

MAXIMUS FEDERAL SERVICES, INC.

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



INDEPENDENT BILLING REVIEW FINAL DETERMINATION

June 7, 2016

[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]

IBR Case Number:	CB16-0000660	Date of Injury:	12/04/2014
Claim Number:	[REDACTED]	Application Received:	04/21/2016
Claims Administrator:	[REDACTED]		
Date(s) of service:	10/26/2015		
Provider Name:	[REDACTED]		
Employee Name:	[REDACTED]		
Disputed Codes:	76001 (changed to 73584), 27724, G0379, and L2999		

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: UPHOLD. MAXIMUS Federal Services has determined that no additional reimbursement is warranted. The Claims Administrator’s determination is upheld and the Claim Administrator does not owe the Provider additional reimbursement. A detailed explanation of the decision is provided later in this letter.

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,

Maximus

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: N/A
- National Correct Coding Initiatives
- Other: IBR Payment Regulations

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 HOPPS reimbursement of billed codes 76001 (changed to 73584), 27724, G0379, and L2999 performed on date of service **10/26/2015**
- Claims Administrator denied charges with rationale “No reimbursement is being made as this procedure is not usually performed in an outpatient surgical facility. Prior authorization is required but was not submitted”
- RFA dated **03/02/2016**, documents Service/Good Requested:
 - 1) Surgery 76001
 - 2) Surgery 27724
 - 3) Surgery 97530
 - 4) Surgery L2999
- RFA does not document services as outpatient or inpatient request.
- Certification of Treatment submitted shows “Authorized Treatment: Removal of Hardware RT Tibia, Non-union repair of RT Tibia, LT Bone graft from ipsilateral femur and Application of a Bone Stimulator; **Approved Codes: 20680, 27724 and 20975**; Discussion: Surgeries, repair and application of bone stimulator are all medically reasonable”
- Provider only billed surgical code 27724: Repair of nonunion or malunion, tibia; with iliac or other autograft (includes obtaining graft); and has a Status Indicator ‘C’ -

Inpatient Only Inpatient Procedures. Not paid under OPSS. Admit patient. Bill as inpatient.

- Provider originally billed code on a UB-04 with Bill Type ‘131’ – Outpatient Hospital, a second UB-04 submitted with Bill Type ‘137’ – Replacement Outpatient Claim (Corrected Claim).
- Code is specific to Inpatient only.
- **Provider’s Pertinent Information Report documents “Admission Date/Time 10/26/15 0740; Discharge Date/Time 10/29/15 1553”**
- UB-04 claims not submitted with a PPS DRG for Inpatient. Box #71 required when the bill is for inpatient admissions.
- Prospective Payment System (PPS) Diagnosis Related Groups (DRGs): The Social Security Amendments of 1983 (P.L. 98-21) provided for establishment of a prospective payment system (PPS) for Medicare payment of inpatient hospital services. (See §20.4 for corresponding information for PPS capital payments and computation of capital and operating outliers for FY 1992.) Under PPS, hospitals are paid a predetermined rate per discharge for inpatient hospital services furnished to Medicare beneficiaries. Each type of Medicare discharge is classified according to a list of DRGs. These amounts are, with certain exceptions, payment in full to the hospital for inpatient operating costs.
- **§ 9792.5.7. Requesting Independent Bill Review:** (b) Unless as permitted by section 9792.5.12, independent bill review shall only be conducted if the only dispute between the provider and the claims administrator is the amount of payment owed to the provider. Any other issue, including issues of contested liability or the applicability of a contract for reimbursement rates under Labor Code section 5307.11 shall be resolved before seeking independent bill review. Issues that are not eligible for independent bill review shall include:
 - (2) The proper selection of an analogous code or formula based on a fee schedule adopted by the Administrative Director, or, if applicable, a contract for reimbursement rates under Labor Code section 5307.11, unless the fee schedule or contract allows for such analogous coding.
- Based on aforementioned documentation, reimbursement of submitted claim is not warranted.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Reimbursement of code 76001 (changed to 73584), 27724, G0379, and L2999

Date of Service: 10/26/2015				
Provider Billed	Plan Allowed	Dispute Amount	Workers’ Comp Allowed Amt.	Notes
\$154,541.60	\$0.00	\$61,054.16	\$0.00	Refer to Analysis

Copy to:

[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]

Copy to:

[REDACTED]
[REDACTED]
[REDACTED]