

**INDEPENDENT BILLING REVIEW FINAL DETERMINATION**

December 18, 2014

[Redacted]  
[Redacted]  
[Redacted]  
[Redacted]

<b>IBR Case Number:</b>	CB14-0001286	<b>Date of Injury:</b>	09/30/2013
<b>Claim Number:</b>	[Redacted]	<b>Application Received:</b>	09/05/2014
<b>Claims Administrator:</b>	[Redacted]	<b>Assignment Date:</b>	10/06/2014
<b>Provider Name:</b>	[Redacted]		
<b>Employee Name:</b>	[Redacted]		
<b>Disputed Codes:</b>	L3650		

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 \$250.00 for the review cost and \$0.00(Provider has already been reimbursed) in additional reimbursement for a total of \$250.00. A detailed explanation of the decision is provided later in this letter.**

The Claim Administrator is required to reimburse the Provider a total of \$250.00 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,

[Redacted]  
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: PPO Contract Discount 2%
- National Correct Coding Initiatives
- Other: Durable Medical Equipment 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 is dissatisfied with denial of HCPCS L3650.
- Pursuant to Labor Code section 5307.1(g)(2), the Administrative Director of the Division of Workers' Compensation orders that Title 8, California Code of Regulations, sections 9789.30 and 9789.31, pertaining to Hospital Outpatient Departments and Ambulatory Surgical Centers Fee Schedule in the Official Medical Fee Schedule, is amended to conform to CMS' hospital outpatient prospective payment system (OPPS). The Administrative Director incorporates by reference, the Centers for Medicare and Medicaid Services' (CMS) Hospital Outpatient Prospective Payment System (OPPS) certain addenda published in the Federal Register notices announcing revisions in the Medicare payment rates. The adopted payment system addenda by date of service are found in the Title 8, California Code of Regulations, and Section 9789.39(b). Based on the adoption of the CMS hospital outpatient prospective payment system (OPPS), CMS coding guidelines and the hospital outpatient prospective payment system (OPPS) were referenced during the review of this Independent Bill Review (IBR) case.
- Based on the provider type, the reimbursement for services is calculated on the Centers for Medicare and Medicaid Services (CMS) Outpatient Prospective Payment System (OPPS). Procedures are assigned APC weights and "Proposed Payment Status Indicators." The HCPCS code L3650 has an assigned status indicator of "A". The "A" indicator definition is "Not paid under OPPS. Paid by fiscal intermediaries/MACs under a fee schedule or payment system other than OPPS."

- Per the OMFS Outpatient Hospital Ambulatory Surgery Center Fee schedule, the maximum allowable fee for durable medical equipment, prosthetics and orthotics shall be determined according to Section 9789.60.” The HCPCS L3650 is an Orthotic and is reimbursable when billed by an Outpatient Hospital or Ambulatory Surgery Center (ASC) under the OMFS DMEPOS fee schedule per Title 8, CCR, section 9789.32(c)(6). Maximum reasonable fees for Durable Medical Equipment, Prosthetics, Orthotics, Supplies shall not exceed 120% of the applicable California fees set forth in the Durable Medical Equipment, Prosthetics/Orthotics, and Supplies (DMEPOS) Fee Schedule.

Provider was sent reimbursement for L3650 in the amount \$81.06 less a 2% discount per PPO contract for a total of \$79.44. Therefore, no additional reimbursement for L3650 is recommended.

The table below describes the pertinent claim line information.

**DETERMINATION OF ISSUE IN DISPUTE:** Reimbursement of code L3650 is warranted.

<b>Date of Service:</b> 9/30/2013							
<b>Durable Medical Equipment</b>							
<b>Service Code</b>	<b>Provider Billed</b>	<b>Plan Allowed</b>	<b>Dispute Amount</b>	<b>Assist Surgeon</b>	<b>Multiple Surgery</b>	<b>Workers' Comp Allowed Amt.</b>	<b>Notes</b>
L3650	\$6119.45	\$427.24	\$81.06	N/A	N/A	\$81.06	<b>DISPUTED SERVICE:</b> Allow \$79.44. <b>Provider has already been sent reimbursement and Claims Administrator is only responsible for IBR application fee.</b>

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