

MAXIMUS FEDERAL SERVICES, INC.

Independent Bill Review
P.O. Box 138006
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Fax: (916) 605-4280



INDEPENDENT BILLING REVIEW FINAL DETERMINATION

October 29, 2014

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

IBR Case Number:	CB14-0000972	Date of Injury:	11/2/1963
Claim Number:	[Redacted]	Application Received:	7/10/2014
Claims Administrator:	[Redacted]		
Provider Name:	[Redacted]		
Employee Name:	[Redacted]		
Disputed Codes:	88305 x 15 units		

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.

IBR Case Assigned: 08/13/2014

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 \$1,470.00 in additional reimbursement for a total of \$1,720.00. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of \$1,720.00 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,

[Redacted]
[Redacted]

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
- Official Medical Fee Schedule

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:** The Provider billed CPT Code 88305 15 Units and was reimbursed \$105.00 by the Claims Administrator. The Provider is seeking \$2, 895.00 in additional compensation for services rendered.
- The Claims Administrator denied full reimbursement of CPT 88305 x 15 units for the following reason: “The procedure code billed does not accurately describe the services performed. Reimbursement was made for a code that is supported by the description and documentation submitted with the billing. Allowance based on maximum number of units allowed per fee schedule guidelines and/or service code description.”
- CPT 88305 1997 AMA CPT (brief) Code Description: “Level IV - Surgical pathology, gross and microscopic examination... abortion... muscle... skin...”
- Provided documentation includes a four (4) page “Pathology Report” by the provider.
- The biopsied anatomic sites are listed in alpha order from “A – O,” 15 individual sites are noted.
- Pathology Report describes each A - O specimen and the quality.
- The Claims Administrator’s denial isn’t clear on whether the “maximum number of units allowed” is based on a Provider/Claims Administrator the contractual agreement.
- Contractual Agreement not yet revived, OMFS will be utilized.
- **OMFS Surgical Pathology section** dictates, “Levels 88302 through 88309 are specifically defined by the assigned specimens.”
- The Provider billed 88305 x 15 units and the documentation supports the level of service.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Based on the aforementioned guidelines and documentation provided, reimbursement is warranted for CPT 88305 x15 units.

Date of Service: 10/25/2013							
Physician Services							
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Assist Surgeon	Units	Workers' Comp Allowed Amt.	Notes
88305	\$ 3,000.00	\$ 105.00	\$ 2,895.00	N/A	15	\$ 1575.00	OMFS \$105.00 x 15 = \$1,575.00 - \$105.00 Reimbursement = \$1,470.00 due Provider

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