

MAXIMUS FEDERAL SERVICES, INC.

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



INDEPENDENT BILLING REVIEW FINAL DETERMINATION

July 2, 2015

[Redacted]
[Redacted]
[Redacted]

IBR Case Number:	CB15-0000634	Date of Injury:	07/05/1993
Claim Number:	[Redacted]	Application Received:	04/24/2015
Claims Administrator:	[Redacted]		
Date Assigned:	5/21/2015		
Provider Name:	[Redacted]		
Employee Name:	[Redacted]		
Disputed Codes:	71020, 80048, 83880 & 85025		

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 \$34.25 in additional reimbursement for a total of \$229.25. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of \$229.25 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

cc: [Redacted]
[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 denial of codes 71020, 80048, 83880 & 85025
- Claims Administrator denied codes indicating on the Explanation of Review “
- 8 CCR 9789.32 - (a) Sections 9789.30 through 9789.38 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 10040-69990. A facility fee is payable only for the specified emergency room and surgical codes and for supplies, drugs, devices, blood products and biologicals that are an integral part of the emergency room visit or surgical procedure. A supply, drug, device, blood product and biological is considered an integral part of an emergency room visit or surgical procedure if: (1) the item has a status code N and is packaged into the APC payment for the emergency room visit or surgical procedure (in which case no additional fee is allowable) or, For services rendered on or after March 1, 2008: the item has a status code N or Q and is packaged into the APC payment for the emergency room visit or surgical procedure (in which case no additional fee is allowable)

- Codes 80048, 83880 & 85025 all have Status Indicators ‘N’, therefore, these codes are included in the APC payment for 99282 that was reimbursed. No further reimbursement is warranted for these codes.
- CPT 71020 has a Q3 status indicator.
- Status Indicator Q – packaged services subject to separate payment under OPSS payment criteria.
- Q3 - codes that may be paid through a composite APC Paid under OPSS; Addendum B displays APC assignments when services are separately payable. Addendum M displays composite APC assignments when codes are paid through a composite APC. (1) Composite APC payment based on OPSS composite-specific payment criteria. Payment is packaged into a single payment for specific combinations of service. (2) In all other circumstances, payment is made through a separate APC payment or packaged into payment for other services.
- APC 0260 is on Addendum B as separately payable and therefore, reimbursement is warranted for 71020

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Reimbursement of code 71020

Date of Service: 2/2/2015						
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Multiple Surgery	Workers' Comp Allowed Amt.	Notes
71020	\$1101.09	\$0.00	\$34.25	N/A	\$34.25	DISPUTED SERVICE: Allow reimbursement \$34.25

Copy to:

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