

**INDEPENDENT BILLING REVIEW FINAL DETERMINATION**

April 7, 2016

[REDACTED]  
[REDACTED]  
[REDACTED]  
[REDACTED]

IBR Case Number:	CB16-0000408	Date of Injury:	12/03/2005
Claim Number:	[REDACTED]	Application Received:	03/11/2016
Claims Administrator:	[REDACTED]		
Date(s) of service:	08/21/2015		
Provider Name:	[REDACTED]		
Employee Name:	[REDACTED]		
Disputed Codes:	64633 and 64634		

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

[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: N/A
- National Correct Coding Initiatives
- Other: MLN Matters: MM7631

## 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 remuneration for Provider services of codes 64633 and 64634 performed on date of service 08/21/2015
- Claims Administrator reimbursed both codes with indication “this bill was reviewed using the Official Medical Fee Schedule of CA.”
- Provider billed codes with Place of Service ‘11,’ office setting.
- Claims Administrator reimbursed per Place of Service ‘24’
- Provider submitted his Certificate of Accreditation with the Accreditation Association for Ambulatory Health Care standards for ambulatory health care organizations.
- Provider’s Procedure Report documents “the patient returns to MPMC facility for therapeutic interventional procedure” and “the patient tolerated the procedure well and was carefully transported to the recovery room in stable condition.”
- Pursuant MLN Matters: MM7631 - Special Consideration for Ambulatory Surgical Centers (Code 24): When a physician/practitioner furnishes services to a patient in a Medicare-participating ASC, the POS code 24 (ASC) will be used.

NOTE: Physicians/practitioners who perform services in a Medicare-participating ASC will use POS code 24 (ASC). **Physicians are not to use POS code 11 (office) for ASC based services unless the physician has an office at the same physical location of the ASC which meets all other requirements for operating as a physician office at the same physical location as the ASC –**

including meeting the “distinct entity” criteria defined in the ASC State Operations Manual that precludes the ASC and an adjacent physician office from being open at the same time -- and the physician service was actually performed in the office suite portion of the facility. That information is in Appendix L of that manual which is at [http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap\\_1\\_ambulatory.pdf](http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_1_ambulatory.pdf) on the CMS website.

- Based on Provider’s “Scope of Service” which states “includes 4 exam rooms, five treatment rooms, one procedure/operating room, and one number of recovery rooms” – Medicare participating ASC needs to have an adjacent office for physician service. Provider’s documentation does not support Place of Service ‘11.’
- Provider’s Scope of Practice from Accredited AAAHC not submitted for IBR.
- Based on lack of supporting documentation, additional reimbursement for Provider services with Place of Service ‘11’ is not warranted.

The table below describes the pertinent claim line information.

**DETERMINATION OF ISSUE IN DISPUTE: Reimbursement of codes 64633 and 64634**

<b>Date of Service:</b> 08/21/2015						
<b>Physician Services</b>						
<b>Service Code</b>	<b>Provider Billed</b>	<b>Plan Allowed</b>	<b>Dispute Amount</b>	<b>Units</b>	<b>Workers’ Comp Allowed Amt.</b>	<b>Notes</b>
64633	\$680.76	\$361.40	\$319.35	1	\$361.35	Refer to Analysis
64634	\$307.19	\$107.28	\$199.91	1	\$107.28	Refer to Analysis

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]