

INDEPENDENT BILLING REVIEW FINAL DETERMINATION

October 9, 2015

[Redacted]
[Redacted]
[Redacted]

IBR Case Number:	CB15-0001649	Date of Injury:	05/07/2014
Claim Number:	[Redacted]	Application Received:	09/15/2015
Assignment Date:	10/07/2015		
Claims Administrator:	[Redacted]		
Date(s) of service:	01/27/2105 – 01/27/2015		
Provider Name:	[Redacted]		
Employee Name:	[Redacted]		
Disputed Codes:	27625, 27698, 28086, and 28300		

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 \$408.35 in additional reimbursement for a total of \$603.35. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of **\$603.35** 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]
[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
- PPO Contract

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 remuneration for 27625, 27698, 28086, and 28300 Physician Services performed on 01/27/2015.**
- **CCR § 9789.30**, subsections (a) adjusted conversion factor, (e) APC payment rate, (f) APC relative weight, (j) Facility Only Services, (q) labor-related share, (r) market basket inflation factor, and (z) wage index, are adjusted to conform to the Medicare hospital outpatient prospective payment system (HOPPS) final rule of December 10, 2013, the relative values in the **2014** Medicare Physician fee schedule, and the wage index values in the Medicare IPSP final rule of August 19, 2013, and associated rules and notices to the IPSP final rule published in the Federal Register.
- The Claims Administrator reimbursed CPT Codes 27698, 28086, and 28300 with the following rationale: “A PPO reduction was made for this bill and/or the bill was repriced according to a negotiated rate.”
- **CCR § 5307.11**: A health care provider or health facility licensed pursuant to Section 1250 of the Health and Safety Code, and a contracting agent, employer, or carrier may contract for reimbursement rates different from those in the fee schedule adopted and revised pursuant to Section 5307.1. When a health care provider or health facility licensed pursuant to Section 1250 of the Health and Safety Code, and a contracting agent, employer, or carrier contract for reimbursement rates different from those in the fee schedule, the medical fee schedule for that health care provider or health facility licensed pursuant to Section 1250 of the Health and Safety Code shall not apply to the contracted reimbursement rates.
- Contractual Agreement was not submitted for IBR As such, contractual terms cannot be verified for CPT 27698, 28086, and 28300; reimbursement upheld.
- The Claims Administrator denied reimbursement for 27625-59 pending documentation.
- Provider seeking \$408.35 of \$2,400.00 for CPT 27625-59.
- NCCI Edits indicate 27625 is a Colum 2 code to Colum 1 Code 27698.
 - Operative report reviewed.
 - Procedures performed at the same anatomical site. However, the Provider performed two distinctly separate procedures, each separately incised and separately closed.
 - The appropriate modifier, modifier -59 was utilized and is reflected on the CMS-1500.
 - Reimbursement is warranted for 27625-59, MPPR applies.
- **Based on the aforementioned documentation and guidelines, reimbursement for is indicated for 27625-59 and is upheld for 27698, 28086, and 28300.**

The table below describes the pertinent claim line information.

