

**MAXIMUS FEDERAL SERVICES, INC.**

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



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**INDEPENDENT BILLING REVIEW FINAL DETERMINATION**

June 3, 2015



IBR Case Number:	CB15-0000330	Date of Injury:	2/5/2014
Claim Number:	[REDACTED]	Application Received:	3/9/2015
Claims Administrator:	[REDACTED]		
Assigned Date:	4/9/2015		
Provider Name:	[REDACTED]		
Employee Name:	[REDACTED]		
Disputed Codes:	29876- RT, 29881 - RT		

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 \$225.94 in additional reimbursement for a total of \$420.94. A detailed explanation of the decision is provided later in this letter.**

The Claim Administrator is required to reimburse the Provider a total of \$420.94 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,

Paul Manchester, MD MPH

Medical Director

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cc:



## 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
- National Correct Coding Initiatives
- Medicare and Medicaid Services (CMS) Outpatient Prospective Payment System (OPPS)
- Other: OMFS Outpatient Hospital Fee Schedule

## 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: Reimbursement of CPT 29876-RT and 29881-RT.**
- Provider billed the disputed CPT codes on a UB04, bill type 131 for date of service 6/13/2014.
- Claims Administrator reimbursement rationale: "The charge exceeds the Official Medical Fee Schedule allowance."
- Based on the provider type, the reimbursement for services is calculated on the Centers for Medicare and Medicaid Services (CMS) Outpatient Prospective Payment System (OPPS). Procedures are assigned APC weights and "Proposed Payment Status Indicators." The surgical HCPCS code 29876 and 29881 have an assigned indicator of "T". The "T" indicator definition is "Significant procedure, multiple procedure reduction applies" and qualifies for separate APC payment.
- UB-04 reflects one line item billed as 29876-RT and 29881-RT.
- The Operative Report documented "Right knee arthroscopy with medial meniscectomy; synovectomy; chondroplasty patella and aspiration of the prepatellar bursa."
- Per submitted contract, workers' compensation services are reimbursed at the lesser of 125% Medicare fee schedule or 95% of maximum allowable rate as specified by state."

- Based on the aforementioned documentation and guidelines, additional reimbursement is indicated for 29876-RT.
- Additional reimbursement calculated based on 95% of the OMFS allowance.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Recommended reimbursement of code 29876-RT and 29881-RT.

Date of Service: 6/13/2014						
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Multiple Surgery	Workers' Comp Allowed Amt.	Notes
29876-RT	\$3380.00	\$2535.00	\$1987.73	100%	\$2760.94	<b>DISPUTED SERVICE:</b> See Analysis. Additional Reimbursement of \$225.94 recommended
29881-RT	\$ 3380.00	\$ 1380.47	\$ 1987.74	50%	\$ 1380.47	<b>DISPUTED SERVICE:</b> No additional reimbursement due, Claims Administrator reimbursed 95% OMFS

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