

MAXIMUS FEDERAL SERVICES, INC.

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



INDEPENDENT BILLING REVIEW FINAL DETERMINATION

October 1, 2015



IBR Case Number:	CB15-0001384	Date of Injury:	03/28/2014
Claim Number:	[REDACTED]	Application Received:	08/14/2015
Claims Administrator:	[REDACTED]		
Date(s) of service:	08/01/2014 – 08/07/2014		
Provider Name:	[REDACTED]		
Employee Name:	[REDACTED]		
Disputed Codes:	Revenue Code 413 (HCPCS C1300)		

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 \$1191.87 in additional reimbursement for a total of \$1386.87. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of \$1386.87 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

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cc:



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
- National Correct Coding Initiatives
- Medicare and Medicaid Services (CMS) Outpatient Prospective Payment System (OPPS)
- Other: OMFS Outpatient Hospital Fee Schedule

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 reimbursement for HCPCS C1300 for dates of service 8/1/-8/7/2014.**
- Provider billed the procedure codes as part of hospital service on a UB04 with bill type 131.
- The Claims Administrator denied the billed procedure code with the following explanation: According to the OMFS this service has a relative value of zero and therefore no payment is due.
- Title 8, CCR 9789.32(a) (a) Sections 9789.30 through 9789.39 shall be applicable to the maximum allowable fees for emergency room visits and surgical procedures rendered on or after July 1, 2004. For purposes of this section, emergency room visits shall be defined by CPT codes 99281-99285 and surgical procedures shall be defined by CPT codes 10021-69990.
 - (c) The maximum allowable fees for services, drugs and supplies furnished by hospitals and ambulatory surgical centers that do not meet the requirements in (a) for a facility fee payment and are not bundled in the APC payment rate for a surgical service or emergency room visit will be determined as follows:
 - (1) The maximum allowable fees for professional medical services which are performed by physicians and other licensed health care providers shall be paid according to Section 9789.10 and Section 9789.11.

- HCPCS C1300: Hyperbaric oxygen under pressure, full body chamber, per 30 minute interval
- Authorization documented “Approved Hyperbaric Treatment – 20 Treatments for compromised left leg 99183.”
- HCPCS C1300 is not listed on the Physician Fee Schedule (9789.10-9789.11).
- A comparable code based on the date of service, and fee schedule is CPT 99183.
- CPT 99183: Physician or other qualified health care professional attendance and supervision of hyperbaric oxygen therapy, per session
- Medical record included authorization for treatment, Hyperbaric Medicine Progress notes and Hospital Encounter notes for each billed date of service for hyperbaric treatment.
- Reimbursement is recommended for CPT 99183 for dates of service 8/1/2014, 8/4/2014, 8/5/2014, 8/6/2014 and 8/7/2014.

DETERMINATION OF ISSUE IN DISPUTE: Recommended reimbursement of code: CPT 99183 x 5.

Date of Service 8/1/2014 – 8/7/2014						
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Multiple Surgery	Workers' Comp Allowed Amt.	Notes
99183	\$ 16475.00	\$ 0.00	\$ 3075.80	N/A	\$ 1191.87	DISPUTED SERVICE: See Analysis.

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