

MAXIMUS FEDERAL SERVICES, INC.

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



INDEPENDENT BILLING REVIEW FINAL DETERMINATION

January 25, 2016

[Redacted]

IBR Case Number:	CB16-0000003	Date of Injury:	03/04/2014
Claim Number:	[Redacted]	Application Received:	01/02/2016
Claims Administrator:	[Redacted]		
Date(s) of service:	06/04/2015		
Provider Name:	[Redacted]		
Employee Name:	[Redacted]		
Disputed Codes:	92526		

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 \$55.74 in additional reimbursement for a total of \$250.74. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of \$250.74 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]

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: 97% Contract Reimbursement
- 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 code 92526 performed on date of service 06/04/2015.
- Claims Administrator reimbursed \$47.24 with indication “The charge has been adjusted to the scheduled allowance”
- §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. (iii) The fees for any physician and non-physician practitioner professional services billed by the hospital shall be calculated in accordance with the OMFS RBRVS, using the OMFS RBRVS total facility relative value units.
- Except for fees determined pursuant to §9789.18.1 et seq., (Anesthesia), the base maximum reasonable fee for physician and non-physician professional medical practitioner services shall be the non-facility or facility fee calculated as follows:
 - (b) Facility site of service fee calculation: $[(\text{Work RVU} * \text{Statewide Work GAF}) + (\text{Facility PE RVU} * \text{Statewide PE GAF}) + (\text{MP RVU} * \text{Statewide MP GAF})] * \text{Conversion Factor} = \text{Base Maximum Fee}$
- §9789.19 Update Table: Other Services Conversion Factor for date of service = \$40.2970.
- Based on aforementioned guidelines, additional reimbursement of 92526 is warranted.

- PPO contract received shows a 3% discount to be applied to reimbursement.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Reimbursement of code 92526

Date of Service: 06/04/2015						
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Multiple Surgery	Workers' Comp Allowed Amt.	Notes
92526	\$426.00	\$47.24	\$55.74	N/A	\$102.98	\$55.74 Due to Provider

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