MAXIMUS FEDERAL SERVICES, INC.
Independent Bill Review
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Independent Bill Review Final Determination Upheld

3/28/2014

[redacted]

Re: Claim Number: [redacted]
Claims Administrator name: [redacted]
Date of Disputed Services: 5/21/2013 – 5/21/2013
MAXIMUS IBR Case: CB13-0000490

Dear [redacted]

Determination
A Request for Independent Bill Review (IBR) was assigned to MAXIMUS Federal Services on 12/20/2013, by the Administrative Director of the California Division of Workers' Compensation pursuant to California Labor Code section 4603.6. MAXIMUS Federal Services has determined that the **Claims Administrator's determination is upheld.** This determination finds that the Claims Administrator does not owe the Provider additional reimbursement.

Pertinent Records and Other Appropriate Information Relevant to the Determination Reviewed:
The following evidence was used to support the decision:

- 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
- Other: OMFS Outpatient Hospital Fee Schedule

Supporting Analysis:
The dispute regards the payment for surgical facility services on date of service 5/21/2013. The facility services were billed on a UB-04/CMS1450 using revenue codes for services and supplies related to a distal radius facture. The Provider billed CPT codes: 25608 and 29125; and HCPCS codes: L8699 and C9399. The Claims Administrator allowed reimbursement of $4,042.30 for the facility services with the explanation "The charge exceeds the Official Medical Fee Schedule allowance and has been adjusted to the schedule."

The Provider is disputing the denial of HCPCS L8699 and C9399 and is requesting an additional allowance of $1,500.00.

CPT 25608 - Open treatment of distal radial intra-articular fracture or epiphyseal separation; with internal fixation of 2 fragments
CPT 29125 - Application of short arm splint (forearm to hand); static
HCPCS L8699 - Prosthetic implant, not otherwise specified
HCPCS C9399 - Unclassified drugs or biologicals

Pursuant to Labor Code section 5307.1(g)(2), the Administrative Director of the Division of Workers' Compensation orders that Title 8, California Code of Regulations, sections 9789.30 and 9789.31, pertaining to Hospital Outpatient Departments and Ambulatory Surgical Centers Fee Schedule in the Official Medical Fee Schedule, is amended to conform to CMS' hospital outpatient prospective payment system (OPPS). The Administrative Director incorporates by reference, the Centers for Medicare and Medicaid Services' (CMS) Hospital Outpatient Prospective Payment System (OPPS) certain addenda published in the Federal Register notices announcing revisions in the Medicare payment rates. The adopted payment system addenda by date of service are found in the Title 8, California Code of Regulations, Section 9789.39(b). Based on the adoption of the CMS hospital outpatient prospective payment system (OPPS), CMS coding guidelines and the hospital outpatient prospective payment system (OPPS) was referenced during the review of this Independent Bill Review (IBR) case.

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 billed HCPCS L8699 has an assigned indicator of "N." The "N" indicator definition is "Payment is packaged into payment for other services, including outliers. Therefore, there is no separate APC payment." Procedure codes with an assigned status indicator of "N" and are considered an integral part of the surgical procedure are not separately payable.

The HCPCS C9399 is an unlisted HCPCS code with the description "unclassified drug or biological". Per the OMFS Outpatient Hospital Fee Schedule, anesthesia, certain drugs, biologicals, and other pharmaceuticals; medical and surgical supplies and equipment integral to performing a procedure are included in the payment rate of the procedure. The services or supplies billed under HCPCS C9399 were described as "cadaver cancellus bone chips." An invoice for the "cadaver cancellus bone chips" was not provided as part of the documentation. Costs incurred to procure donor tissue are included in the surgical procedure allowance. Based on the documentation, no additional reimbursement is recommended for the billed HCPCS code C9399.

There is no additional allowance recommended for the Official Medical Fee Schedule codes HCPCS L8699 and C9399.

The chart below provides a comparison of billed charges and reimbursement rates for the codes and dates of services at issue.

Validated Code	Validated Units	Dispute Amount	Total Fee Schedule Allowance	Provider Paid Amount	Allowed Recommended Reimbursement	Fee Schedule Utilized
L8699	1	$1100.00	$0.00	$0.00	$0.00	OMFS
C9399	1	$400.00	$0.00	$0.00	$0.00	OMFS

Chief Coding Specialist Decision Rationale:
This decision was based on OMFS Outpatient Hospital Fee Schedule and comparison with explanation of review (EOR). This was determined correctly by the Claims Administrator and the payment of $0.00 is upheld.

This decision constitutes the final determination of the Division of Workers' Compensation Administrative Director, is binding on all parties, and is not subject to further appeal except as specified in Labor Code section 4603.6(f)

Sincerely,

[redacted], RHIT

Copy to:
[redacted]

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