

MAXIMUS FEDERAL SERVICES, INC.

Independent Bill Review
P.O. Box 138006
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Fax: (916) 605-4280



INDEPENDENT BILLING REVIEW FINAL DETERMINATION

January 23, 2015

[Redacted]
[Redacted]
[Redacted]

IBR Case Number:	CB14-0001690	Date of Injury:	09/26/2013
Claim Number:	[Redacted]	Application Received:	11/10/2014
Claims Administrator:	[Redacted]		
Assigned Date:	12/10/2014		
Provider Name:	[Redacted]		
Employee Name:	[Redacted]		
Disputed Codes:	26418, 29130 and 99199		

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 \$127.94 in additional reimbursement for a total of \$377.94. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of \$377.94 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 Discount 5%
- 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 26418, 29130 and 99199
- Claims administrator reimbursed claim indicating on the Explanation of Review “The Official Medical Fee Schedule does not list this code. An allowance has been made for a comparable service.”
- 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. Table A in Section 9789.34 contains an "adjusted conversion factor" which incorporates the standard conversion factor, wage index and inflation factor. The maximum payment rate for ASCs and non-listed hospitals can be determined as follows: 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).
- CPT 99199 was denied by claims administrator stating “A charge was made for a “separate procedure” that does not meet the criteria for separate payment. See Physician’s Fee Schedule General Instructions for separate procedures rule.” Based on this rule, claims administrator was correct in denying code 99199 as it does not warrant reimbursement.
- PPO contract received shows a 5% discount is to be applied to reimbursement.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Reimbursement of code 26415 is recommended.

Date of Service: 09/26/2013						
Hospital Outpatient Surgical Services						
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Multiple Surgery	Workers' Comp Allowed Amt.	Notes
26415	\$1085.06	\$868.05	\$217.01	100%	\$995.99	DISPUTED SERVICE: Allow reimbursement \$127.94
29130	\$71.17	\$39.91	\$31.26	50%	\$33.81	DISPUTED SERVICE: No reimbursement recommended
99199	\$395.00	\$0.00	\$395.00	N/A	\$0.00	DISPUTED SERVICE: No reimbursement recommended

Copy to:

[REDACTED]

Copy to:

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