

MAXIMUS FEDERAL SERVICES, INC.

Independent Bill Review
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Independent Bill Review Final Determination Reversed

9/10/2014

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

IBR Case Number:	CB13-0000825	Date of Injury:	07/01/2013
Claim Number:	[REDACTED]	Application Received:	12/16/2013
Claims Administrator:	[REDACTED]		
Date(s) of service:	07/01/2013 – 07/01/2013		
Provider Name:	[REDACTED]		
Employee Name:	[REDACTED]		
Disputed Codes:	76377, 99050, 70450, 72125, 72128, 72131 and 94760.		

Dear [REDACTED],

Determination:

A Request for Independent Bill Review (IBR) was assigned to MAXIMUS Federal Services on 03/17/2014, by the Administrative Director of the California Division of Workers' Compensation pursuant to California Labor Code section 4603.6. MAXIMUS Federal Services has determined that the **Claims Administrator's determination is reversed. The Claims Administrator is required to reimburse you the IBR fee of \$335.00 and the amount found owing of \$131.50, for a total of \$466.50.**

Pertinent Records and Other Appropriate Information Relevant to the Determination Reviewed - The following evidence was used to support the decision:

- 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
- Other: American Medical Association Current Procedural Terminology, 2013.

Supporting Analysis:

Pursuant to Labor Code section 5307.1(g)(2), the Administrative Director of the Division of Workers' Compensation orders that Title 8, California Code of Regulations, sections 9789.30 and 9789.31, pertaining to Hospital Outpatient Departments and Ambulatory Surgical Centers Fee Schedule in the Official Medical Fee Schedule, is amended to conform to CMS' hospital outpatient prospective payment system (OPPS). The Administrative Director incorporates by reference, the Centers for Medicare and Medicaid Services' (CMS) Hospital Outpatient Prospective Payment System (OPPS) certain addenda published in the Federal Register notices announcing revisions in the Medicare payment rates. The adopted payment system addenda by date of service are found in the Title 8, California Code of Regulations, and Section 9789.39(b). Based on the adoption of the CMS hospital outpatient prospective payment system (OPPS), CMS coding guidelines and the hospital outpatient prospective payment system (OPPS) were referenced during the review of this Independent Bill Review (IBR) case.

The dispute regards the payment for surgical facility services on date of service 7/1/2013. The facility services were billed on UB-04/CMS1450 using revenue codes for services and supplies related to an emergency room visit billed with the following CPT codes: 76377; 99050; 70450; 72125; 72128; 72131; 94760; and 99283. The Provider is disputing the payment and non-payment of the following codes: 76377; 99050; 70450; 72125; 72128; 72131; and 94760.

The Claims Administrator reimbursed \$1,109.44 for the following billed procedure codes: 99283; 70450; 72128; 72131 and 72125 with the following explanation, "This bill has been re-priced according to your PPO contract." The provider believes a higher rate of reimbursement is warranted.

Procedure codes denied by the Claims Administrator and the corresponding denial descriptions are as follows:

CPT 76377 x 3 (units) and CPT 94760: "There is no separate facility fee for this service under the California Outpatient Hospital/ASC fee schedule labor code 5307.1."

CPT 99050 X 2 (units): "Not paid under the Medicare Hospital Outpatient Prospective Payment System. Payment is based on the CA OMFS Labor code 5307.1. The procedure, material, service or report does not normally warrant a charge. This service/procedure is included in the value of another procedure performed on the same day."

For purposes of this review, the relevant CPT codes and the definitions, according to the American Medical Association Current Procedural Terminology, will be provided.

