

**MAXIMUS FEDERAL SERVICES, INC.**

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



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**INDEPENDENT BILLING REVIEW FINAL DETERMINATION**

June 12, 2015

████████████████████  
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████████████████████  
████████████████████

IBR Case Number:	CB15-0000413	Date of Injury:	10/14/2014
Claim Number:	██████████	Application Received:	03/04/2015
Claims Administrator:	██		
Date Assigned:	4/20/2015		
Provider Name:	██		
Employee Name:	██		
Disputed Codes:	99823, 72100, 70120		

Dear ████████████████████  
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 \$13.99 in additional reimbursement for a total of \$208.99. A detailed explanation of the decision is provided later in this letter.**

The Claim Administrator is required to reimburse the Provider a total of \$208.99 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: ██████████  
██

## 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
- Medicare and Medicaid Services (CMS) Outpatient Prospective Payment System (OPPS)
- Other: Title 8, CCR, §9789.17.1

## 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 code 99283 and reimbursement of codes 72100 and 71020
- Claims Administrator denied code 99283 indicating on the Explanation of Review “Per CCI edits, the value of this procedure is included in the value of the comprehensive procedure”
- Provider billed code 99283 along with 90471 which was reimbursed by Claims Administrator. A code pair does exist between billed codes 90471 and 99283 which states these two codes generally should not be billed together. However, Modifier Indicator column does show a ‘1’ which means if an approved modifier is appended to the appropriate code and documentation is submitted to support the use of the code then the edit may be overridden. Provider did not bill with any modifier and therefore reimbursement of code 99283 is not warranted.
- Provider also billed codes 72100 and 71020 both technical components.
- Claims administrator reduced payment on code 72100
- As of 1/1/2014 Official Medical Fee Schedule of Title 8 §9789.17.1 Radiology Diagnostic Imaging Multiple Procedures: (1) Full payment is made for each PC and TC with the highest payment under the physician fee schedule. (3) Payment is made at 50

percent for subsequent TC services furnished to the same patient, in the same session, on the same day, by one or more physicians in the same group practice (NPI)

- Based on information reviewed, additional reimbursement is warranted for code 72100.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Reimbursement of code 72100 is recommended.

<b>Date of Service:</b> 10/15/2014						
<b>Service Code</b>	<b>Provider Billed</b>	<b>Plan Allowed</b>	<b>Dispute Amount</b>	<b>Multiple Surgery</b>	<b>Workers' Comp Allowed Amt.</b>	<b>Notes</b>
72100	\$1649.00	\$28.27	\$42.26	100%	\$42.26	<b>DISPUTED SERVICE:</b> Allow reimbursement \$13.99
71020	\$1023.00	\$22.87	\$34.25	50%	\$17.14	<b>DISPUTED SERVICE:</b> No further reimbursement is recommended

National Correct Coding Initiative information:

<b>File</b>	<b>Column 1</b>	<b>Column 2</b>	<b>Modifier</b>
Hospital APC Version 20.3	90471	99283	Allowed

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