

MAXIMUS FEDERAL SERVICES, INC.

Independent Bill Review
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Fax: (916) 605-4280



INDEPENDENT BILLING REVIEW FINAL DETERMINATION

January 21, 2016

[REDACTED]
[REDACTED]
[REDACTED]

IBR Case Number:	CB15-0002332	Date of Injury:	04/04/2015
Claim Number:	[REDACTED]	Application Received:	12/29/2015
Claims Administrator:	[REDACTED]		
Date(s) of service:	04/14/2015		
Provider Name:	[REDACTED]		
Employee Name:	[REDACTED]		
Disputed Codes:	24340, 76496-TC, 64450, and C1713		

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 \$2,833.65 in additional reimbursement for a total of \$3,028.65. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of \$3,028.65 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
- 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 denied codes 24340-RT, 76496-TC, 64450-RT-59, and C1713 performed on 04/14/2015.
- Claims Administrator denied 24340-RT with indication “Per CCI Edits, this procedure is included in the value of a comprehensive or Mutually Exclusive Procedure billed on the same day”
- As a pair code exists between 24340 and reimbursed code 24342, Modifier Indicator column shows ‘1’ which states if an approved modifier is appended to the column 2 code, and documentation supports billed code then the edit may be overridden.
- Approved modifier –RT was appended to column 2 code 24340. Provider’s Operative Report documents 24340 service performed on 4/14/2015.
- Reimbursement of 24340-RT is warranted.
- Claims Administrator denied code 76496-TC with indication “Not paid under the Medicare Hospital Outpatient Prospective Payment System. Payment is based on the CA OMFS Labor Code 5307.1”
- Pursuant Section 9789.32: (B) For Other Services rendered on or after September 1, 2014 to hospital outpatients, the maximum allowable hospital outpatient facility fees shall be paid according to the OMFS RBRVS. (i) If the Other Service has a Professional Component/Technical Component under the OMFS RBRVS, the hospital outpatient

facility fee shall be the Technical Component amount determined according to the OMFS RBRVS.

- 76496-TC: Unlisted fluoroscopic procedure (eg, diagnostic, interventional) with a status indicator 'C', Carriers will establish RVUs and payment amounts for these services, generally on an individual case basis following review of documentation such as an operative report.
- Based on aforementioned guidelines, reimbursement of 76496-TC is warranted.
- Claims Administrator's denial of 64450-RT-59 states "Per CCI Edits, this procedure is included in the value of a comprehensive or Mutually Exclusive Procedure billed on the same day"
- Modifier Indicator column shows a '1', and code was submitted with approved modifier - RT and documentation supports service performed on date of service 4/14/2015.
- Reimbursement of 64450-RT is warranted.
- Claims Administrator denied code C1713 stating "code is either deleted, non-covered, bundled, invalid or the status indicator is not allowable under the providers jurisdiction"
- C1713 - Anchor/screw for opposing bone-to-bone or soft tissue-to-bone (implantable), is typically a packaged service. However, Provider submitted "Request for Facility & Implant Authorization" dated April 13, 2015. Document requests authorization for reimbursement of implants (if needed) with a cost range of \$500-\$1500.00 and billing CPT C1713. Document is signed and dated by an authorized signature from Claims Administrator.
- § 5307.11: A health care provider or health facility licensed pursuant to Section 1250 of the Health and Safety Code, and a contracting agent, employer, or carrier may contract for reimbursement rates different from those in the fee schedule adopted and revised pursuant to Section 5307.1. When a health care provider or health facility licensed pursuant to Section 1250 of the Health and Safety Code, and a contracting agent, employer, or carrier contract for reimbursement rates different from those in the fee schedule, the medical fee schedule for that health care provider or health facility licensed pursuant to Section 1250 of the Health and Safety Code shall not apply to the contracted reimbursement rates.
- Operative report documents implants used in 4/14/2015 procedure.
- 8 CCR §9789.60. (2)Dispensed durable medical equipment: cost (purchase price plus sales tax plus shipping and handling) plus 50% of cost up to a maximum of cost plus \$25.00 not to exceed the provider's usual and customary charge for the item.
- Invoice submitted documents total due $\$1,115.50 + \$25.00 = \$1140.50$
- Based on aforementioned guidelines and documentation, reimbursement of C1713 is warranted.
- Opportunity for Claims Administrator letter sent on 12/30/2015. A response from Claims Administrator was not received for review.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Reimbursement of codes 24340, 76496-TC, 64450, and C1713

Date of Service: 04/14/2015						
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Multiple Surgery	Workers' Comp Allowed Amt.	Notes
24340	\$4750.00	\$0.00	\$1614.69	Yes	\$1,614.69	\$1,614.69 Due to Provider
76496-TC	\$575.00	\$0.00	\$53.68	N/A	\$53.68	\$53.68 Due to Provider
64450	\$375.00	\$0.00	\$24.78	N/A	\$24.78	\$24.78 Due to Provider
C1713	\$1449.50	\$0.00	\$1449.50	N/A	\$1,140.50	\$1,140.50 Due to Provider

National Correct Coding Initiative information:

File	Column 1	Column 2	Modifier
Hospital APC Version - 21.1	24340	64450	Allowed
Hospital APC Version - 21.1	24342	24340	Allowed
Hospital APC Version - 21.1	24342	64450	Allowed

Copy to:

[REDACTED]
[REDACTED]
[REDACTED]

Copy to:

[REDACTED]
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