

MAXIMUS FEDERAL SERVICES, INC.

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



INDEPENDENT BILLING REVIEW FINAL DETERMINATION

January 21, 2016

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

| | | | |
|-----------------------|-------------------------|-----------------------|------------|
| IBR Case Number: | CB15-0002319 | Date of Injury: | 10/07/2013 |
| Claim Number: | [REDACTED] | Application Received: | 12/23/2015 |
| Claims Administrator: | [REDACTED] | | |
| Date(s) of service: | 10/21/2015 – 10/21/2015 | | |
| Provider Name: | [REDACTED] | | |
| Employee Name: | [REDACTED] | | |
| Disputed Codes: | 88300, 27726, and 29896 | | |

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 \$5,743.46 in additional reimbursement for a total of \$5,938.46. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of **\$5,938.46** 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
- OMFS

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 88300, 27726, and 29896 for date of service 10/21/2015.**
- The Claims Administrator denied charges with the following rationale:
 - 11/13/2015 Letter from Claim Administrator stating “not deemed medical necessity.”
 - 11/24/2015 EOR indicates invalid diagnosis indicator
- **SBR indicates the following codes in dispute: 88300, 27726, and 29896.**
- UB-04 diagnosis indicates: S82.62XP Displaced fracture of lateral malleolus of left fibula, subsequent encounter for closed fracture with malunion.
- Authorization signed by the claims administrator indicates the following services relating to claim as “approved” and “medically necessary”:
 - 27620 Arthrotomy, ankle, with joint exploration, with or without biopsy, with or without removal of loose or foreign body.
 - 28320 Repair, nonunion or malunion; tarsal bones
 - 20900, Bone graft, any donor area; minor or small (eg, dowel or button)
 - 29898 Arthroscopy, ankle (tibiotalar and fibulotalar joints), surgical; debridement, extensive
- 29896 Deleted Code. Deleted on 03/01/1990 - Code listed on SBR, Opportunity to Dispute Eligibly and Assignment Letter; Determination Upheld.
- Approved services and Operative Note reflects 27726 Repair of fibula nonunion and/or malunion with internal fixation and 88300, Status Indicator “X” Level i - surgical pathology, gross examination only.
- OMFS Update for Hospital Outpatient and Ambulatory Surgical Center (ASC) Services
- Effective December 1, 2014, For services rendered on or after December 1, 2014, section 9789.31, subsections (a) and (b) are amended to incorporate by reference selected sections of the updated calendar year 2014 version of CMS’ hospital outpatient prospective payment system (HOPPS) published in the Federal Register on December 10, 2013, the updated fiscal year **2014** versions of CMS’ IPPS Tables 2, 4A, 4B, 4C, and 4J in the final rule of August 19, **2013** and associated rules and notices to the IPPS final rule, respectively
- **CCR § 9789.33**, For services rendered on or after September 1, 2014, Status Indicators; “S”, “T”, “X”, or “V”, “Q1,” Q2,” or “Q3” must qualify for separate payment.” must qualify for separate payment. APC relative weight x adjusted conversion factor x 1.212 workers’ compensation multiplier, pursuant to Section 9789.30(aa). See Section 9789.39(b) for the APC relative weight by date of service.
- **CCR § 9789.32 (c) (B) (i)** If the Other Service has a Professional Component/Technical Component under the OMFS RBRVS, the hospital outpatient facility fee shall be the **Technical Component** amount determined according to the OMFS RBRVS.
- **Based on the aforementioned documentation and guidelines, reimbursement is indicated for 88300 (TC) and 27726, and is not indicated for 29896.**

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: 88300, 27726, and 29896

| Date of Service: 10/21/2015 | | | | | | |
|------------------------------------|------------------------|---------------------|-----------------------|--------------|-----------------------------------|--------------------------|
| HOPPS, ASC | | | | | | |
| Service Code | Provider Billed | Plan Allowed | Dispute Amount | Units | Workers' Comp Allowed Amt. | Notes |
| 88300 | \$1,268.00 | \$0.00 | \$13.88 | 1 | \$12.37 | Refer to Analysis |
| 27726 | \$29,963.80 | \$0.00 | \$5,731.09 | 1 | \$5,731.09 | Refer to Analysis |
| 29896 | N/A | \$0.00 | \$1,497.56 | 1 | \$0.00 | Refer to Analysis |

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