

## INDEPENDENT BILLING REVIEW FINAL DETERMINATION

March 10, 2015

[REDACTED]  
[REDACTED]  
[REDACTED]

<b>IBR Case Number:</b>	CB14-0001803	<b>Date of Injury:</b>	05/17/2014
<b>Claim Number:</b>	[REDACTED]	<b>Application Received:</b>	11/24/2014
<b>Claims Administrator:</b>	[REDACTED]	<b>Assignment Date:</b>	01/02/2015
<b>Provider Name:</b>	[REDACTED]		
<b>Employee Name:</b>	[REDACTED]		
<b>Disputed Codes:</b>	15100, 15004, 29130, 99060		

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 \$250.00 for the review cost and \$467.56 in additional reimbursement for a total of \$717.56. A detailed explanation of the decision is provided later in this letter.**

The Claim Administrator is required to reimburse the Provider a total of \$717.56 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
- American Medical Association CPT 2014

## 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 questioning reimbursement formula for 15100, 15004, 29130 & 99060 Ambulatory Services performed on 05/20/2014.
- The Claims Administrator reimbursement rational for CPT 15100 & 15004: “Charges exceeds the Official Medical Fee Schedule Allowance. The charge has been adjusted the scheduled allowance.” And “This charge has been adjusted to comply with the rate and rules of the contract indicated.” Additionally, CPT 15004, “The charge has been adjusted in accordance with the OPPS Multiple Procedure Rule.”
- Charges submitted with UB-04, bill type “831,” Ambulatory Services.
- **CPT 15100 Code Description:** Split-thickness autograft, trunk, arms, legs; first 100 sq cm or less, or 1% of body area of infants and children.
  - **Relative Weight 31.1050**
- **CPT 15004 Code Description:** Wound prep. Status indicator “T,” subject to MPPR.
  - **Relative Weight 5.6377**
- **Contractual Agreement** not available for IBR, Provider indicates “10%” of OMFS.
- Title 8, Article 5.3, Services on or after January 1, 2004, Prior to September 1, 2014, Section 9789.38. Appendix X. 42 C.F.R. § 419.44 (a) Multiple surgical procedures. When more than one surgical procedure for which payment is made under the hospital outpatient prospective payment system is performed during a single surgical encounter, the Medicare program payment amount and the beneficiary copayment amount are based on – (1) The full amounts for the procedure with the highest APC payment rate; and (2) One-half of the full program and the beneficiary payment amounts for all other covered procedures.
- Additional reimbursement is warranted for CPT 15000 and CPT 15004.

