

MAXIMUS FEDERAL SERVICES, INC.

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



INDEPENDENT BILLING REVIEW FINAL DETERMINATION

August 28, 2015

[REDACTED]
[REDACTED]
[REDACTED]

IBR Case Number:	CB15-0001231	Date of Injury:	11/09/2009
Claim Number:	[REDACTED]	Application Received:	07/28/2015
Claims Administrator:	[REDACTED]		
Date(s) of service:	10/28/2014		
Provider Name:	[REDACTED]		
Employee Name:	[REDACTED]		
Disputed Codes:	96361, 96367, 96372-59, 96375, 96415, 96417, J9355		

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 \$1127.46 in additional reimbursement for a total of \$1322.46. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of \$1322.46 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]
[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)

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 codes 96361, 96367, 96372-59, 96375, 96415, 96417, J9355
- Claims Administrator denied codes with indication on the Explanation of Review “No separate payment was made because the value of the service is included within the value of another service performed on the same day”
- §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:

- (2) the item is furnished in conjunction with an emergency room visit or surgical procedure and has been assigned Status Code G, H or K
- J9355 has a status indicator 'K', however, services reimbursed are not for an emergency room visit, surgical procedure or Facility Only Service.
- Reimbursement of J9355 is warranted.
- 9789.13.2. Physician-Administered Drugs, Biologicals, Vaccines, Blood Products (b) (1) Injection services (codes 96365 through 96379) are not paid for separately, if the physician is paid for any other physician fee schedule service furnished at the same time. **Pay separately for those injection services only if no other physician fee schedule service is being paid.**
- A physician fee schedule service was not paid and therefore, reimbursement of codes 96367, 96372-59 and 96375 is warranted.
- Claims Administrator reimbursed code 96413 - Chemotherapy administration, intravenous infusion technique; up to 1 hour, single or initial substance/drug
- 9789.13.2 Physician-Administered Drugs, Biologicals, Vaccines, Blood Products (2) pay separately for cancer chemotherapy injections (CPT codes 96401-96549) in addition to the visit furnished on the same day.
- Provider billed code 96361 - Report 96361 to identify hydration if provided as a secondary or subsequent service after a different initial service [96360, 96365, 96374, 96409, **96413**] is administered through the same IV access
- Provider billed code 96417 - Chemotherapy administration, intravenous infusion technique; each additional sequential infusion (different substance/drug), up to 1 hour (List separately in addition to code for primary procedure); Use 96417 in conjunction with 96413.
- Provider billed code 96415 - Chemotherapy administration, intravenous infusion technique; each additional hour (List separately in addition to code for primary procedure); Use 96415 in conjunction with 96413.
- Based on information reviewed, additional reimbursement for codes billed is warranted.

The table below describes the pertinent claim line information.

