

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 2, 2016

[Redacted]
[Redacted]
[Redacted]

IBR Case Number:	CB16-0000188	Date of Injury:	09/18/2008
Claim Number:	[Redacted]	Application Received:	02/09/2016
Claims Administrator:	[Redacted]		
Date(s) of service:	07/01/2015		
Provider Name:	[Redacted]		
Employee Name:	[Redacted]		
Disputed Codes:	27702		

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 \$4,606.60 in additional reimbursement for a total of \$4,801.60. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of \$4,801.60 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

[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:
- 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 seeking remuneration of 27702 performed on date of service 07/01/2015
- Claims Administrator denied code with rationale “Service is only reimbursed on an inpatient basis”
- RFA not submitted for review.
- Communication from Claims Administrator to Provider authorizing service “Right total ankle replacement” faxed to Provider on 6/24/2015. Specific code to be billed on documented.
- Billed code 27702 has a status indicator ‘C’ inpatient code only for 2014.
- Provider’s report documents ankle arthroplasty performed on 7/1/2015.
- § 9789.32 (e) Hospital outpatient departments and ambulatory surgical centers shall not be reimbursed for procedures on the inpatient only list, referenced in Section 9789.31(a), Addendum E, except that pre-authorized services rendered are payable at the pre-negotiated fee arrangement. The pre-authorization must be provided by an authorized agent of the claims administrator to the provider. **The fee agreement and pre-authorization must be memorialized in writing prior to performing the medical services.** The fee agreement and pre-authorization must be memorialized in writing prior to performing the medical services.

- (f) Critical access hospitals and hospitals that are excluded from acute PPS are exempt from this fee schedule.
- (g) Out of state hospital outpatient departments and ambulatory surgical centers are exempt from this fee schedule.
- (h) Hospital outpatient departments and ambulatory surgical centers billing for facility fees and other services under this Section shall be submitted in accordance with the e-billing regulations beginning with Section 9792.5.0 or the standardized paper billing regulations beginning with Section 9792.5.2. Reimbursement for code 27700 is warranted.
- A pre-negotiated fee arrangement was not identified in review. Therefore, reimbursement is based upon comparable code 27700 with weight 42.9663.
- Based on aforementioned guidelines, reimbursement of 27702 is warranted.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Reimbursement of code 27702

Date of Service: 07/01/2015					
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Workers' Comp Allowed Amt.	Notes
27702	\$167,640.80	\$629.56	\$48,837.10	\$5,236.16	\$4606.60 Due to Provider

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]