effective 4/1/2013, §9789.39 Addendum B for services occurring on or after 04/01/2013.
- Date of service is 08/01/2014
- CPT 29826-51 Addendum B CY 2014 for services on or after 04/01/2013 reflects a status indicator of “N” and there is no separate payment; there is no weight reflected.
- Status indicator of ‘N’ indicates services are bundled into payment of another services performed on the same day.
- Claims Administrator based payment of CPT 29826-51 on Addendum B CY 2013; Calculations, including PPO discount are correct for this fee schedule. Additional reimbursement is not warranted.
- Based on the aforementioned documentation and guidelines, additional reimbursement is warranted for 29821-51 & 29827 based on Addendum B CY 2014 pursuant to §9789.39 of the OMFS for services occurring on or after 04/01/2013.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Reimbursement of code 29827, 29821-51 & 29826-51.

Date of Service: 8/01/2014						
Ambulatory Services						
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Units	Workers' Comp Allowed Amt.	Notes
29827	\$3,866.17	\$3,230.51	\$248.05	1	\$3,479.55	90% PPO Contract \$248.05 Disputed Amount Due Provider
29821-51	\$1,933.09	\$1,615.26	\$124.53	1	\$1,739.78	90% PPO Contract \$124.53 Disputed Amount Due Provider
29826-51	\$1,933.09	\$879.02	\$860.77	1	\$860.77	Additional Reimbursement not Warranted – Refer to Analysis.

Copy to:

[REDACTED]
[REDACTED]
[REDACTED]

Copy to:

Division of Workers' Compensation Medical Unit
1515 Clay Street, 18th Floor
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