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

MAXIMUS Federal Services

INDEPENDENT BILLING REVIEW FINAL DETERMINATION

January 7, 2016

[redacted]

IBR Case Number:	CB15-0002271	Date of Injury:	12/12/1999
Claim Number:	[redacted]	Application Received:	12/11/2015
Claims Administrator:	[redacted]		
Date(s) of service:	01/08/2015 – 01/08/20105		
Provider Name:	[redacted]		
Employee Name:	[redacted]		
Disputed Codes:	63650-59		

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 $2,145.79 in additional reimbursement for a total of $2,340.79. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of **$2,340.79** 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]

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
- AMA CPT
- OMFS

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 100 % ASC remuneration for 63650-59 for date of service 01/08/2015**
- The Claims Administrator's reimbursement rational indicates the following: "payment reflects Physician Fee Schedule Surgery Section, rule 7 guidelines for multiple or bi-lateral surgical services."
- UB-04 reflects **Bill Type "831**."
- Opportunity to Dispute Eligibility communicated to Claims Administrator on 12/31/2015; response not yet received.
- Contractual Agreement not submitted for IBR.
- For services rendered on or after December 1, 2014, section 9789.30, subsections (a) adjusted conversion factor, (e) APC payment rate, (f) APC relative weight, (j) Facility Only Services, (q) labor-related share, (r) market basket inflation factor, and (z) wage index, are adjusted to conform to the Medicare hospital outpatient prospective payment system (HOPPS) final rule of December 10, 2013, the relative values in the 2014 Medicare Physician fee schedule, and the wage index values in the Medicare IPPS final rule of August 19, 2013, and associated rules and notices to the IPPS final rule published in the Federal Register.
- Based on the provider type, the reimbursement for services is calculated on the Centers for Medicare and Medicaid Services (CMS) Outpatient Prospective Payment System (OPPS). Procedures are assigned APC weights and "Proposed Payment Status Indicators." The CPT 63650 has an assigned indicator of "S". The "S" indicator definition is "Significant procedure, not discounted when multiple" and **qualifies for separate APC payment**.
- 63650, Status Indicator "S," and is not subject to MPPR.
- For services rendered on or after September 1, 2014 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.
- **Based on the aforementioned documentation and guidelines, additional reimbursement for 63650-59 is warranted.**

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: 63650-59

Date of Service: 01/08/2015 Ambulatory Services						
Service Code	**Provider Billed**	**Plan Allowed**	**Dispute Amount**	**Units**	**Workers' Comp Allowed Amt.**	**Notes**
63650-59	$8,625.00	$2,146.33	$2,146.36	1	$4,292.12	**$2,145.79 Due Provider Refer to Analysis**

Copy to:

[redacted]

Copy to:

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