

INDEPENDENT BILLING REVIEW FINAL DETERMINATION

January 20, 2015

[REDACTED]
[REDACTED]
[REDACTED]

IBR Case Number:	CB14-0001657	Date of Injury:	06/11/2010
Claim Number:	[REDACTED]	Application Received:	11/03/2014
Claims Administrator:	[REDACTED]		
Assigned Date:	12/03/2014		
Provider Name:	[REDACTED]		
Employee Name:	[REDACTED]		
Disputed Codes:	63047		

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 \$1359.53 in additional reimbursement for a total of \$1609.53.

A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of \$1609.53 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:
- 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 dissatisfied with reimbursement of code 63047.
- The Administrative Director incorporates by reference, the Centers for Medicare and Medicaid Services' (CMS) Hospital Outpatient Prospective Payment System (HOPPS) certain addenda published in the Federal Register notices announcing revisions in the Medicare payment rates. See Section 9789.39(b) for the adopted payment system addenda by date of service. Sections 9789.30 through 9789.39 shall be applicable to the maximum allowable fees for emergency room visits and surgical procedures rendered on or after July 1, 2004. For purposes of this section, emergency room visits shall be defined by CPT codes 99281-99285 and surgical procedures shall be defined by CPT codes 10021-69990. A facility fee is payable only for the specified emergency room and surgical codes and for supplies, drugs, devices, blood products and biologicals that are an integral part of the emergency room visit or surgical procedure. For services rendered on or after January 1, 2013: APC relative weight x adjusted conversion factor x 1.22 workers' compensation multiplier for hospital outpatient departments and 0.82 workers' compensation multiplier for ambulatory surgical centers, pursuant to Section 9789.30(x)
- Provider billed code 63047 primary procedure for laminectomy. Operative report submitted details laminectomies performed. Claims administrator did not reimburse code 63047 properly as the primary procedure. Therefore, additional reimbursement is warranted.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Additional reimbursement of code 63047 is recommended.

Date of Service: 03/13/2014						
Hospital Outpatient Dept. and Ambulatory Surgical Centers Services						
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Multiple Surgery	Workers' Comp Allowed Amt.	Notes
63047	\$22,000.00	\$1,923.19	\$1,359.53	100%	\$3,282.72	DISPUTED SERVICE: Allow reimbursement \$1,359.53

Copy to:

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