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

INDEPENDENT BILLING REVIEW FINAL DETERMINATION

January 23, 2015

[redacted]

IBR Case Number:	CB14-0001708	Date of Injury:	04/17/1997
Claim Number:	[redacted]	Application Received:	11/13/2014
Claims Administrator:	[redacted]		
Date(s) of service:	03/04/2014 – 06/05/2014		
Provider Name:	[redacted]		
Employee Name:	[redacted]		
Disputed Codes:	90784, 90788 and 95938		

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 $250.00 for the review cost and $45.81 in additional reimbursement for a total of $295.81. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of $295.81 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,

[redacted]
Medical Director

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
- Official Medical Fee Schedule
- Negotiated contracted rates: PPO Discount 2%
- 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 90784, 90788 and 95938
- Provider denied codes 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."
- Pursuant to Labor Code section 5307.1(g) (2), the Acting Administrative Director of the Division of Workers' Compensation orders that Title 8, California Code of Regulations, sections 9789.30 through 9789.39, pertaining to Hospital Outpatient Departments and Ambulatory Surgical Centers Fee Schedule in the Official Medical Fee Schedule, are adjusted to conform to the hospital outpatient prospective payment system (HOPPS) final rule of November 15, 2012.
- Provider billed multiple CPT codes including 95938 and 22551.
- Pursuant NCCI Edits, CPTs 95938 and 22551 are not to be billed together. Claims administrator was correct to deny code 95938 and reimbursement is not warranted.
- Provider submitted a corrected bill including CPTs 90784 and 90788 which claims administrator denied incorrectly.
- Based on information reviewed, reimbursement of codes 90784 and 90788 is warranted.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Reimbursement of codes 90784 and 90788 is recommended.

Date of Service:03/04/2014 –03/05/2014						
Ambulatory Surgery Services						
Service Code	**Provider Billed**	**Plan Allowed**	**Dispute Amount**	**Multiple Surgery**	**Workers' Comp Allowed Amt.**	**Notes**
90784	$31.37	$0.00	$31.37	N/A	$30.74	**DISPUTED SERVICE**: Allow reimbursement $30.74
90788	$15.38	$0.00	$15.38	N/A	$15.07	**DISPUTED SERVICE**: Allow reimbursement $15.07
95938	$253.27	$0.00	$253.27	N/A	$0.00	**DISPUTED SERVICE**: No reimbursement recommended.

National Correct Coding Initiative information:

File	**Column 1**	**Column 2**	**Modifier**
Hospital APC Version 20.0 01/01/2014-03/31/2014	22551	95938	Allowed

Copy to:

[redacted]

Copy to:

[redacted]