

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 23, 2015

[REDACTED]
[REDACTED]
[REDACTED]

IBR Case Number:	CB14-0001687	Date of Injury:	07/22/2014
Claim Number:	[REDACTED]	Application Received:	11/10/2014
Claims Administrator:	[REDACTED]		
Date(s) of service:	07/22/2014 – 07/22/2014		
Provider Name:	[REDACTED]		
Employee Name:	[REDACTED]		
Disputed Codes:	15100, 14040-51, 15004-51, 11750-51 and 29130-51		

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 \$542.77 in additional reimbursement for a total of \$792.77. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of \$792.77 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: PPO contract discount 10%
- 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 codes 15100, 14040-51, 15004-51, 11750-51 and 29130-51
- Provider denied code 29130-51 indicating on the Explanation of Review “In accordance with clinical based coding edits (National Correct Coding Initiative/Outpatient code editor) component codes of comprehensive surgery; musculoskeletal system procedure (20000-29999) has been disallowed.”
- Per ASC payment information, CPT 29130 is a packaged service/item and is not reimbursed in a separate payment. Claims administrator was correct to deny code 29130.
- 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)
- PPO contract discount of 10% is to be applied to reimbursed codes.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Reimbursement of codes 15100, 14040-51 and 15004-51 is warranted.

Date of Service: 07/22/2014						
Outpatient Hospital Surgical Services						
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Multiple Surgery	Workers' Comp Allowed Amt.	Notes
15100	\$2051.97	\$1267.02	\$579.76	100%	\$1705.49	DISPUTED SERVICE: Allow reimbursement \$438.47
14040-51	\$622.36	\$462.74	\$97.39	50%	\$517.28	DISPUTED SERVICE: Allow reimbursement \$54.54
15004	\$185.82	\$104.69	\$62.55	50%	\$154.45	DISPUTED SERVICE: Allow reimbursement \$49.76
11750	\$144.69	\$130.22	\$14.47	N/A	\$106.57	DISPUTED SERVICE: No reimbursement recommended
29130	\$50.70	\$0.00	\$50.70	N/A	\$0.00	DISPUTED SERVICE: Packaged service; Not a separate payment

Copy to:

[REDACTED]
[REDACTED]
[REDACTED]

Copy to:

[REDACTED]
[REDACTED]
[REDACTED]