

**INDEPENDENT BILLING REVIEW FINAL DETERMINATION**

July 22, 2015

[Redacted]  
[Redacted]  
[Redacted]

IBR Case Number:	CB15-0000999	Date of Injury:	01/26/2015
Claim Number:	[Redacted]	Application Received:	06/18/2015
Claims Administrator:	[Redacted]		
Date(s) of service:	01/26/2015		
Provider Name:	[Redacted]		
Employee Name:	[Redacted]		
Disputed Codes:	80048, 84484, 85025, 85379, 71010		

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:
- National Correct Coding Initiatives
- Medicare and Medicaid Services (CMS) Outpatient Prospective Payment System (OPPS)
- Other: §9789.32. Outpatient Hospital Department and Ambulatory Surgical Center 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 is requesting reimbursement for denied codes 80048, 84484, 85025, 85379, 71010 billed as Emergency Room Services on a UB-04.
- Claims Administrator denied codes indicating on the Explanation of Review “Services reduced to the Outpatient Perspective Payment System (OPPS) (MOPS)” and “this is a packaged item. Services or procedures included in the AOC rate, but not paid Separately”
- §9789.32. Outpatient Hospital Department and Ambulatory Surgical Center Fee Schedule - Applicability. (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. For purposes of this section, emergency room visits and surgical procedures shall be defined by HCPCS codes set forth in section 9789.39(b) by date of service. A facility fee is payable only for the specified emergency room, surgical codes, Facility Only Services, and for supplies, drugs, devices, blood products and biologicals that are an integral part of the emergency room visit, surgical procedure, or Facility Only Service. A supply, drug, device, blood product and biological is considered an integral part of an emergency

room visit, surgical procedure, or Facility Only Service if: (1) the item has a status code N and is packaged into the APC payment for the emergency room visit or surgical procedure (in which case no additional fee is allowable) or, For services rendered on or after March 1, 2008: the item has a status code N or Q and is packaged into the APC payment for the emergency room visit or surgical procedure (in which case no additional fee is allowable) or, For services rendered on or after March 1, 2009: the item has a status code N, Q1, Q2, or Q3 and is packaged into the APC payment for the emergency room visit or surgical procedure (in which case no additional fee is allowable) or, For services rendered on or after September 1, 2014: the item has a status code N, Q1, Q2, or Q3 and is packaged into the APC payment for the emergency room visit, surgical procedure, or Facility Only Service (in which case no additional fee is allowable).

- Codes 80048, 84484, 85025 and 85379 all have status indicator ‘N’. Code 71010 has status indicator ‘Q3’.
- Based on LC 9789.32 and coding guidelines, reimbursement of codes 80048, 84484, 85025, 85379, 71010 is not warranted.

The table below describes the pertinent claim line information.

**DETERMINATION OF ISSUE IN DISPUTE:** Reimbursement of codes 80048, 84484, 85025, 85379, 71010

<b>Date of Service:</b> 01/26/2105						
<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>
80048, 84484, 85025, 85379, 71010	\$6172.71	\$0.00	\$5926.37	N/A	\$0.00	<b>DISPUTED SERVICE:</b> No reimbursement recommended.

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