

MAXIMUS FEDERAL SERVICES, INC.

Independent Bill Review
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INDEPENDENT BILLING REVIEW FINAL DETERMINATION

June 16, 2016

[Redacted]

IBR Case Number:	CB16-0000854	Date of Injury:	04/10/1997
Claim Number:	[Redacted]	Application Received:	05/23/2016
Claims Administrator:	[Redacted]		
Date(s) of service:	02/16/2016		
Provider Name:	[Redacted]		
Employee Name:	[Redacted]		
Disputed Codes:	63685 and 76000-59		

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 \$18,964.87 in additional reimbursement for a total of \$19,159.87. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of \$19,159.87 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,

Maximus

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
- 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 seeking additional reimbursement for codes 63685 & 76000-59 performed on date of service 02/16/2016.**
- The Provider billed the disputed codes on a UB04, with bill type 131, Outpatient services.
- Claims Administrator based reimbursement with “Workers Compensation Jurisdictional Fee Schedule Adjustment”
- A PPO Contractual agreement not submitted for reviewed.
- 76000: Fluoroscopy (**separate procedure**), up to 1 hour physician or other qualified health care professional time, other than 71023 or 71034 (eg, cardiac fluoroscopy)
- **NCCI Policy Manual for Medicare Service: Separate Procedure:** If a CPT code descriptor includes the term “separate procedure”, the CPT code may not be reported separately with a related procedure. CMS interprets this designation to prohibit the separate reporting of a “separate procedure” when performed with another procedure in an anatomically related region often through the same skin incision, orifice, or surgical approach.
- A CPT code with the “separate procedure” designation may be reported with another procedure if it is performed at a separate patient encounter on the same date of service or at the same patient encounter in an anatomically unrelated area often through a separate skin incision, orifice, or surgical approach.

