

**MAXIMUS FEDERAL SERVICES, INC.**

Independent Bill Review  
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**INDEPENDENT BILLING REVIEW FINAL DETERMINATION**

December 14, 2015



IBR Case Number:	CB15-0002099	Date of Injury:	09/23/1997
Claim Number:	[REDACTED]	Application Received:	11/11/2015
Claims Administrator:	[REDACTED]		
Date(s) of service:	07/21/2015 – 07/21/2015		
Provider Name:	[REDACTED]		
Employee Name:	[REDACTED]		
Disputed Codes:	36415 and 80053		

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 \$20.84 in additional reimbursement for a total of \$215.84. A detailed explanation of the decision is provided later in this letter.**

The Claim Administrator is required to reimburse the Provider a total of \$215.84 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]

## 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
- National Correct Coding Initiatives
- Medicare and Medicaid Services (CMS) Outpatient Prospective Payment System (OPPS)
- Other: OMFS Outpatient Hospital Fee Schedule

## 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 reimbursement for CPT 36415 and 80053.**
- Claims Administrator denied the billed procedure codes 80053 and 36415 with the following rationale: There is no separate facility fee for this service under the California Outpatient Hospital/ASC Fee Schedule Labor Code 5307.1.
- The Provider billed 36415, 80053, G0431 and G0434 for date of service 7/21/2015 on the UB04.
- The Claims Administrator reimbursed the Provider for the drug screen codes(G0434 and G0431), and denied reimbursement for CPT 80053 and 36415.
- Title 8, CCR 9789.32 (a) Sections 9789.30 through 9789.39 shall be applicable to the maximum allowable fees for emergency room visits, surgical procedures, and Facility Only Services rendered on or after September 1, 2014.
  - (c) The maximum allowable fees for services, drugs and supplies furnished by hospitals and ambulatory surgical centers that do not meet the requirements in (a) for a facility fee payment and are not bundled in the APC payment rate for services in (a) will be determined as follows:
  - (4) The maximum allowable fee for clinical diagnostic tests shall be determined according to Section 9789.50.
- **§ 9789.50. Pathology and Laboratory.**

- (a) Effective for services after January 1, 2004, the maximum reasonable fees for pathology and laboratory services shall not exceed one hundred twenty (120) percent of the rate for the same procedure code in the CMS' Clinical Diagnostic Laboratory Fee Schedule, as established by Sections 1833 and 1834 of the Social Security Act (42 U.S.C. §§ 1395l and 1395m) and applicable to California.
- Reimbursement is recommended for CPT 36415 and 80053 based on OMFS Pathology and Clinical Laboratory Fee Schedule.

DETERMINATION OF ISSUE IN DISPUTE: Recommended reimbursement of code: CPT 36415 and 80053.

Date of Service 7/21/2015						
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Multiple Surgery	Workers' Comp Allowed Amt.	Notes
36415	\$ 7.00	\$ 0.00	\$ 3.60	N/A	\$3.60	<b>DISPUTED SERVICE:</b> See Analysis.
80053	\$73.00	\$0.00	\$17.29	N/A	\$17.24	<b>DISPUTED SERVICE:</b> See Analysis.

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