

INDEPENDENT BILLING REVIEW FINAL DETERMINATION

December 16, 2015

[REDACTED]
[REDACTED]
[REDACTED]

IBR Case Number:	CB15-0002162	Date of Injury:	09/21/2014
Claim Number:	[REDACTED]	Application Received:	11/23/2015
Claims Administrator:	[REDACTED]		
Date(s) of service:	05/12/2015		
Provider Name:	[REDACTED]		
Employee Name:	[REDACTED]		
Disputed Codes:	62319		

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 \$111.60 in additional reimbursement for a total of \$306.60. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of \$306.60 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

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: N/A
- 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 seeking remuneration for 62319 on date of service 05/12/2015
- Claims Administrator reimbursement rationale “workers’ compensation state fee schedule adjustment Labor Code 6307.1”
- Pursuant Official Medical Fee Schedule-Hospital Outpatient Departments and Ambulatory Surgical Centers Services on or after January 1, 2004, Section 9789.33. Determination of Maximum Reasonable Fee: For services rendered on or after September 1, 2014 Ambulatory Surgical Centers surgical procedures, APC relative weight x adjusted conversion factor x 0.808 workers’ compensation multiplier, pursuant to Section 9789.30(aa). See Section 9789.39(b) for the **APC relative weight by date of service**. Table A in Section 9789.34 contains an "adjusted conversion factor" which incorporates the standard conversion factor, wage index and inflation factor. The maximum payment rate for ASCs and non-listed hospitals can be determined according to Table A and subdivision (a).
- Documentation submitted supports service performed on date of service 5/12/2015.
- Based on aforementioned guidelines and documentation, additional reimbursement of 62319 is warranted.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Reimbursement of code 62319

Date of Service: 05/12/2015						
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Units	Workers' Comp Allowed Amt.	Notes
62319	\$2,625.64	\$620.60	\$2,005.04	1	\$732.20	\$111.60 Due to Provider

Copy to:

[REDACTED]
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