

**MAXIMUS FEDERAL SERVICES, INC.**

Independent Bill Review  
P.O. Box 138006  
Sacramento, CA 95813-8006  
Fax: (916) 605-4280



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**INDEPENDENT BILLING REVIEW FINAL DETERMINATION**

September 15, 2015



IBR Case Number:	CB15-0001388	Date of Injury:	06/26/2009
Claim Number:	[REDACTED]	Application Received:	08/19/2015
Claims Administrator:	[REDACTED]		
Assigned Date:	9/8/2015		
Provider Name:	[REDACTED]		
Employee Name:	[REDACTED]		
Disputed Codes:	73560-LT, 72170, and 99202		

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 \$60.33 in additional reimbursement for a total of \$255.33. A detailed explanation of the decision is provided later in this letter.**

The Claim Administrator is required to reimburse the Provider a total of \$255.33 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

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cc:



## 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
- National Correct Coding Initiatives
- Medicare and Medicaid Services (CMS) Outpatient Prospective Payment System (OPPS)
- Other: OMFS Outpatient Hospital 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: Provider seeking reimbursement for CPT 73560-LT, 72170 and 99202 for date of service 3/5/2015.**
- Provider billed the procedure codes as part of a facility service on a UB04 with bill type 131.
- In addition to the disputed codes, the Provider billed CPT 73562 and 77073 for date of service 3/5/2015.
- Claims administrator reimbursed the Provider \$34.78 for CPT 77073 and denied reimbursement for CPT 99202, 73560-LT and 72170.
- Title 8, CCR 9789.32(a) Sections 9789.30 through 9789.39 shall be applicable to the maximum allowable fees for emergency room visits and surgical procedures rendered on or after July 1, 2004 and before September 1, 2014. Sections 9789.30 through 9789.39 shall be applicable to the maximum allowable fees for emergency room visits, surgical procedures, and Facility Only Services rendered on or after September 1, 2014. For purposes of this section, emergency room visits and surgical procedures shall be defined by HCPCS codes set forth in section 9789.39(b) by date of service.
  - (c) (B) For Other Services rendered on or after September 1, 2014 to hospital outpatients, the maximum allowable hospital outpatient facility fees shall be paid according to the OMFS RBRVS.

- The Medical Record substantiated the billed code 99202. Medical Records included documentation for a new patient exam, review of tests and exams. Reimbursement recommended for CPT 99202 based on the OMFS RBRVS.
- Reimbursement is not recommended for CPT 73560-LT and 72170 based on the following rules and guidelines:
  - CPT code 77073 (bone length studies...) includes radiologic examination of the lower extremities. CPT codes for radiologic examination of lower extremity structures should not be reported in addition to CPT code 77073 for examination of the radiologic films for the bone length studies. However, if a separate and distinct radiologic examination with additional films of a specific area of a lower extremity is performed to evaluate a different problem, the appropriate CPT code for the additional radiologic examination may be reported with an NCCI-associated modifier.
  - Reason noted for radiological services (77073, 73560-LT and 72170) was indicated as new patient exam, right knee pain and painful knee replacement. Narrative indicated for CPT 73560: "X-Ray knee right 3 views and 1 view left." The medical record did not document a different problem, other than right knee pain/replacement. Separate reimbursement for CPT 73560-LT and 72170 was not substantiated.
  - Provider was reimbursed for CPT 77073. Per NCCI edits, code pair exists between CPT 77073: 73560 and 77073:72170.
  - CPT 73560 and 72170 are included in the procedure billed and reimbursed as CPT 77073, separate reimbursement is not recommended for CPT 73560 and 72170.

DETERMINATION OF ISSUE IN DISPUTE: Recommended reimbursement of code: CPT 99202.

Date of Service 12/30/2014						
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Multiple Surgery	Workers' Comp Allowed Amt.	Notes
99202	\$ 209.72	\$ 0.00	\$ 72.40	N/A	\$ 60.33	<b>DISPUTED SERVICE:</b> See Analysis.
73560-LT	\$698.37	\$0.00	\$31.87	N/A	\$0.00	<b>DISPUTED SERVICE:</b> See Analysis.
72170	\$831.01	\$0.00	\$29.53	N/A	\$0.00	<b>DISPUTED SERVICE:</b> See Analysis.
77073	\$1187.40	34.78	N/A	N/A	N/A	<b>NOT A DISPUTED SERVICE</b>

National Correct Coding Initiative information:

File	Column 1	Column 2	Modifier
Hospital Version 21.0	77073	72170	Allowed
Hospital Version 21.0	77073	73560	Allowed

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