

**MAXIMUS FEDERAL SERVICES, INC.**

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



**INDEPENDENT BILLING REVIEW FINAL DETERMINATION**

December 30, 2015

[Redacted]  
[Redacted]  
[Redacted]  
[Redacted]

IBR Case Number:	CB15-0002216	Date of Injury:	06/29/2013
Claim Number:	[Redacted]	Application Received:	12/2/2015
Claims Administrator:	[Redacted]		
Date(s) of service:	06/19/2015		
Provider Name:	[Redacted]		
Employee Name:	[Redacted]		
Disputed Codes:	15878-50, 15879-50, 15877, 86850, 86900, 86901, and Rev Code 250		

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 \$686.57 in additional reimbursement for a total of \$881.57. A detailed explanation of the decision is provided later in this letter.**

The Claim Administrator is required to reimburse the Provider a total of \$881.57 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, M.D., M.P.H.  
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

## 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 HOPPS remuneration for 15878-50, 15879-50, 15877, 86850, 86900, 86901, and Rev Code 250 services performed on 06/19/2015.**
- Claims Administrator reimbursement rational based on packaged payment.
- **Section 9789.33 status indicators** “S”, “T”, “X”, or “V”, “Q1”, “Q2”, or “Q3”. Status code indicators “Q1”, “Q2”, and “Q3” must qualify for separate payment for services on or after September 1, 2014 calculation as follows: APC relative weight x adjusted conversion factor x 1.212 workers’ compensation multiplier, pursuant to Section 9789.30(aa). See Section 9789.39(b) for the APC relative weight by date of service.
- Codes 86580, 86900 and 86901 have status indicator ‘Q1’ while 15878, 15879 and 15877 have status indicator ‘T’.
- Based on aforementioned guidelines, reimbursement for 86580, 86900 and 86901 is not warranted.
- Multiple REV code 250 was billed and some absent a HCPCS code.
- As the HCPCS code was not specified, reimbursement of REV code 250 is included with the surgical procedure and is not separately reimbursable.
- Provider is requesting additional payment on the surgical codes 15878-50, 15879-50 and 15877.
- DWC utilizes Medicare regulations for modifier -50. Bilateral procedures are procedures performed on both sides of the body during the same operative session. Medicare makes payment for bilateral procedures based on the lesser of the actual charges or 150 percent of

the Medicare Physician Fee Schedule (MPFS) amount when the procedure is authorized as a bilateral procedure.

- **Determining Maximum Payment for Multiple Surgeries:** If a procedure is performed on the same day as another procedure, base the payment on the lower of (a) the actual charge, or (b) the fee schedule amount for the procedure reduced by the applicable percentage. Rank the procedures subject to the multiple surgery rule (indicator “2”) in descending order by fee schedule amount and apply the appropriate reduction to this code:
  - (A) 100 percent of the fee schedule amount for the highest valued procedure; and
  - (B) 50 percent of the fee schedule amount for the second through the fifth highest valued procedures; or
  - (C) if more than five procedures with indicator “2” are billed, pay for the first five according to (A) and (B) above and pay “by report” for the sixth and subsequent procedures. Payment determined on a “by report” basis should never be lower than 50 percent of the full payment amount. Pay by the unit for services that are already reduced (e.g. 17003).
- Partial PPO contract received shows a 98% reimbursement.
- **Based on the aforementioned guidelines, additional reimbursement is indicated for 15787-50.**

**DETERMINATION OF ISSUE IN DISPUTE: 86850 and 86922**

<b>Date of Service</b> 06/19/2015							
<b>HOPPS</b>							
<b>Service Code</b>	<b>Provider Billed</b>	<b>Plan Allowed</b>	<b>Dispute Amount</b>	<b>Multiple Surgery</b>	<b>Units</b>	<b>Workers' Comp Allowed Amt.</b>	<b>Notes</b>
15878-50	\$7849.55	\$2330.93	\$2380.17	100%	1	\$4616.88	\$2285.95 Due to Provider less overpayments = <b>\$686.57</b>
15879-50	\$7849.55	\$2330.93	\$24.63	50%	1	\$2308.44	<b>\$22.49 Overpaid</b>
15877	\$7849.58	\$3116.10	-\$1545.79	50%	1	\$1539.21	<b>\$1576.89 Overpaid</b>

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