

MAXIMUS FEDERAL SERVICES, INC.

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



INDEPENDENT BILLING REVIEW FINAL DETERMINATION

May 21, 2015

[REDACTED]
[REDACTED]
[REDACTED]

IBR Case Number:	CB15-0000283	Date of Injury:	01/07/2014
Claim Number:	[REDACTED]	Application Received:	02/27/2015
Claims Administrator:	[REDACTED]		
Date Assigned:	3/25/2015		
Provider Name:	[REDACTED]		
Employee Name:	[REDACTED]		
Disputed Codes:	L3098-LT and L3098-RT		

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,

Paul Manchester, MD, MPH
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

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 codes L3098-LT and L3098-RT
- Claims Administrator denied codes indicating on the Explanation of Review “The charge was denied as the report/documentation does not indicate that the service was performed”
- On review of the Provider’s submitted, nowhere does the Provider document that any wrist braces were dispensed to the patient on the date of service. Provider does document in his report for date of service 10/15/2014 “Request for Authorization: 70225 left 8: wrist brace MD L3908, 70215 Right 8” wrist brace MD L3908; 1. Right and left wrist braces...”
- Provider’s Appeal/Second Review states “Also, attached please find a medication log sheet verifying the wrist braces were dispensed to the patient at the time of service.”
- A form titled The Spine and Orthopedic Center Medication Record shows patient’s name and date of birth along with two bar codes stuck on to the form. Nowhere on this form does it state that the provider dispensed these braces to the patient. A piece of paper with stickers attached does not verify that any equipment was given to the patient. Provider must document in his report that the equipment was actually dispensed to the patient on the date of service in order to support the codes billed.

- Based on information reviewed, documentation does not support billed codes L3098-LT and L3098-RT were dispensed to the patient and therefore, reimbursement of codes L3098-LT and L3098-RT is not warranted.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Reimbursement of codes L3098-LT and L3098-RT

Date of Service: 10/15/2014							
Physician Services							
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Units	Multiple Surgery	Workers' Comp Allowed Amt.	Notes
L3098-Lt	\$300.00	\$0.00	\$300.00	1	N/A	\$0.00	DISPUTED SERVICE: No reimbursement recommended
L3098-RT	\$300.00	\$0.00	\$300.00	1	N/A	\$0.00	DISPUTED SERVICE: No reimbursement recommended

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