

MAXIMUS FEDERAL SERVICES, INC.

Independent Bill Review
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Fax: (916) 605-4280



INDEPENDENT BILLING REVIEW FINAL DETERMINATION

February 10, 2016

[Redacted]

| | | | |
|-----------------------|--------------------|-----------------------|------------|
| IBR Case Number: | CB16-0000050 | Date of Injury: | 07/20/2015 |
| Claim Number: | [Redacted] | Application Received: | 01/12/2016 |
| Claims Administrator: | [Redacted] | | |
| Date(s) of service: | 08/21/2015 | | |
| Provider Name: | [Redacted] | | |
| Employee Name: | [Redacted] | | |
| Disputed Codes: | 49650-LT and 49585 | | |

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 \$557.00 in additional reimbursement for a total of \$752.00. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of \$752.00 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

[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: PPO Contract 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 seeking additional reimbursement of \$557.00 per PPO contract agreement for services performed on 08/21/2015.
- Provider billed service codes 49650 and 49585 on a UB04 with bill type 131 for outpatient services.
- Claims Administrator reimbursed \$6138.00 with indication “Charge for this procedure exceeds the OPPS schedule allowance” and “Network adjustments applied”
- Communication from Claims Administrator to Provider dated 8/18/2015 documents “authorization” for 49605, repair of umbilical lesion, and 49585, repair of umbilical hernia, age 5 years or older; reducible.
- Operative Report submitted documents “Procedures: 1. Robotic-assisted left inguinal hernia repair with mesh, 2. Open umbilical hernia repair” which Provider details in his Description of Operation.
- PPO contract received details “PPO Rate” means the Lesser of one hundred percent (100%) of Facility’s Eligible Billed Charges for Health Services, or the total reimbursement amount that Facility and Company have agreed upon as specified in the Plan Compensation Schedule (“PCS”) attached hereto as Attachment 2.

