

MAXIMUS FEDERAL SERVICES, INC.

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



INDEPENDENT BILLING REVIEW FINAL DETERMINATION

November, 9 2015



IBR Case Number:	CB15-0001861	Date of Injury:	09/13/2002
Claim Number:	[REDACTED]	Application Received:	10/12/2015
Claims Administrator:	[REDACTED]		
Date(s) of service:	06/08/2015 – 06/08/2015		
Provider Name:	[REDACTED]		
Employee Name:	[REDACTED]		
Disputed Codes:	A4550, 77003, 72265, Q9965, and 62284		

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

MAXIMUS FEDERAL SERVICES, INC.

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cc:

[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
- National Correct Coding Initiatives
- Other: Outpatient Hospital and Ambulatory Surgery Center 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:** The Provider is seeking reimbursement for CPT A4550, 77003, 72265, Q9965 and 66284.
- The Provider billed the disputed CPT codes on a UB04 with bill type 131 for date of service 6/8/2015.
- The Provider was reimbursed 80.86 for CPT 72265.
- Per review of the EOR, the disputed codes (A4550, 77003, Q9965 and 66284) were denied with the following rationale: The charge for this procedure was not paid since the value of this procedure is included/bundled within the value of another procedure performed.
- Title 8, CCR 9789.32 (a) 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 and before September 1, 2014. Sections 9789.30 through 9789.39 shall be applicable to the maximum allowable fees for **emergency room visits, surgical procedures**, and Facility Only Services rendered on or after September 1, 2014.
- (1) For services rendered on or after September 1, 2014: the item has a status code N, Q1, Q2, or Q3 and is packaged into the APC payment for the emergency room visit, surgical procedure, or Facility Only Service (in which case no additional fee is allowable).
- CPT/HCPCS codes 62284, 77003 and Q9965 are all status code "N" procedures.

- **Status Code N** = Items and Services Packaged into APC Rates. Paid under OPPS; Payment is packaged into payment for other services. Therefore, there is no separate APC payment.
- Title 8 CCR 9789.32(c)(B) For Other Services rendered on or after September 1, 2014 to hospital outpatients, the maxi-mum allowable hospital outpatient facility fees shall be paid according to the OMFS RBRVS.
- (i) If the Other Service has a Professional Component/Technical Component under the OMFS RBRVS, the hospital outpatient facility fee shall be the Technical Component amount determined according to the OMFS RBRVS.
- CPT 72265 was reimbursed based on the TC component listed in the OMFS RBRVS. No additional reimbursement due.
- HCPCS A4550 is bundled code and included in the services of the primary codes (72265, 62284).
- Additional Reimbursement is not recommended for the disputed codes.

The table below describes the pertinent claim line information.

- **DETERMINATION OF ISSUE IN DISPUTE:** Reimbursement not recommended for codes: A4550, 77003, 72265, Q9965 and 66284.

Date of 6/8/2015							
Outpatient Hospital Services							
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Assist Surgeon	Multiple Surgery	Workers' Comp Allowed Amt.	Notes
A4550	\$ 327.00	\$ 0.00	\$ 0.00	N/A	100%	\$0.00	DISPUTED SERVICE: See Analysis.
77003	\$776.00	\$0.00	\$776.00	N/A	N/A	\$0.00	DISPUTED SERVICE: See Analysis.
72265	\$1446.00	\$80.86	\$614.04	N/A	N/A	\$80.86	DISPUTED SERVICE: See Analysis.
Q9965	\$166.00	\$0.00	\$166.00	N/A	N/A	\$0.00	DISPUTED SERVICE: See Analysis.
66284	\$5108.00	\$0.00	\$5108.00	N/A	N/A	\$0.00	DISPUTED SERVICE: See Analysis.

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