

MAXIMUS FEDERAL SERVICES, INC.

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



INDEPENDENT BILLING REVIEW FINAL DETERMINATION

July 2, 2015

[Redacted]
[Redacted]
[Redacted]

IBR Case Number:	CB15-0000627	Date of Injury:	12/30/2013
Claim Number:	[Redacted]	Application Received:	4/22/2015
Claims Administrator:	[Redacted]		
Date Assigned:	5/21/2014		
Provider Name:	[Redacted]		
Employee Name:	[Redacted]		
Disputed Codes:	96361, 96374, 36415, 80053, 82962, 83874, 84146, 84484, 85027 & 85007		

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 \$86.57 in additional reimbursement for a total of \$281.57. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of \$281.57 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 denial of codes 96361, 96374, 36415, 80053, 82962, 83874, 84146, 84484, 85027 & 85007
- Claims Administrator denied codes 36415, 80053, 82962, 83874, 84146, 84484, 85027 & 85007 indicating on the Explanation of Review “No separate payment was made because the value of the service is included within the value of another service performed on the same day”
- Title 8, California Code of Regulations Chapter 4.5, Division of Workers’ Compensation Subchapter 1 Administrative Director-Administrative Rules Article 5.3 Official Medical Fee Schedule-Hospital Outpatient Departments and Ambulatory Surgical Centers Services on or after January 1, 2004: Section 9789.32. Applicability. (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. A facility fee is payable only for the specified emergency room, surgical codes, Facility Only Services, and for supplies, drugs, devices, blood products and biologicals that are an integral part of the emergency room visit, surgical procedure, or

Facility Only Service. A supply, drug, device, blood product and biological is considered an integral part of an emergency room visit, surgical procedure, or Facility Only Service if: (1) the item has a status code N and is packaged into the APC payment for the emergency room visit or surgical procedure (in which case no additional fee is allowable) or, For services rendered on or after March 1, 2008: the item has a status code N or Q and is packaged into the APC payment for the emergency room visit or surgical procedure (in which case no additional fee is allowable) or, For services rendered on or after March 1, 2009: the item has a status code N, Q1, Q 2, or Q3 and is packaged into the APC payment for the emergency room visit or surgical procedure (in which case no additional fee is allowable) or, For services rendered on or after September 1, 2014: the item has a status code N, Q1, Q2, or Q3 and is packaged into the APC payment for the emergency room visit, surgical procedure, or Facility Only Service (in which case no additional fee is allowable).

- Billed codes 36415, 80053, 82962, 83874, 84146, 84484, 85027 & 85007 all have status indicator ‘N’ and therefore reimbursement is not warranted.
- Claims Administrator denied billed codes 96361 and 96374 indicating on the Explanation of Review “An allowance is not paid for injection services (96365-96379) if the physician is paid for any other physician fee schedule service on the same date of service (9789.1.2(B)(1))”
- Codes 96374 and 96361 both have status indicator ‘S’ Procedure, Not Discounted when Multiple. Paid under OPSS; Separate APC payment
- Reimbursement of 96374 and 96361 is warranted.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Reimbursement of codes 96374 and 96361

Date of Service: 12/19/2014						
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Multiple Surgery	Workers’ Comp Allowed Amt.	Notes
96374	\$354.00	\$0.00	\$68.48	N/A	\$68.48	DISPUTED SERVICE: Allow reimbursement \$68.48
96361	\$229.00	\$0.00	\$18.09	N/A	\$18.09	DISPUTED SERVICE: Allow reimbursement \$18.09

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