

**MAXIMUS FEDERAL SERVICES, INC.**

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

July 15, 2015



|                       |              |                       |            |
|-----------------------|--------------|-----------------------|------------|
| IBR Case Number:      | CB15-0000873 | Date of Injury:       | 06/21/2005 |
| Claim Number:         | [REDACTED]   | Application Received: | 05/29/2015 |
| Claims Administrator: | [REDACTED]   |                       |            |
| Assigned Date:        | 06/30/2015   |                       |            |
| Provider Name:        | [REDACTED]   |                       |            |
| Employee Name:        | [REDACTED]   |                       |            |
| Disputed Codes:       | 93459        |                       |            |

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]

## 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
- OMFS Outpatient Hospital and ASC 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 additional reimbursement for CPT 93459.
- Provider billed the outpatient cardiac service on a UB04 with bill type 131.
- Title 8, CCR 9789.32: (a) Sections 9789.30 through 9789.39 shall be applicable to the maximum allowable fees for emergency room visits and surgical procedures rendered on or after July 1, 2004 and before September 1, 2014. 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.
- **Facility Only Services:** Services with a “NA” in the column labeled “**Non-Facility NA Indicator**” “Facility Only Services” means services, defined by Medicare, that rarely or are never performed in the non-facility setting, and are not: 1. emergency room visits; 2. surgical procedures; or 3. An integral part of the emergency room visit or surgical procedure, in accordance with section 9789.32. See section 9789.39(b) for the CMS Physician Fee Schedule Relative Value File which contains the description of the Facility Only Services by date of service.
- **CPT 93459, is not a “Facility Only Service.”** According to the Medicare Physician Fee Schedule Relative Value File the CPT 93459 has a “NA” in the column labeled “Facility NA Indicator.” Facility NA Indicator: An “NA” in this field indicates that this procedure is rarely or never performed in the facility setting.

- Title 8, CCR 9789.32: (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:
  - (B) For Other Services rendered on or after September 1, 2014 to hospital outpatients, the maximum allowable hospital outpatient facility fees shall be paid according to the OMFS RBRVS.
  - If the Other Service has a Professional Component/Technical Component under the OMFS RBRVS, the hospital outpatient facility fee shall be the Technical Component amount determined according to the OMFS RBRVS.
- Based on the above mentioned rules and guidelines additional reimbursement is not recommended. The Claims Administrator reimbursed the Provider based on the Technical Component amount of the OMFS RBRVS for CPT 93459 (\$1030.62 – \$51.48 PPO Discount). Application of PPO discount was not in dispute.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Reimbursement is not recommended for CPT 93459.

| Date of Service: 2/11/2015 |                 |              |                |                  |                            |  |
|----------------------------|-----------------|--------------|----------------|------------------|----------------------------|--|
| Service Code               | Provider Billed | Plan Allowed | Dispute Amount | Multiple Surgery | Workers' Comp Allowed Amt. | Notes                                  |
| 93459                      | \$ 25397.00     | \$978.13     | \$ 2126.25     | 100%             | \$ 978.13                  | <b>DISPUTED SERVICE: See Analysis.</b> |

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