

**MAXIMUS FEDERAL SERVICES, INC.**

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



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**INDEPENDENT BILLING REVIEW FINAL DETERMINATION**

March 11, 2015

[Redacted]  
[Redacted]  
[Redacted]

|                       |              |                       |            |
|-----------------------|--------------|-----------------------|------------|
| IBR Case Number:      | CB14-0001902 | Date of Injury:       | 04/10/2013 |
| Claim Number:         | [Redacted]   | Application Received: | 12/09/2014 |
| Claims Administrator: | [Redacted]   |                       |            |
| Assigned Date:        | 1/7/2015     |                       |            |
| Provider Name:        | [Redacted]   |                       |            |
| Employee Name:        | [Redacted]   |                       |            |
| Disputed Codes:       | 82486        |                       |            |

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

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
- Negotiated contracted rates:
- National Correct Coding Initiatives/Medically Unlikely Edits

## 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 reimbursement of code 82486 x 39 units.
- Claims administrator reimbursed \$59.12 for two units of 82486 indicating on the Explanation of Review “The billing of the procedure code has exceeded the National Correct Coding Initiative Medically Unlikely Edits amount for the number of times this procedure can be billed on a date of service. All allowance has either not been paid or the maximum allowance for the MUE has been paid. (9789.12.13 c)”
- Medically Unlikely Edits (MUE) (Units of Service): Most HCPCS/CPT codes describe procedures that may be reported a maximum number of times by a single provider for the same beneficiary on the same date of service. If a provider bills units of service for HCPCS/CPT codes in excess of established limits, the edits prevent payment. The Medically Unlikely Edit values are set based upon anatomic considerations, HCPCS/CPT code descriptors, HCPCS/CPT coding instructions, CMS policies, nature of analyte, nature of service/procedure, nature of equipment, and/or clinical judgment based on input from many sources.
- MUEs – All physician and other practitioner claims are subject to these edits – as stated in Medicare’s National Correct Coding Initiative Tools.

