INDEPENDENT BILLING REVIEW FINAL DETERMINATION

December 30, 2014

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 Claim Administrator’s determination is reversed and the Claim Administrator owes the Provider additional reimbursement of $250.00 for the review cost and $367.80 in additional reimbursement for a total of $617.79. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of $617.79 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,

[Name]
Medical Director

cc: [Name]
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
- Medicare and Medicaid Services (CMS) Outpatient Prospective Payment System (OPPS)
- NCCI Edits V. 20.0 (1/1/2014-3/31/2014)

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 64483-L4, 64484-L5, 64484-S1, & 01936 Ambulatory Surgical Services performed on Injured Worker 02/27/2014.
- Claims Administrator reimbursement rational for CPT 01936 and CPT 64483-L4 indicated “Per CCI Edits, The Value of This Procedure is Included in the Value of the Comprehensive Procedure.”
- Based on the NCCI edits Code 1936, is a status indicator “N” and is “Packaged into payment for other services – no separate APC Payment.”
- Operative Note indicates 64483-L4 is the Primary Procedure.
- CPT 64483-L4 has a status “T” indicator indicating separate APC payment allowed.
- Claims Administrator reimbursement rational for CPT Codes 64484-L5 & 64484-S1: “This add-on code has been denied as the principal procedure was not billed.”
- CPT 64484-L4-S1 are add-on codes to parent code 64483-L4 and are separately reimbursable.

The table below describes the pertinent claim line information.

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<th>Date of Service</th>
<th>Service Code</th>
<th>Provider</th>
<th>Plan Allowed</th>
<th>Dispute Amount</th>
<th>Units</th>
<th>Workers’ Comp</th>
<th>Notes</th>
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</thead>
</table>

DETERMINATION OF ISSUE IN DISPUTE: Reimbursement of code
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<th>Item</th>
<th>Cost</th>
<th>Deduction</th>
<th>Total</th>
<th>Quantity</th>
<th>Amount</th>
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