

**MAXIMUS FEDERAL SERVICES, INC.**

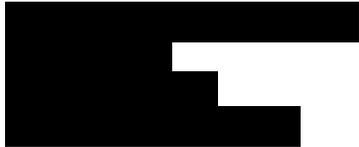
Independent Bill Review  
P.O. Box 138006  
Sacramento, CA 95813-8006  
Fax: (916) 605-4280



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**INDEPENDENT BILLING REVIEW FINAL DETERMINATION**

June 30, 2015



IBR Case Number:	CB15-0000585	Date of Injury:	10/30/2014
Claim Number:	[REDACTED]	Application Received:	04/14/2015
Claims Administrator:	[REDACTED]		
Assigned Date:	05/14/2015		
Provider Name:	[REDACTED]		
Employee Name:	[REDACTED]		
Disputed Codes:	Revenue Code 274 & 681		

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 \$1,208.24 in additional reimbursement for a total of \$1403.24. A detailed explanation of the decision is provided later in this letter.**

The Claim Administrator is required to reimburse the Provider a total of \$1403.24 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]

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### 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: OMFS Inpatient 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: Reimbursement of HCPCS L0484 and G0390 billed as part of an inpatient services 10/30/2014 – 11/02/2014 with DRG 460.**
- Claims Administrator reimbursed the Provider for DRG 460.
- Provider is requesting additional reimbursement for the Trauma Activation code and Orthotic.
- §9789.22. Payment of Inpatient Hospital Services:
  - (a) Unless otherwise provided by applicable provisions of this fee schedule, the maximum payment for inpatient medical services shall be determined by multiplying 1.20 by the product of the hospital's composite factor and the applicable DRG weight and by making any adjustments required by this fee schedule. The fee determined under this subdivision shall be a global fee, constituting the maximum reimbursement to a hospital for inpatient medical services not exempted under this section.
  - (k) The following are exempt from the maximum reimbursement formula set forth in Section 9789.22(a) and are paid on a reasonable cost basis.

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(7) The cost of durable medical equipment provided for use at home is exempt from this Inpatient Hospital Fee Schedule. The cost of durable medical equipment shall be paid pursuant to Section 9789.60

- L0484: Tlso, triplanar control, two piece rigid plastic shell without interface liner, with multiple straps and closures, posterior extends from sacrococcygeal junction and terminates just inferior to scapular spine, anterior extends from symphysis pubis to sternal notch, lateral strength is enhanced by overlapping plastic, restricts gross trunk motion in the sagittal, coronal, and transverse planes, includes a carved plaster or cad-cam model, custom fabricated
- HCPCS L0484 is exempt from the inpatient fee calculation, and reimbursed according to Section 9789.60. Additional reimbursement is recommended.
- Reimbursement for HCPCS L0484 is recommended based on Section 9789.60 and Cal Labor Code 5307.1.
- Provider submitted an invoice for L0484. Invoice documented a paid cost of \$1,006.87.
- Based on the above rules and guidelines, the Trauma Code G0390 is not exempt from the fee schedule and is included in the global fee for the DRG. No additional reimbursement recommended for HCPCS G0390.

The table below describes the pertinent claim line information.

**DETERMINATION OF ISSUE IN DISPUTE:** Recommended reimbursement of code HCPCS L0484

<b>Date of Service:</b> 10/31/2014 - 11/3/2014					
<b>Service Code</b>	<b>Provider Billed</b>	<b>Plan Allowed</b>	<b>Dispute Amount</b>	<b>Workers' Comp Allowed Amt.</b>	<b>Notes</b>
L0484	\$ 5,575.05	\$ 0.00	\$ 1830.67	\$ 1,208.24	<b>DISPUTED SERVICE:</b> See Analysis. Additional Reimbursement of \$1,208.24 recommended. The lesser of 120% of documented paid cost or OMFS Fee schedule allowance.
G0390	\$7,433.18	\$0.00	\$1,335.94	\$0.00	<b>DISPUTED SERVICE:</b> See Analysis.
DRG 460	\$257,887.69	\$45,817.38	N/A	N/A	<b>NOT A DISPUTED SERVICE</b>

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