

**MAXIMUS FEDERAL SERVICES, INC.**

Independent Bill Review  
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**INDEPENDENT BILLING REVIEW FINAL DETERMINATION**

May 5, 2015

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

IBR Case Number:	CB15-0000192	Date of Injury:	05/11/2012
Claim Number:	[REDACTED]	Application Received:	02/12/2015
Claims Administrator:	[REDACTED]		
Date Assigned:	3/9/2015		
Provider Name:	[REDACTED]		
Employee Name:	[REDACTED]		
Disputed Codes:	29888, 29881 and L1830		

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 \$195.00 for the review cost and \$330.43 in additional reimbursement for a total of \$525.43. A detailed explanation of the decision is provided later in this letter.**

The Claim Administrator is required to reimburse the Provider a total of \$525.43 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 3%
- 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 29888, 29881 and L1830.
- Both codes 29888 and 29881 have Status Indicators ‘T’ which states: Procedure, Multiple Reduction Applies. Paid under OPPS; Separate APC payment.
- 29888 was reimbursed based on  $RW = 82.2078 \times CF = 80.45 \times 1.22 = \$8068.61$  x PPO discount 3% = \$7826.55. Provider was reimbursed \$8068.61 and therefore, no further reimbursement is warranted.
- Claims Administrator reimbursed code 29881 \$1079.10 indicating on the Explanation of Review “The Hospital Outpatient Allowance was calculated as required under section 9789.33 of Title 8, CCR Labor Code 5307.1.”
- 29881 - Arthroscopy, knee, surgical; with meniscectomy (medial OR lateral, including any meniscal shaving) including debridement/shaving of articular cartilage (chondroplasty), same or separate compartment(s), when performed.
- Based on calculation for OPPS for code 29881:  $RW = 29.6106 \times CF = 80.45 \times 1.22 = \$1453.13$ . PPO contract discount of 3% = \$1409.54 – payment of \$1079.10 = \$330.44 due for code 29881.
- Provider billed DME code L1830 - Ko immob canvas long pre ots; **Services furnished to a hospital outpatient that are paid under a fee schedule or payment system other than OPPS**

