

**MAXIMUS FEDERAL SERVICES, INC.**

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



**INDEPENDENT BILLING REVIEW FINAL DETERMINATION**

March 9, 2015

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

IBR Case Number:	CB14-0001872	Date of Injury:	05/02/2014
Claim Number:	[REDACTED]	Application Received:	12/05/2014
Claims Administrator:	[REDACTED]		
Assigned Date:	1/5/2015		
Provider Name:	[REDACTED]		
Employee Name:	[REDACTED]		
Disputed Codes:	27822-LT, 64445-LT-59, 64448-LT-59, 93005-59		

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 \$4713.72 in additional reimbursement for a total of \$4963.72. A detailed explanation of the decision is provided later in this letter.**

The Claim Administrator is required to reimburse the Provider a total of \$4963.72 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, MD, MPH  
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 27822-LT, 64445-LT-59, 64448-LT-59, 93005-59
- Claims administrator reimbursed \$1579.85 indicating on the Explanation of Review “This bill has been re-priced according to your PPO contract”
- Based on review of the operative report, 64445-LT-59 and 64448-LT-59 were performed during the surgical procedure 27822-LT.
- Pursuant CMS NCCI edits; the physician should not report COT codes 00100-01999, 62310-62319, or 64400-64530 for anesthesia for a procedure. Additionally, the physician should not unbundle the anesthesia procedure and report component codes individually. Therefore, reimbursement of codes 64445 and 64448 is not warranted.
- Billed CPT code 93005-59 was reimbursed per the Physician Fee Schedule for Facilities and no further reimbursement is warranted.
- 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, pursuant to Section 9789.30(x).
- 27822 does indeed have a Relative Weight of 52.78 along with the hospital’s conversion factor of 98.99 and OPPS multiplier 1.22 totaling \$6374.12.

- A PPO discount of 5% is to be applied to reimbursement for a total of \$6055.42 for code 27822.
- Based on information reviewed, additional reimbursement of code 27822 is warranted.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Additional reimbursement of code 27822-LT is recommended.

Date of Service: 5/13/2014						
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Multiple Surgery	Workers' Comp Allowed Amt.	Notes
27822-LT	\$29222.00	\$1341.70	\$6055.41	N/A	\$6055.41	<b>DISPUTED SERVICE:</b> Allow reimbursement \$4713.72
93005-59	\$459.00	\$9.55	\$33.31	N/A	\$9.55	<b>DISPUTED SERVICE:</b> No reimbursement recommended
64445	\$1079.50	\$0.00	\$0.00	N/A	\$0.00	<b>DISPUTED SERVICE:</b> No reimbursement recommended
64448	\$1859.50	\$0.00	\$0.00	N/A	\$0.00	<b>DISPUTED SERVICE:</b> No reimbursement recommended

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