

MAXIMUS FEDERAL SERVICES, INC.

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



INDEPENDENT BILLING REVIEW FINAL DETERMINATION

April 7, 2016

[Redacted]
[Redacted]
[Redacted]
[Redacted]

IBR Case Number:	CB16-0000253	Date of Injury:	06/01/2013
Claim Number:	[Redacted]	Application Received:	02/18/2016
Assignment Date:	03/30/2016		
Claims Administrator:	[Redacted]		
Date(s) of service:	08/25/2015 – 09/29/2015		
Provider Name:	[Redacted]		
Employee Name:	[Redacted]		
Disputed Codes:	92507		

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 \$186.05 in additional reimbursement for a total of \$381.05. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of **\$381.05** 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]
[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
- 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 remuneration for 92057 Speech/hearing therapy Treatment of speech, language, voice, communication, and/or auditory processing disorder; individual submitted for the following dates of service: 08/25, 09/04, 09/08, 09/15 and 09/29/2015.**
- Initial EOR reflects DWC Bill Adjustment Code G2; this service requires prior authorization and none was identified.
- Authorization dated 03/30/2015 transmitted to the Provider from the Claims Administrator reflects the following certified service:
 - **Six cognitive and behavioral visits bi-weekly.**
- Based on the Provider and bill type, services are reimbursable in accordance with OMFS HOPPS “other services.”
- Contractual Agreement indicates 95% OMFS.
- **Pursuant to Labor Code section 5307.1(g)(2)**, the Acting Administrative Director of the Division of Workers’ Compensation orders that Title 8, California Code of Regulations, sections 9789.30 through 9789.39, pertaining to Hospital Outpatient Departments and Ambulatory Surgical Centers Fee Schedule in the Official Medical Fee Schedule, are adjusted to conform to the hospital outpatient prospective payment system (HOPPS) final rule of December 10, 2013, the wage index values in the hospital inpatient prospective payment system (IPPS) final rule of August 19, 2013, and associated rules and notices to the IPPS final rule, and the relative values in the physician fee schedule final rule of November 27, 2013 published in the Federal Register which change the Medicare payment system.
- **CPT 92051 Addenda D1** reflects **Status Indicator “A”** Not paid under OPSS. Paid by fiscal

intermediaries under a fee schedule or payment system other than OPPS

- **CCR § 9789.32 (c)** The maximum allowable fees for services, drugs and supplies furnished by hospitals and ambulatory surgical centers that do not meet the requirements in (a) for a facility fee payment and are not bundled in the APC payment rate for services in (a) will be determined as follows:
 - (1)(A) For services rendered before September 1, 2014, the maximum allowable hospital outpatient facility fees for **professional medical services which are performed by physicians and other licensed health care providers to hospital outpatients** shall be paid according to Section 9789.10 and Section 9789.11.
 - **(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.
 - (ii) For Other Services, which do not meet the requirement in (i), the hospital outpatient facility fee shall be determined based solely on the non-facility practice expense relative value units applicable under 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.**

The base facility fee is calculated as follows: Non-Facility Site of Service Practice Expense (PE) Relative Value Unit (RVU) * Statewide Geographic Adjustment Factor (GAF) for PE * RBRVS Conversion Factor (CF) = Base facility fee.

- **Based on the aforementioned documentation and guidelines, additional reimbursement is indicated for 97110 for dates of service 08/25, 09/04, 09/08, 09/15 and 09/29/2015**

The table on page 4 describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: 92057

Date of Service: 08/25/2015, 09/04, 09/08, 09/15 and 09/29/2015						
Physical Medicine						
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Units	Workers' Comp Allowed Amt.	Notes
92057	\$2,053.50	\$0.00	\$432.51	1	\$186.05	PPO 95% OMFS \$37.21 per unit Refer to Analysis

Copy to:

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