

MAXIMUS FEDERAL SERVICES, INC.

Independent Bill Review
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INDEPENDENT BILLING REVIEW FINAL DETERMINATION

March 22, 2016

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

IBR Case Number:	CB16-0000309	Date of Injury:	02/12/2013
Claim Number:	[REDACTED]	Application Received:	02/24/2016
Assignment Date:	03/14/2016		
Claims Administrator:	[REDACTED]		
Date(s) of service:	05/15/2013 – 05/15/2013		
Provider Name:	[REDACTED]		
Employee Name:	[REDACTED]		
Disputed Codes:	96367, 96368, 80053, 85027, 96411, 96413, 96415, 96416, and 99212-25		

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

[REDACTED]
[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: Contract Agreement
- Other: CCR § 5307.11, § 9789.32

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 remuneration 96367, 96368, 80053, 85027, 96411, 96413, 96416, and 99212-25 for date of service 05/15/2013**
- The Contract Agreement (copy) received for this review states the following under heading, **“Amendment to Participating Hospital Agreement”**:

This Amendment to Participating Hospital Agreement (“Amendment”) is entered into by and between Claims Administrator and Facility effective this August 1, 2007 to amend the agreement between the parties dated October 1, 1991 (“Agreement”)

1. Amendment of Fee Addendum. The Fee Addendum is hereby deleted in its entirety and replaced as follows: Applicable for Group Health, **Workers’ Compensation** and Other Payment Programs: A. Hospital Services All services **shall be reimbursed at 90% of Provider’s billed charges.**

As an Exempt Facility under the California Workers' Compensation Official Medical Fee Schedule, **all Workers' Compensation services shall be reimbursed under the rates/items listed above.**"

- Contractual Agreement **does not indicate** "eligible billed charges" or "eligible billed charges in accordance with a state mandated fee schedule." Contractual Agreement specifically indicates '90% of Provider's billed charges,' and acknowledges the Provider's "Exempt" status relating to the OMFS. **However, page 2, item 13** reflects the following contractual provision: '**Nothing in this Agreement shall be construed as to require Payer to reimburse a greater amount** or to cover more services than if this Agreement were not in effect,' " indicating reimbursement subject to applicable sections of the OMFS for non-facility charges and the PPO Contract for facility related charges.
- **Exempt Facilities** under the OMFS are exempt from **Facility Only** reimbursement **but are not exempt** from reimbursement under various OMFS fee schedules such as DMEPOS, Laboratory, OMFS RBRVS, etc.
- **CCR § 5307.11:** A health care provider or health facility licensed pursuant to Section 1250 of the Health and Safety Code, and a contracting agent, employer, or carrier may contract for reimbursement rates different from those in the fee schedule adopted and revised pursuant to Section 5307.1. When a health care provider or health facility licensed pursuant to Section 1250 of the Health and Safety Code, and a contracting agent, employer, or carrier contract for reimbursement rates **different from those in the fee schedule**, the medical fee schedule for that health care provider or health facility licensed pursuant to Section 1250 of the Health and Safety Code **shall not apply to the contracted reimbursement rates.**
- **For services On or after July 15, 2004 and before January 1, 2014 HOPPS**
Administrative Rules Regulation effective Feb. 15, 2007 § **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 a surgical service or emergency room visit will be determined as follows:
(1) **The maximum allowable fees for professional medical services which are performed by physicians and other licensed health care providers shall be paid according to Section 9789.10 and Section 9789.11.**
- Initial EOR reflects CPT **96367** Tx/proph/dg addl seq iv inf Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); additional sequential infusion of a new drug/substance, up to 1 hour (list separately in addition to code for primary procedure) and **96368** Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); concurrent infusion (list separately in addition to code for primary procedure) **reimbursed with "comparable" codes.**
- **CPT codes 96367 and 96368 are unlisted codes for date of service 05/15/2013.**
- OMFS allows for comparable code assignment providing the comparable procedure reflects the same amount of time, complexity, expertise, etc., as required for the procedure Performed. EOR's reflect the code replacement as follows:
 - 96367 re-coded to 90780 reimbursed \$285.99' \$190.66 higher than OMFS allowable of \$90.41.
 - 96368 re-coded to 97781 reimbursed \$343.52; \$309.12 higher than OMFS allowable of \$85.88
- **Additional reimbursement is not indicated for CPT 96367 or 96368.**

