

MAXIMUS FEDERAL SERVICES, INC.

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



INDEPENDENT BILLING REVIEW FINAL DETERMINATION

December 5, 2014

[Redacted]
[Redacted]
[Redacted]

IBR Case Number:	CB14-0000571	Date of Injury:	04/23/2013
Claim Number:	[Redacted]	Application Received:	04/14/2014
Claims Administrator:	[Redacted]	Assignment Date:	06/17/2014
Provider Name:	[Redacted]		
Employee Name:	[Redacted]		
Disputed Codes:	L8699		

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,

[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
- Med-Legal Official Medical Fee Schedule
- AMA CPT 2013

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 disputing \$0.00 reimbursement for L8699 service code relating to Ancillary Services performed on 04/26/2013.
- Claims Administrator denied reimbursement for the following reason: “There is no separate facility fee for this service under the California Outpatient Hospital/ASC fee schedule.”
- **L8699 Code Description:** “Prosthetic implant, not otherwise specified.”
- The Provider billed HCPCS code L8699-Prosthetic device NOS. Per status indicator, HCPCS code L8699 has a payment indicator of N1.
- Payment indicator N1 is a packaged service/item and no separate payment is allowed.
- Although Authorization from the Claims Administrator, dated 5/13/2013 item # 4, under the heading of “Approved” services states, “**open treatment of distal phalangeal fracture, finger or thumb, includes internal fixation,**” the statement indicates the **procedure** itself as authorized and does not specifically indicate the prosthetic device as authorized.
- **CPT Code 26765 Code Description:** “**Open treatment of distal phalangeal fracture, finger or thumb, includes internal fixation,** when performed, each,” was billed by the Provider and, as directed by the 5/13/2013 Authorization, item #4, was reimbursed by the Claims Administrator for this **procedure**.
- The payment for HCPCS L8699 is packaged into payment for other services, including outliers and there is no separate APC payment.

- Additional reimbursement for the implant (L8699) is not warranted.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: L8699

Date of Service: 04/6/2013							
Ancillary Services							
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Assist Surgeon	Units	Workers' Comp Allowed Amt.	Notes
L8699	\$4,607.79	\$0.00	\$4,607.79	N/A	1	\$0.00	Refer to Analysis
26765	N/A	N/A	N/A	N/A	1	N/A	Not A Disputed Service

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