

MAXIMUS FEDERAL SERVICES, INC.

Independent Bill Review
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INDEPENDENT BILLING REVIEW FINAL DETERMINATION

April 7, 2015

[Redacted]
[Redacted]
[Redacted]

IBR Case Number:	CB15-0000108	Date of Injury:	06/29/1999
Claim Number:	[Redacted]	Application Received:	01/27/2015
Claims Administrator:	[Redacted]		
Assigned Date:	2/13/2015		
Provider Name:	[Redacted]		
Employee Name:	[Redacted]		
Disputed Codes:	93455 and C9602		

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 \$195.00 for the review cost and \$11333.21 in additional reimbursement for a total of \$11528.21. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of \$11528.21 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: [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
- Medicare and Medicaid Services (CMS) Outpatient Prospective Payment System (OPPS)

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 codes 93455 and C9602-LC
- Claims administrator reimbursed C9602-LC \$1900.00 indicating on the Explanation of Review "Allowed fee is based on invoice/proof of cost". Claims administrator reimbursed the amount of the stent that was used in the procedure C9602 - Percutaneous transluminal coronary atherectomy, with drug eluting intracoronary stent, with coronary angioplasty when performed; single major coronary artery or branch.
- Code C9602 has a status indicator 'T' - Significant procedure, multiple procedure reduction applies" and qualifies for separate APC payment. Report submitted documents the 'stent with balloon angioplasty and rotational atherectomy' on page 2. C9602 was the procedure performed and therefore, additional reimbursement is warranted.
- Documentation submitted for review included billed UB-04, the Pre-Catheterization H&P report and the Hospital Encounter 2/25/2014 Admission Report by the physician.
- Claims administrator reimbursed \$1258.43 for code 93455.
- 93455 - Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with catheter placement(s) in bypass graft(s) (internal mammary, free

