

MAXIMUS FEDERAL SERVICES, INC.

Independent Bill Review
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INDEPENDENT BILLING REVIEW FINAL DETERMINATION

February 23, 2016

[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]

IBR Case Number:	CB16-0000133	Date of Injury:	12/16/1993
Claim Number:	[REDACTED]	Application Received:	01/29/2016
Claims Administrator:	[REDACTED]		
Date(s) of service:	08/26/2015 – 08/26/2015		
Provider Name:	[REDACTED]		
Employee Name:	[REDACTED]		
Disputed Codes:	86828		

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 \$64.63 in additional reimbursement for a total of \$258.63. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of **\$258.63** 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

[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
- OMFS

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 remuneration for 86828 Antibody to human leukocyte antigens (hla), solid phase assays (eg, microspheres or beads, elisa, flow cytometry); qualitative assessment of the presence or absence of antibody(ies) to hla class i and class ii hla antigens, performed on 08/26/2015.**
- The Claims Administrator denied charges as a packaged APC rate.
- EOR's and UB-04, Bill Type 131, do not reflect services other than laboratory.
- Opportunity to Dispute Eligibility communicated to Claims Administrator 02/01/2016; response not yet received.
- **SBR reflects dispute of \$64.63 for CPT 86828.**
- Contractual Agreement not submitted for review.
- **Administrative rules pursuant to Labor Code section 5307.1(g)(2)**
For services rendered on or after December 1, 2014, section 9789.31, subsections (a) and (b) are amended to incorporate by reference selected sections of the updated calendar year 2014 version of CMS' hospital outpatient prospective payment system (HOPPS) published in the Federal Register on December 10, 2013, the updated fiscal year 2014 versions of CMS' IPPS Tables 2, 4A, 4B, 4C, and 4J in the final rule of August 19, 2013 and associated rules and notices to the IPPS final rule, respectively. The adjustments to these subsections are specified in section 9789.39 by date of service. Subsection (c) and (d) are adjusted to incorporate by reference the **2014** Fiscal Year IPPS Payment Impact File and the Medicare Physician Fee Schedule Relative Value File, respectively. The adjustments to these subsections are specified in section 9789.39 by date of service. Subsection (e) is adjusted to incorporate by reference the 2014 revision of the American Medical Associations' Physician "Current Procedural Terminology"; and subsection (f) is adjusted to incorporate by reference the **2014** revision of CMS' Alphanumeric "Healthcare Common Procedure Coding System".
- **CCR § 9789.50. Pathology and Laboratory** (a) Effective for services after January 1, 2004, the maximum reasonable fees for pathology and laboratory services shall not exceed **one hundred twenty (120) percent** of the rate for the same procedure code in the CMS' Clinical Diagnostic Laboratory Fee Schedule, as established by Sections 1833 and 1834 of the Social Security Act (42 U.S.C. §§ 1395l and 1395m) and applicable to California.
- **CPT 86828 Wt. = 59.99**
- **Based on the aforementioned documentation and guidelines, reimbursement is warranted for 86828.**

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: 86828

Date of Service: 08/26/2015 Laboratory						
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Units	Workers' Comp Allowed Amt.	Notes
86828	\$1,647.73	\$0.00	\$64.63	1	\$64.63	Refer to Analysis

[REDACTED]

[REDACTED]