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 24, 2014

[redacted]

IBR Case Number:	CB14-0000949	**Date of Injury:**	07/08/2008
Claim Number:	[redacted]	**Application Received:**	07/03/2014
Claims Administrator:	[redacted]	**Assignment Date:**	07/25/2014
Provider Name:	[redacted]		
Employee Name:	[redacted]		
Disputed Codes:	L5999 x 5		

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: UPHOLD. MAXIMUS Federal Services has determined that no additional reimbursement is warranted. The Claims Administrator's determination is upheld and the Claim Administrator does not owe the Provider additional reimbursement. A detailed explanation of the decision is provided later in this letter.

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

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 reimbursement of HCPCS code L5999, which is an unlisted code and not on the OMFS.
- Claims Administrator reimbursed $64404.88 indicating on the Explanation of Review "The PPO recommended allowance is in accordance with your [redacted] PPO contract."
- Documentation included authorization from Utilization Review Program which states: "Medical Treatment: Prosthetics-Right above knee prosthesis; Req Qty: 1; Auth Qty: 1; Decision: Approved; Decision Date: 12/09/2013." Also noted on the authorization "Any payments made will be reimbursed per the prevailing California Official Medical Fee Schedule (OMFS), or Contractual Agreement whichever is less. Payment is subject to applicable statutes and regulations, including, but not limited to, Labor Code §139.3 and 139.31 and California Business and Professions codes."
- Maximus requested a copy of the PPO contract. Provider submitted a one (1) page document of the PPO contract which Provider states: "Attached is a copy of our [redacted] contract wherein the possibility of an unlisted code is addressed. [redacted] reserves the right to price such a component, and we maintain that [redacted], as [redacted] agent, set the price when it authorized service to injured worker. All other fees would be paid per the established [redacted] rate. The authorization for the L5999 codes

established the fee for these unlisted codes. Any negotiation regarding payment of these codes should have happened at the time of authorization. That is when it was relevant."

- Authorization received does not establish any codes that were to be billed or cost to be reimbursed. Just the medical treatment is mentioned with the approval.
- Nothing was reviewed that shows evidence of procedure code L5999, along with the billed cost per code, being submitted to the Claims Administrator prior to the Utilization Review's authorization having been approved. No Request for Medical treatment was received to verify if the cost the Provider was expecting was established prior to the device being delivered.
- Based on lack of documentation to support the amount billed for L5999, additional reimbursement of L5999 is not warranted.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Reimbursement of code L5999 x 5 is not warranted.

Date of Service: 12/13/2013							
Durable Medical Equipment							
Service Code	**Provider Billed**	**Plan Allowed**	**Dispute Amount**	**Units**	**Multiple Surgery**	**Workers' Comp Allowed Amt.**	**Notes**
L5999	$115,524.82	$64,404.88	$30,400.00	5	N/A	$0.00	**DISPUTED SERVICE**: No additional reimbursement is recommended.

Copy to:

[redacted]

Copy to:

[redacted]