

**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:	CB15-001862	Date of Injury:	10/12/2011
Claim Number:	[REDACTED]	Application Received:	10/12/2015
Claims Administrator:	[REDACTED]		
Date(s) of service:	04/27/2015 – 04/27/2015		
Provider Name:	[REDACTED]		
Employee Name:	[REDACTED]		
Disputed Codes:	63655, 63685, and 95972		

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 \$195.00 for the review cost and \$15,847.49 in additional reimbursement for a total of \$16,042.49. A detailed explanation of the decision is provided later in this letter.**

The Claim Administrator is required to reimburse the Provider a total of \$16,042.49 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,

Paul Manchester, MD MPH

Medical Director

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cc:



## 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
- Medicare and Medicaid Services (CMS) Outpatient Prospective Payment System (OPPS)
- Other: OMFS Outpatient Hospital 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:

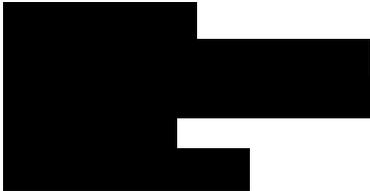
- **ISSUE IN DISPUTE: Provider seeking additional reimbursement for CPT codes 63655, 63685 and 95972 for date of service 4/27/2015.**
- The Provider billed the disputed codes on a UB04, with bill type 131 for date of service 4/27/2015.
- The Claims Administrator reimbursed the Provider a total of \$23,841.13 for CPT 63655, and 63685, and denied 95972 for lack of supporting documentation of service rendered.
- Submitted medical record substantiated the billed codes.
- PPO Contractual agreement submitted and reviewed.
- Contractual agreement Workers' Compensation; As payment for such Health Services rendered, Facility agrees to accept the lesser of the PPO Rate as set forth in the PCS or ninety-five percent (95%) of the California Division of Workers' Compensation Official Medical Fee Schedule ("OMFS").
- Contractual agreement Out Patient Services: 3(d) Payment for an outpatient surgery visit is based on the primary procedure. PCS rate for Primary Procedure 63685: 65 % of Eligible Billed Charges not to exceed \$ 45,974,
- Opportunity to Dispute Eligibility communicated to Claims Administrator on 10/13/2015; response not yet received.
- Compared to the contractual rate for the Primary Procedure (63685), 95% of the OMFS allowance is the lessor allowance.

- CPT 63685 and 63655 are status code “S” procedures.
- “S” Procedure or Service, Not Discounted When Multiple. Paid under OPPS; separate APC payment.
- Additional reimbursement is warranted for the CPT codes 63655, 63685 and 95972.

DETERMINATION OF ISSUE IN DISPUTE: Recommended reimbursement of code: CPT 63655, 63685 and 95972.

Date of Service 4/27/2015						
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Multiple Surgery	Workers' Comp Allowed Amt.	Notes
63685	\$ 18,813.75	\$ 17873.06	\$ 28362.31	100%	\$ 11,936.13	<b>DISPUTED SERVICE:</b> See Analysis.
63655	\$18813.75	\$5968.07	43378.01	100%	\$27,704.81	<b>DISPUTED SERVICE:</b> See Analysis.
95972	\$12542.00	\$0.00	\$212.61	N/A	\$47.68	<b>DISPUTED SERVICE:</b> See Analysis.

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