

**MAXIMUS FEDERAL SERVICES, INC.**

Independent Bill Review  
P.O. Box 138006  
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Fax: (916) 605-4280

**Independent Bill Review Final Determination Reversed**

6/25/2014

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

|                       |                       |                       |            |
|-----------------------|-----------------------|-----------------------|------------|
| IBR Case Number:      | CB13-0000888          | Date of Injury:       | 6/26/2013  |
| Claim Number:         | [REDACTED]            | Application Received: | 12/17/2013 |
| Claims Administrator: | [REDACTED]            |                       |            |
| Date(s) of service:   | 6/26/2013 – 6/26/2013 |                       |            |
| Provider Name:        | [REDACTED]            |                       |            |
| Employee Name:        | [REDACTED]            |                       |            |
| Disputed Codes:       | 96360 and 99284       |                       |            |

Dear [REDACTED];

**Determination:**

A Request for Independent Bill Review (IBR) was assigned to MAXIMUS Federal Services on 1/31/2014, 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 \$102.20, for a total of \$437.20.**

**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 or negotiated contract: PPO Contract
- Other: OMFS Outpatient Hospital Fee Schedule, National Correct Coding Initiative/Outpatient Code Editor Version 19.1 (4/1/2013-6/30/2013)

**Supporting Analysis:**

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 6/26/2013. The Provider is disputing the payment amount for CPT 99284 and the denial of 96360. The Claims Administrator bundled the billed codes 99284 and 96360 together on one line and reimbursed the Provider \$300.59 with the explanation "Charge for a "separate procedure" that does not meet the criteria for payment. See the OMFS General Instructions for Separate Procedures rule."

CPT 99284 – Emergency department visit for the evaluation and management of a patient, which requires these 3 key components: A detailed history; A detailed examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patients and/or family's needs. Usually, the presenting problem(s) are of high severity, and require urgent evaluation by the physician physicians, or other qualified health care professionals but do not pose an immediate significant threat to life or physiologic function.

CPT 96360 – Intravenous infusion, hydration; initial, 31 minutes to 1 hour

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." The CPT code 99284 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 the billed code 99284 with status indicator Q3 should have been based on the following calculation: 3.2164 (APC RW) X 80.45 (Adjusted CF) X 1.22 = 315.69 minus PPO discount (2%). The Claims Administrator reimbursed the Provider less than the calculated OMFS allowance; therefore, additional reimbursement is warranted per the OMFS Outpatient Hospital and ASC fee schedule.

The second disputed code is 96360. Per CMS coding guidelines, hospital outpatient facilities may separately report drug administration 96360 services when appropriate. The Emergency Treatment Record documented an IV infusion (0.9% NaCl IV bolus 1,000ml). The billed code 96360 warrants reimbursement based on the OMFS Outpatient Hospital and ASC fee schedule. Per the OMFS Outpatient Hospital and Ambulatory Surgery Center (ASC) fee schedule, 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 (OMFS Physicians Fee Schedule). The CPT 96360 is a new code replaced the old CPT code 90760 as of 12/31/2008. The OMFS Physician Services Fee Schedule is based on the 1997 CPT code book; therefore the allowance for the billed CPT 96360 is based on the OMFS Physician Services Fee Schedule code 90780. Reimbursement is warranted for the procedure code 90780.

