

MAXIMUS FEDERAL SERVICES, INC.

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



INDEPENDENT BILLING REVIEW FINAL DETERMINATION

July 24, 2015

[REDACTED]

IBR Case Number:	CB15-0000911	Date of Injury:	01/14/2015
Claim Number:	[REDACTED]	Application Received:	06/04/2015
Claims Administrator:	[REDACTED]		
Assigned Date:	07/07/2015		
Provider Name:	[REDACTED]		
Employee Name:	[REDACTED]		
Disputed Codes:	CPT 36415, 73562-LT, 73590-LT, 73610-LT, 96365-59, and 96375-59		

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 \$85.16 in additional reimbursement for a total of \$280.16. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of \$280.16 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

MAXIMUS FEDERAL SERVICES, INC.

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Fax: (916) 605-4280



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
- National Correct Coding Initiatives
- Medicare and Medicaid Services (CMS) Outpatient Prospective Payment System (OPPS)
- Other: OMFS Outpatient Hospital 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 reimbursement for CPT 36415, 73562-LT, 73590-LT, 73610-LT, 96365-59, and 96375-59**
- Provider billed the procedure codes as part of an emergency room service on a UB04 with bill type 131.
- Per Title 8, CCR 9789.32 (c) (B) For Other Services rendered on or after September 1, 2014 to hospital outpatients, the maximum allowable hospital outpatient facility fees shall be paid according to the OMFS RBRVS.
- CPT codes 96365 and 96375 are listed on the CMS Physician Fee Schedule Relative Value File, with a PC/TC Indicator of "5."
- Title 8, CCR 9789.12.9 The Medicare PC/TC Indicators have been adapted for workers' compensation and have the following meanings: 5 = Incident To Codes-This indicator identifies codes that describe services covered incident to a physician's service when they are provided by auxiliary personnel employed by the physician and working under his or her direct personal supervision. These services are not payable when they are provided to hospital inpatients or patients in a hospital outpatient department. Modifiers 26 and TC cannot be used with these codes.
- Based on the above mentioned rules and guidelines reimbursement is not recommended for CPT 96365 or 96375.

- Title 8, CCR 9789.32 (a) (1) For services rendered on or after September 1, 2014: the item has a status code N, Q1, Q2, or Q3 and is packaged into the APC payment for the emergency room visit, surgical procedure, or Facility Only Service (in which case no additional fee is allowable).
- CPT 36415 is assigned a status indicator of “N”. N = Items and Services Packaged into APC Rates. Paid under OPPS; Payment is packaged into payment for other services, including outliers. Therefore, there is no separate payment.
- Per Title 8, CCR 9789.32 (c) (B) For Other Services rendered on or after September 1, 2014 to hospital outpatients, the maximum allowable hospital outpatient facility fees shall be paid according to the OMFS RBRVS. (i) If the Other Service has a Professional Component/Technical Component under the OMFS RBRVS, the hospital outpatient facility fee shall be the Technical Component amount determined according to the OMFS RBRVS.
- Based on the above mentioned rules and guidelines reimbursement is not recommended for CPT 73562-LT, 73590-LT and 73610-LT
- Per submitted contract “Reimbursement for services rendered to ill/injured employees shall be a 3% discount from the amount payable under guidelines established under any California State law or regulation pertaining to health care services rendered for occupationally ill/injured employees.”
- Reimbursement is recommended for CPT codes: 73562-LT, 73590-LT and 73610-LT based on the OMFS allowance minus the PPO discount of 3%.

DETERMINATION OF ISSUE IN DISPUTE: Recommended reimbursement of code: 73562-LT, 73590-LT and 73610-LT

Date of Service 1/14/2015						
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Multiple Surgery	Workers' Comp Allowed Amt.	Notes
36415	\$ 39.00	\$ 0.00	\$ 3.60	N/A	\$ 0.00	DISPUTED SERVICE: See Analysis.
96365-59	\$522.00	\$0.00	\$83.92	N/A	\$0.00	DISPUTED SERVICE: See Analysis
96375-59	\$446.00	\$0.00	\$53.90	N/A	\$0.00	DISPUTED SERVICE: See Analysis
73562-LT	\$489.00	\$0.00	\$47.81	N/A	\$42.19	DISPUTED SERVICE: See Analysis. Additional Reimbursement of \$42.19 recommended.
73590-LT	\$439.00	\$0.00	\$33.02	N/A	\$32.03	DISPUTED SERVICE: See Analysis. Additional Reimbursement of \$32.03 recommended.
73610-LT	\$525.00	\$0.00	\$43.50	N/A	\$10.94	DISPUTED SERVICE: See Analysis. Additional Reimbursement of \$10.94 recommended.

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