

INDEPENDENT BILLING REVIEW FINAL DETERMINATION

March 2, 2016



IBR Case Number:	CB16-0000087	Date of Injury:	08/13/2009
Claim Number:	[REDACTED]	Application Received:	01/19/2016
Claims Administrator:	[REDACTED]		
Date(s) of service:	07/23/2015 – 07/23/2015		
Provider Name:	[REDACTED]		
Employee Name:	[REDACTED]		
Disputed Codes:	63685		

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, 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
- Contractual Agreement
- 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 additional remuneration 63685, Insertion or replacement of spinal neurostimulator pulse generator or receiver, direct or inductive coupling, for date of service 07/23/2016.**
- The Claims Administrator indicates 63685 reimbursement was based in accordance with Contractual Agreement.
- The Provider indicates “\$31,566.00,” the Contractual Rate for 63685 expected payment as it is the “Lesser Of.”
- **CCR § 9789.30** subsections (a) adjusted conversion factor, (e) APC payment rate, (f) APC relative weight, (j) Facility Only Services, (q) labor-related share, (r) market basket inflation factor, and (z) wage index, are adjusted to conform to the Medicare hospital outpatient prospective payment system (HOPPS) final rule of December 10, 2013, the relative values in the **2014** Medicare Physician fee schedule, and the wage index values in the Medicare IPPS final rule of August 19, 2013, and associated rules and notices to the IPPS final rule published in the Federal Register.
- **Contractual Agreement § 2.2 1.1** “Facility agrees that in the event a Covered Individual, who is covered for workers' compensation benefits by an Affiliate or under a workers' compensation arrangement administered by an Affiliate, (seeks services for a work-related illness or injury, Facility shall provide such Health Services as are Medically Necessary. As payment for such Health Services rendered, Facility agrees to accept the **lesser of** the (Claims Administrator) set forth in the PCS or the California Workers' Compensation Fee Schedule.”
- 63685 Wt. = 237.1326
- Provider Adjusted Conversion Factor: 83.31
- Workmans' Compensation Multiplier: 1.212
- EORs indicate the following reimbursement:
 - Check Number 0001043503 **\$6,670.00**, DCN# WCA1401906 09/09/2015
 - Check Number 303998 **\$17,183.71**, Re-Evaluation DCN# 220151109FICIWCA91694, 11/9/2015.
 - Total Reimbursed to Provider: **\$23,943.71**
- OMFS calculation for 63685 is **\$23,943.69** which is less than the Contractual Rate of “\$31,566.00.”
- **Based on the documentation submitted, additional reimbursement for 63685 is not indicated.**

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: 63685

Date of Service: 07/23/2015 Hospital Outpatient						
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Units	Workers' Comp Allowed Amt.	Notes
90853	\$100.00	\$23,943.71	\$100.00	1	\$23,943.69	Refer to Analysis

[REDACTED]

[REDACTED]