

MAXIMUS FEDERAL SERVICES, INC.

Independent Bill Review
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Fax: (916) 605-4280



INDEPENDENT BILLING REVIEW FINAL DETERMINATION

July 21, 2015

[Redacted]
[Redacted]
[Redacted]

IBR Case Number:	CB15-0000992	Date of Injury:	10/18/2011
Claim Number:	[Redacted]	Application Received:	06/17/2015
Claims Administrator:	[Redacted]		
Date(s) of service:	04/24/2015		
Provider Name:	[Redacted]		
Employee Name:	[Redacted]		
Disputed Codes:	D7951 and D6100		

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 \$4607.50 in additional reimbursement for a total of \$4802.50. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of \$4802.50 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: PPO Contract
- National Correct Coding Initiatives

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 is dissatisfied with denial of codes D7951 and D6100
- Claims Administrator denied codes indicating on the Explanation of Review “For pymt consideration, provide a desc of proc/service”
- Provider’s Report submitted documents “Certified surgical removal implant #12(D6100) was performed. Full thickness flap was laid on the upper left entry into maxillary left sinus (D7951). Placed guided tissue barrier due to slight tear in membrane.”
- Request for Authorization dated 09/03/14 documents D6100 Removal of Implant #12 \$1050.00.
- Letter dated 09/17/2014 from Utilization Review states “After review of the request it has been determined that the requested treatment/service meets medical necessity and is authorized.”
- Request for Authorization dated 02/27/15 states D7951 Maxillary Left Sinus Augmentation via Lateral Open Approach \$3800.00.
- Letter dated 04/02/2015 from Utilization Review states “After review of the request it has been determined that the requested treatment/service meets medical necessity and is authorized.”
- Based on information reviewed, reimbursement of codes is warranted.
- EOR received states the charges were priced in accordance to a PPO contract. A copy of the contract was not submitted for this review. Provider submitted the RFA with his usual

and customary pricing and therefore, reimbursement is based on billed charges. EOR also shows a 5% discount to be applied to reimbursement.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Reimbursement of codes D7951 and D6100

Date of Service: 04/24/2015							
Physician Services							
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Assist Surgeon	Multiple Surgery	Workers' Comp Allowed Amt.	Notes
D7951	\$3800.00	\$0.00	\$3800.00	N/A	N/A	\$3610.00	DISPUTED SERVICE: Allow reimbursement \$3610.00
D6100	\$1050.00	\$0.00	\$1050.00	N/A	N/A	\$997.50	DISPUTED SERVICE: Allow reimbursement \$997.50

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