AMA CPT 2013 code descriptions relevant to this dispute are as follows:

- **CPT 76377:** 3D rendering with interpretation and reporting of computed tomography, magnetic resonance imaging, ultrasound, or other tomographic modality with image post processing under concurrent supervision; requiring image post processing on an independent workstation
- **CPT 99050:** Services provided in the office at times other than regularly scheduled office hours, or days when the office is normally closed (e.g., holidays, Saturday or Sunday), in addition to basic service

- **CPT 70450:** Computed tomography, head or brain; without contrast material
- **CPT 72128:** Computed tomography, thoracic spine; without contrast material
- **CPT 72131:** Computed tomography, lumbar spine; without contrast material
- **CPT 72125:** Computed tomography, cervical spine; without contrast material
- **CPT 94760:** Noninvasive ear or pulse oximetry for oxygen saturation; single determination

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). Reimbursement calculations cannot be determined based on contractual agreement between the Provider and Claims Administrator as this documentation, requested from both parties on 3/17/2014, is not yet received.

In absence of the contractual agreement, this review concurs with the Claims Administrator's reimbursement for CPT Codes 76377 X 3 (units) and 94760 as these codes, per Addendum B, 2013 OPPS Payment by HCPCS, have a Status Indicator of "N" and thus are not typically paid under the California Outpatient Hospital/ASC fee schedule labor code 5307.1. Therefore, further reimbursement is not recommended for CPT Codes 76733 and 94760.

For CPT Codes 70450; 72128; 72131 and 72125, all of these CPT codes have a "Q3" Status Indicator and are typically paid through one Composite APC. The APC Composite Code for this series is 0332, with a reimbursement of \$197.35. Given the total reimbursement for these codes, it is clear that the Claims Administrator did not utilize the composite code option. It is unclear what the mean percentage of reimbursement is as all of these codes were paid at different rates and do not coincide OMFS. Since the contractual agreement is not available, reimbursement will be determined utilizing OMFS. CPT codes in this series that are eligible for reimbursement will be provided in the reimbursement table.

The last CPT code in question is CPT 99050. Although not typically reimbursed in accordance with the California Outpatient Hospital/ASC fee schedule labor code 5307.1, this CPT has been known to be included into contractual agreements for reimbursement. As stated earlier, in the absence of the contractual agreement, CPT Code 99050 will be reimbursed at the OMFS rate. The reimbursement calculation can be found in the reimbursement table on page 4 of this review.

This decision, based on the aforementioned guidelines and submitted documentation, determined that additional reimbursement of \$131.50 for Official Medical Fee Schedule code 74050, 72125 and 99050 is warranted.

The chart below provides a comparison of billed charges and reimbursement rates for the codes and date of services at issue.

Validated Code	Validated Units	Dispute Amount	Total Fee Schedule Allowance	Provider Paid Amount	Allowed Recommended Reimbursement	Fee Schedule Utilized
76377	3	\$130.00	\$0.00	\$0.00	\$0.00.	OMFS
94760	1	\$17.17	\$0.00	\$0.00	\$0.00	OMFS
74050	1	\$85.19	\$230.58	\$199.01	\$53.73	OMFS
72128	1	\$81.64	\$230.58	\$244.94	\$0.00	OMFS
72131	1	\$81.64	\$230.58	\$244.94	\$0.00	OMFS
72125	1	\$150.97	\$230.58	\$175.61	\$54.97	OMFS
99050	2	\$39.52	\$22.80	\$0.00	\$22.80	OMFS
Total					\$131.50	OMFS

MAXIMUS Federal Services, as the Independent Bill Review Organization, has determined the Claims Administrator owes the Provider additional reimbursement. The Claims Administrator is required to reimburse the Provider for the IBR application fee (**\$335.00**) and the OMFS amount for CPT codes 74050, 72125, and 99050 (**\$131.50**) for a total of **\$466.50**.

The Claims Administrator is required to reimburse the provider \$466.50 within 45 days of date on this notice per section 4603.2 (2a). This decision constitutes the final determination of the Division of Workers' Compensation Administrative Director, is binding on all parties, and is not subject to further appeal except as specified in Labor Code section 4603.6(f).

Sincerely,

██████████, RHIT
Chief Coding Reviewer

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