

MAXIMUS FEDERAL SERVICES, INC.

Independent Bill Review
P.O. Box 138006
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Fax: (916) 605-4280



INDEPENDENT BILLING REVIEW FINAL DETERMINATION

March 25, 2015

[REDACTED]
[REDACTED]
[REDACTED]

IBR Case Number:	CB14-0001945	Date of Injury:	02/27/2001
Claim Number:	[REDACTED]	Application Received:	12/17/2014
Claims Administrator:	[REDACTED]		
Assigned Date:	1/22/2015		
Provider Name:	[REDACTED]		
Employee Name:	[REDACTED]		
Disputed Codes:	64636 x 2, 64635, 64636-50 x 2 and 64635-50		

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 \$1289.44 in additional reimbursement for a total of \$1539.44. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of \$1539.44 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

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 64636 x 2, 64635, 64636-50 x 2 and 64635-50
- Claims administrator reimbursed codes using the CA Facility Allowable Physician Fee Schedule.
- Provider billed codes on a CMS 1500 form with Place of Service as 11, Office
- Claims administrator submitted documentation stating: “Provider submitted a separate bill for the technical portion with facility charges performed at an Ambulatory Surgery Center (ASC) and a second billing for the professional fees stating services were provided in the doctor’s office. The provider is billing for professional fees performed in the office (POS 11) which pays at a higher rate than when same service is performed at the Ambulatory Surgery Center (POS 24). The provider has already been reimbursed the difference of RVU fees when they billed the facility fees performed at the ASC. Exhibit E.”
- Exhibit E included a copy of the fee schedule for billed codes along with the regulations for the OMFS. No claim form or EOR submitted showing ASC billed codes was found for this review. All claim forms reviewed show Place of Service 11.
- Based on information reviewed, additional reimbursement for codes 64636 x 2, 64636-50 x 2, 64635, 64635-50 is warranted.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Additional reimbursement of codes 64636 x 2, 64635, 64636-50 x 2 and 64635-50 is recommended

Date of Service: 9/5/2014							
Physician Services							
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Units	Multiple Surgery	Workers' Comp Allowed Amt.	Notes
64636	\$700.00	\$202.90	\$423.52	2	100%	\$626.42	DISPUTED SERVICE: Allow reimbursement \$423.52
64635	\$800.00	\$382.10	\$362.57	1	100%	\$744.67	DISPUTED SERVICE: Allow reimbursement \$362.57
64636-50	\$700.00	\$304.36	\$322.06	2	100%	\$626.42	DISPUTED SERVICE: Allow reimbursement \$322.06
64635-50	\$800.00	\$191.05	\$181.28	1	50%	\$372.34	DISPUTED SERVICE: Allow reimbursement \$181.29

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