INDEPENDENT BILLING REVIEW FINAL DETERMINATION

March 12, 2015

Dear [Name],

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 $267.25 in additional reimbursement for a total of $517.25. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of $517.25 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: [Name]
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:
- National Correct Coding Initiatives
- Other: OMFS Coding Guidelines

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 is dissatisfied with denial of codes 93320 and 93325.
- Claims administrator denied codes indicating on the Explanation of Review “Per CCI Edits, the value of this procedure is included in the value of the comprehensive procedure.”
- Provider billed codes 93320 and 93325 along with 93307 which was reimbursed by the claims administrator.
- 93320 - Doppler echocardiography, pulsed wave and/or continuous wave with spectral display (list separately in addition to codes for echocardiographic imaging 93307, 93308, 93312, 93314, 93315, 93316, 93317, 93350); complete
- 93325 – Doppler color flow velocity mapping (list separately in addition to code for echocardiography 76825, 76826, 76827, 76828, 93307, 93308, 93312, 93314, 93320, 93321, 93350)
- The coding for physician services in the OMFS Physician Services Fee Schedule is based on procedure codes, descriptors, and modifiers of the American Medical Association's Physicians' Current Procedural Terminology (CPT) 1997. The OMFS 1997 code descriptions for both 93320 and 93325 indicate both codes can be listed separately and in addition to 93307. Based on the Fee Schedule in effect for the date of service 6/12/2013, the denial of CPT 93320 and 93325 by the Claims Administrator was not correct.
- Based on information reviewed, reimbursement of codes 93320 and 93325 is warranted.
The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Reimbursement of codes 93320 and 93325 is recommended.

<table>
<thead>
<tr>
<th>Service Code</th>
<th>Provider Billed</th>
<th>Plan Allowed</th>
<th>Dispute Amount</th>
<th>Units</th>
<th>Multiple Surgery</th>
<th>Workers’ Comp Allowed Amt.</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>93320</td>
<td>$157.16</td>
<td>$0.00</td>
<td>$157.16</td>
<td>1</td>
<td>N/A</td>
<td>$157.16</td>
<td>DISPUTED SERVICE: Allow reimbursement $157.16</td>
</tr>
<tr>
<td>93325</td>
<td>$110.08</td>
<td>$0.00</td>
<td>$110.08</td>
<td>1</td>
<td>N/A</td>
<td>$110.09</td>
<td>DISPUTED SERVICE: Allow reimbursement $110.09</td>
</tr>
</tbody>
</table>

Copy to:

[Redacted]

Copy to:

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