Dear [Name]

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 $335.00 for the review cost and $216.03 in additional reimbursement for a total of $551.03. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of $551.03 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,

[Name]
Chief Coding Reviewer

cc: [Names]
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: PPO Contract Discount 2%
- 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:** The dispute regards the payment amount for emergency department services billed by an Outpatient Hospital Facility. The facility services were billed on a UB-04/CMS1450 using revenue codes for services and supplies related to an emergency room visit on 06/26/2013.
- Provider is disputing the payment amount for CPT codes 25260, 26350, 90781, 90780, 90799, 96376 and 99285.
- Claims Administrator bundled these codes together as “Facility Charges” and reimbursed $5018.61 with the explanation “Charge for a “separate procedure” that does not meet the criteria for payment. See the OMFS General Instructions for Separate Procedures.”
- Based on the provider type, the reimbursement for services is calculated on the Centers for Medicare and Medicaid Services (CMS) Outpatient Prospective Payment System (OPPS). Procedures are assigned APC weights and "Proposed Payment Status Indicators." CPT codes 26350 and 25260 have an assigned indicator “T” which states the code with the higher relative weight will be paid at 100% APC payment. Any additional
procedures with a status “T” indicator will be discounted 50% of their APC payment. The CPT code 99285 has an assigned indicator of "Q3". The "Q3" indicator definition is “Codes That May Be Paid through a Composite APC.”

- Per the OMFS Outpatient Hospital and Ambulatory Surgery Center (ASC) Fee Schedule, 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” rendered on or after January 1, 2013 allowances are calculated as follows: 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). The Provider is considered an outpatient hospital department. The allowance for billed code 25260 with status indicator T should have been based on the following calculation: 32.3471(Relative Weight) x 80.45(CF) x 1.22 = 3174.84 – 2% (PPO discount) = $3111.34. Billed CPT 26350 should have been: 28.9725(Relative Weight) x 80.45 x 1.22 = 2843.62 – 2% = 2786.75 – 50% (status T indicator rule) = 1393.37. The allowance for the billed code 99285 with status indicator Q3 should have been based on the following calculation: 4.8338 (RW) X 80.45 (CF) X 1.22 = 474.43 - 2% = 464.94.

- CPT codes 90781, 90780 and 90799 were all bundled into the “Facility Charge” Claims Administrator noted in the Explanation of Review. No NCCI edits were found on these codes and per OMFS Guidelines are payable.

- CPT code 96376 - Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); each additional sequential intravenous push of the same substance/drug provided in a facility (List separately in addition to code for primary procedure) – has status indicator N which states “paid under OPPS; payment is packaged into payment for other services, including outliers. Therefore, there is no separate APC payment.

The table below describes the pertinent claim line information.

**DETERMINATION OF ISSUE IN DISPUTE: Based on information reviewed, additional reimbursement of codes 26350, 25260, 90781, 90780, 90799 and 99285 is warranted.**

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<td><strong>Service Code</strong></td>
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