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

INDEPENDENT BILLING REVIEW FINAL DETERMINATION

December 31, 2014

[redacted]

IBR Case Number:	CB14-0001036	**Date of Injury:**	05/09/2012
Claim Number:	[redacted]	**Application Received:**	07/24/2014
Claims Administrator:	[redacted]	**Assignment Date:**	10/01/2014
Provider Name:	[redacted]		
Employee Name:	[redacted]		
Disputed Codes:	L3670, 82962, 29823 and 29824		

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 $250.00 for the review cost and $3714.69 in additional reimbursement for a total of $3964.69. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of $3964.69 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,

[redacted]
Medical Director

cc: [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 is dissatisfied with codes L3670, 82962, 29823 and 29824
- Claims Administrator reimbursed outpatient procedures indicating on the Explanation of Review "This charge was adjusted to comply with the rate and rules of the contract indicated."
- CPT 82962 has an 'N' status indicator which states "Paid under OPPS; payment is packaged into payment for other services. Therefore, there is no separate APC payment." No separate reimbursement is recommended for code 82962.
- L3670 has a status indicator of 'A' which states "Paid by fiscal intermediaries/MACs under a fee schedule or payment system other than OPPS (Ambulance, Clinical lab, DMEPOS, etc.)". The maximum allowable fee for durable medical equipment, prosthetics and orthotics shall be determined according to Section 9789.60. Additional payment is warranted for HCPCS code L3670.
- The Administrative Director incorporates by reference, the Centers for Medicare and Medicaid Services' (CMS) Hospital Outpatient Prospective Payment System (HOPPS) certain addenda published in the Federal Register notices announcing revisions in the Medicare payment rates. See Section 9789.39(b) for the adopted payment system addenda by date of service. For services rendered on or after January 1, 2013: APC

payment rate x 1.22 workers' compensation multiplier for hospital outpatient departments and 0.82 workers' compensation multiplier for ambulatory surgical centers, pursuant to Section 9789.30(x).

- Both 29823 and 29824 are reimbursed separate APC payments and therefore additional reimbursement is warranted for these two CPT codes.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Additional reimbursement of codes L3670, 29823 and 29824 is warranted.

Date of Service: 3/13/2014						
DMEPOS and Outpatient Surgery Services						
Service Code	**Provider Billed**	**Plan Allowed**	**Dispute Amount**	**Multiple Surgery**	**Workers' Comp Allowed Amt.**	**Notes**
L3670	$150.00	$145.50	$9.07	N/A	$149.93	**DISPUTED SERVICE**: Allow reimbursement $4.43
29823 & 29824	$6793.52	$2879.45	$3914.46	Yes	$6589.71	**DISPUTED SERVICE**: Allow reimbursement $3710.26

Copy to:

[redacted]

Copy to:

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