

**MAXIMUS FEDERAL SERVICES, INC.**

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



**INDEPENDENT BILLING REVIEW FINAL DETERMINATION**

January 12, 2016

[Redacted]

IBR Case Number:	CB15-0002285	Date of Injury:	01/10/2011
Claim Number:	[Redacted]	Application Received:	12/16/2015
Claims Administrator:	[Redacted]		
Date(s) of service:	09/26/2013		
Provider Name:	[Redacted]		
Employee Name:	[Redacted]		
Disputed Codes:	27266 and 94761		

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 \$818.30 in additional reimbursement for a total of \$1,013.30. A detailed explanation of the decision is provided later in this letter.**

The Claim Administrator is required to reimburse the Provider a total of \$1,013.30 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, M.D., M.P.H.  
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

## 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 full remuneration for 27266 and 94761 services performed on 09/26/2013. CPT 94761 is not in dispute.**
- CPT 94761 Noninvasive ear or pulse oximetry denied by the Claims Administrator has a status indicator of “N” and is not separately reimbursable.
- Reimbursement of 94761 is not warranted.
- Claims Administrator reimbursed code 27266 in the amount of \$369.57 with indication “this charge was adjusted to comply with the rate and rules of the contract indicated”
- Contract agreement not submitted for review.
- Provider billed codes on a UB-04 with Bill Type 131 Hospital Outpatient
- For services rendered on or after March 1, 2009, use: CPT codes 99281-99285 and CPT codes 10021-69990 with status code indicators “S”, “T”, “X”, “V”, “Q1”, “Q2”, or “Q3”. Status code indicators “Q1”, “Q2”, and “Q3” must qualify for separate payment.
- For services rendered on or after January 1, 2013: APC relative weight x adjusted conversion factor x 1.22 workers’ compensation multiplier for hospital outpatient departments and 0.82 workers’ compensation multiplier for ambulatory surgical centers, pursuant to Section 9789.30(x).
- 2013 fee schedule reflects 27266 and has a status indicator of “T” - **Procedure, Multiple Reduction Applies.** Paid under OPPS; Separate APC payment.
- Procedure Note submitted documents services performed on date of service 9/26/2013.
- Opportunity for Claims Administrator to Dispute Eligibility letter was sent on 12/18/2015. A response from Claims Administrator was not received for this review.
- Based on aforementioned guidelines and documentation, additional reimbursement of 27266 is warranted.
- Provider states a 3% PPO reimbursement is to be applied to reimbursement.

The table below describes the pertinent claim line information.27266

**DETERMINATION OF ISSUE IN DISPUTE: Additional reimbursement for code 27266 is warranted.**

<b>Date of Service: 09/26/2013</b>						
<b>Hospital Outpatient</b>						
<b>Service Code</b>	<b>Provider Billed</b>	<b>Plan Allowed</b>	<b>Dispute Amount</b>	<b>Units</b>	<b>Workers' Comp Allowed Amt.</b>	<b>Notes</b>
27266	\$1432.40	\$369.57	\$818.30	1	\$1389.43	\$818.30 Due to Provider

Copy to:

[REDACTED]  
[REDACTED]  
[REDACTED]

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