

MAXIMUS FEDERAL SERVICES, INC.

Independent Bill Review
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INDEPENDENT BILLING REVIEW FINAL DETERMINATION

July 7, 2015

[Redacted]

IBR Case Number:	CB15-000739	Date of Injury:	01/25/2003
Claim Number:	[Redacted]	Application Received:	05/12/20015
Claims Administrator:	[Redacted]		
Date(s) of service:	11/05/2014		
Provider Name:	[Redacted]		
Employee Name:	[Redacted]		
Disputed Codes:	63685		

[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 \$21,118.59 in additional reimbursement for a total of \$21,313.59. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of \$21,313.59 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 reimbursement of code 63685
- Claims Administrator reimbursed \$5,795.02 indicating on the Explanation of Review “This hospital outpatient allowance was calculated as required under section 9789.33 of Title 8, CCR labor code 5307.1”
- Section 9789.33. Determination of Maximum Reasonable Fee. (a) In accordance with section 9789.32, the maximum allowable payment for outpatient facility fees for hospital emergency room services, surgical services, or for Facility Only Services performed at a hospital outpatient department, or for surgical services performed at an ambulatory surgical center shall be determined based on the following. In accordance with Section 9789.30(aa), an extra percentage reimbursement shall be used in lieu of an additional payment for high cost outlier cases.
- For services rendered on or after September 1, 2014: Status Code Indicators “S”, “T”, “X”, or “V”, “Q1”, “Q2”, or “Q3”. Status code indicators “Q1”, “Q2”, and “Q3” must qualify for separate payment; Hospital Outpatient Department Services that are surgical procedures: APC relative weight x adjusted conversion factor x 1.212 workers’ compensation multiplier, pursuant to Section 9789.30(aa). See Section 9789.39(b) for the APC relative weight by date of service.
- 63685 has a status indicator of ‘S’ with a relative weight of 229.8982

