

MAXIMUS FEDERAL SERVICES, INC.

Independent Bill Review
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Fax: (916) 605-4280



INDEPENDENT BILLING REVIEW FINAL DETERMINATION

February 10, 2016

[Redacted]

IBR Case Number:	CB16-0000059	Date of Injury:	01/22/2013
Claim Number:	[Redacted]	Application Received:	01/14/2016
Claims Administrator:	[Redacted]		
Date(s) of service:	08/10/2015		
Provider Name:	[Redacted]		
Employee Name:	[Redacted]		
Disputed Codes:	63035 and 63030		

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 \$335.00 for the review cost and \$42.80 in additional reimbursement for a total of \$237.80. A detailed explanation of the decision is provided later in this letter.

The Claims Administrator is required to reimburse the Provider a total of \$237.80 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: 95% PPO 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 of 63035 and 63030 for Hospital Outpatient Services performed on 08/10/2015.
- Provider billed codes on a UB04 with claim type 137.
- Claims Administrator denied CPT 63035 with indication “The service is incidental with payment packaged or bundled into another service or APC payment”
- 63035 has a status indicator ‘N’ – **Packaged**, Paid under OPSS; payment is packaged into payment for other services. Therefore, there is no separate APC payment. Items and Services Packaged into APC Rates.
- Title 8, CCR §9789.30: For services rendered on or after September 1, 2014: the item has a **status code N**, Q1, Q2, or Q3 and is packaged into the APC payment for the emergency room visit, surgical procedure, or Facility Only Service (in which case no additional fee is allowable).
- Reimbursement of 63035 is not warranted.
- Claims Administrator reimbursed \$6436.00 for CPT 63030 with rationale “the charge exceeds the APC rate for this service”
- Correct allowable amount calculated for APC 0208 as follows:
APC Relative Weight * Facility Specific Conversion Factor * 1.212 = Allowed
= 55.0874 * 101.47 * 1.212 = \$6819.79

- PPO contract shows a 5% discount to be applied to reimbursement.
- Based on HOPPS, additional reimbursement is owed for 63030.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Reimbursement of 63030.

Date of Service: 08/10/2015						
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Multi Surg	Workers' Comp Allowed Amt.	Notes
63030	\$13,573.00	\$6,436.00	\$383.75	100%	\$6478.80	\$42.80 Due to Provider

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