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

INDEPENDENT BILLING REVIEW FINAL DETERMINATION

May 26, 2016

[redacted]

IBR Case Number:	CB16-0000725	Date of Injury:	09/03/2014
Claim Number:	[redacted]	Application Received:	05/02/2016
Assignment Date:	05/23/2016		
Claims Administrator:	[redacted]		
Date(s) of service:	01/12/2016 – 01/12/2016		
Provider Name:	[redacted]		
Employee Name:	[redacted]		
Disputed Codes:	36415, 80053, 85027, and 81001		

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 $36.58 in additional reimbursement for a total of $231.58. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of **$231.58** 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,

MAXIMUS

Cc: [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
- OMFS

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 36145 Venipuncture and Laboratory Services 80053, 85027 and 81001 for date of service 01/12/2016.**
- The Claims Administrator denied charges with indicating contractual agreement.
- Contractual Agreement not submitted for IBR.
- Opportunity to Dispute Eligibility communicated to Claims Administrator on 05/03/2016; response not yet received.
- Contractual Agreement not submitted for review.
- EOR's indicate "TC" modifier. UB-04 does not reflect a modifier appended to codes in dispute. Review will conclude without TC modifier as per original UB-04 submission.
- **CCR § 5307.1(g)(2)** The Administrative Director of the Division of Workers' Compensation orders that the pathology and clinical laboratory fee schedule portion of the Official Medical Fee Schedule (OMFS) contained in title 8, California Code of Regulations, section 9789.50, has been adjusted to conform to the changes to the Medicare payment system that were adopted by the Centers for Medicare & Medicaid Services (CMS) for calendar year 2015. Effective for services rendered on or after January 1, 2015, the maximum reasonable fees for pathology and laboratory services shall not exceed 120% of the applicable California fees set forth in the calendar year 2015 Clinical Laboratory Fee Schedule.
- Weights
  - 36145 = 3.00
  - 80053 = 14.37
  - 85027 = 8.83
  - 81001 = 4.31
- **Based on the aforementioned documentation and guidelines, reimbursement is warranted for 36415, 80053, 85027, and 81001**

The table on page 4 describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: 36415, 80053, 85027, and 81001

Date of Service: 01/12/2016 Laboratory						
Service Code	**Provider Billed**	**Plan Allowed**	**Dispute Amount**	**Units**	**Workers' Comp Allowed Amt.**	**Notes**
36415	$7.00	$0.00	$3.60	1	$3.60	**Refer to Analysis**
80053	$73.00	$0.00	$17.24	1	$17.24	**Refer to Analysis**
85027	$54.00	$0.00	$12.70	1	$10.57	**Refer to Analysis**
81001	$22.00	$0.00	$5.17	1	$5.17	**Refer to Analysis**

Copy to:

[redacted]

[redacted]