

MAXIMUS FEDERAL SERVICES, INC.

Independent Bill Review
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INDEPENDENT BILLING REVIEW FINAL DETERMINATION

March 22, 2016

[Redacted]

IBR Case Number:	CB16-0000254	Date of Injury:	01/07/2002
Claim Number:	[Redacted]	Application Received:	02/19/2016
Claims Administrator:	[Redacted]		
Date(s) of service:	07/02/2015		
Provider Name:	[Redacted]		
Employee Name:	[Redacted]		
Disputed Codes:	C1820		

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: UPHOLD. MAXIMUS Federal Services has determined that no additional reimbursement is warranted. The Claims Administrator’s determination is upheld and the Claim Administrator does not owe the Provider additional reimbursement. A detailed explanation of the decision is provided later in this letter.

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

[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: N/A
- 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 C1820 performed on 07/02/2015
- Claims Administrator denied code with indication “This code is either not valid or not available in the California Fee Schedule”
- Copy of PPO contract received shows “Facility shall be paid the lesser of (1) the Anthem Rate(s) set forth in this PCS or (b) **Facility’s Eligible Billed Charges** for Covered Services”
- C1820: N - Packaged Items and Services Packaged into APC Rates. Paid under OPPTS; payment is packaged into payment for other services. Therefore, there is no separate APC payment.
- As the contract states the “lesser of” language, “N” = “0” in OMFS and therefore would be the lesser of.
- Reimbursement of C1820 is not warranted.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Reimbursement of code C1820

Date of Service: 07/02/2015					
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Workers' Comp Allowed Amt.	Notes
C1820	\$149,231.16	\$30,831.46	\$7,030.00	\$0.00	Refer to Analysis

[REDACTED]

[REDACTED]