

**MAXIMUS FEDERAL SERVICES, INC.**

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



**INDEPENDENT BILLING REVIEW FINAL DETERMINATION**

April 15, 2016

[Redacted]

IBR Case Number:	CB16-0000489	Date of Injury:	09/14/2015
Claim Number:	[Redacted]	Application Received:	03/23/2016
Claims Administrator:	[Redacted]		
Date(s) of service:	09/22/2015		
Provider Name:	[Redacted]		
Employee Name:	[Redacted]		
Disputed Codes:	27823-LT, 73600-RT, and 76000		

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 \$1,331.68 in additional reimbursement for a total of \$1,526.68. A detailed explanation of the decision is provided later in this letter.**

The Claim Administrator is required to reimburse the Provider a total of \$1,526.68 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
- 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 remuneration for billed services 27823, 73600 and 76000 for date of service 09/22/2015.**
- **Authorization** for services ORIF left ankle identified in review.
- Provider billed the procedure codes as part of an outpatient service on a UB04 with bill type 131.
- Claims administrator denied reimbursement for CPT 73600, 96361 and 96366.
- § 5307.11: A health care provider or health facility licensed pursuant to Section 1250 of the Health and Safety Code, and a contracting agent, employer, or carrier may contract for reimbursement rates different from those in the fee schedule adopted and revised pursuant to Section 5307.1. When a health care provider or health facility licensed pursuant to Section 1250 of the Health and Safety Code, and a contracting agent, employer, or carrier contract for reimbursement rates different from those in the fee schedule, the medical fee schedule for that health care provider or health facility licensed **pursuant to Section 1250 of the Health and Safety Code shall not apply to the contracted reimbursement rates.**
- PPO contract submitted: “Nothing in this Agreement shall be construed as to require Payer to reimburse a greater amount or to cover more services than if this Agreement were not in effect” and “**Outpatient Discount: 25%; Maximum cap for surgery cases is \$3500;**”

- C. Services Included or Not Included: the rates specified in paragraphs A and B above are all-inclusive of services rendered and items furnished by the facility or during the time in which a patient is in the facility...”
- Per PPO contract, codes 73600 and 76000 are inclusive of the billed surgery code 27823.
- Opportunity for Claims Administrator to Dispute sent on 3/28/2016. A response from Claims Administrator was not submitted for this review.
- Based on the PPO contract, additional reimbursement is due for billed surgery code 27823.

DETERMINATION OF ISSUE IN DISPUTE: Recommended reimbursement of code: CPT 27823-LT, 73600-RT, and 76000.

Date of Service 09/22/2015					
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Workers' Comp Allowed Amt.	Notes
27823	\$36,082.00	\$2,168.32	\$5713.14	\$3,500.00	<b>PPO Contract \$1,331.68 Due to Provider</b>
73600	\$120.00	\$0.00	\$30.12	\$0.00	<b>Refer to Analysis</b>
76000	\$713.00	\$0.00	\$62.20	\$0.00	<b>Refer to Analysis</b>

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