

INDEPENDENT BILLING REVIEW FINAL DETERMINATION

October 15, 2015

[REDACTED]
[REDACTED]
[REDACTED]

IBR Case Number:	CB15-0001660	Date of Injury:	07/02/2006
Claim Number:	[REDACTED]	Application Received:	09/21/2015
Claims Administrator:	[REDACTED]		
Date(s) of service:	04/13/2015		
Provider Name:	[REDACTED]		
Employee Name:	[REDACTED]		
Disputed Codes:	87640-91-L1		

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

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: N/A
- 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 87640-L1.
- Claims Administrator's denial rationale "Service/item included in the value of other services per CCI edits. Related service could be on a separate bill"
- Pursuant Medicare MLN Matters Number MM8764: 1/1/2014 Add new modifier L1 (Separately payable lab test) to the valid modifier list
- The new Laboratory billing modifier is "L1". So if the hospital determines that the Laboratory test is in a hospital patient scenario that should be paid then bill it on bill type 131 and put L1 on the Lab CPT codes that are to be paid.
- CMS has instructed the MAC to modify the logic for packaged laboratory services. If packaged laboratory services are submitted on a bill type 131 with modifier L1, change the Status Indicator (SI) from N to A.
- Bill type 131 and modifier L1 - when the hospital provides a laboratory test (directly or under arrangement) during the same encounter as other hospital outpatient services that is clinically unrelated to the other hospital outpatient services, **and the laboratory test is ordered by a different practitioner than the practitioner who ordered the other hospital outpatient services provided in the hospital outpatient setting.**
- Lab reports submitted document the same ordering Physician for all lab tests.
- Based on coding guidelines, reimbursement of 87640 is not warranted.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Reimbursement of code 87640-L1

Date of Service: 04/13/2015						
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Multiple Surgery	Workers' Comp Allowed Amt.	Notes
87640-L1	\$300.00	\$0.00	\$300.00	N/A	\$0.00	DISPUTED SERVICE: See analysis

Copy to:

[REDACTED]
[REDACTED]
[REDACTED]

Copy to:

[REDACTED]
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