

**MAXIMUS FEDERAL SERVICES, INC.**

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



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**INDEPENDENT BILLING REVIEW FINAL DETERMINATION**

July 31, 2015

[REDACTED]  
[REDACTED]  
[REDACTED]

IBR Case Number:	CB15-0001019	Date of Injury:	07/06/2012
Claim Number:	[REDACTED]	Application Received:	06/23/2015
Claims Administrator:	[REDACTED]		
Date(s) of service:	2/18/2015 – 02/18/2015		
Provider Name:	[REDACTED]		
Employee Name:	[REDACTED]		
Disputed Codes:	0232T-LT		

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 \$969.62 in additional reimbursement for a total of \$1,164.62. A detailed explanation of the decision is provided later in this letter.**

The Claim Administrator is required to reimburse the Provider a total of **\$1,164.62** 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, M.D., M.P.H.  
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

## 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 remuneration for 0232T Injection(s), platelet rich plasma, any site, including image guidance, harvesting and preparation provided on February 18, 2015.**
- The Claims Administrator denied **0232T** services with the following rationale: “the charge exceeds the official medical fee schedule allowance.”
- HCPCS code 0232T, Injection(s), platelet rich plasma, any site, including image guidance, harvesting and preparation when performed. Reimbursement is supported for 0232T as there was a submitted primary treating physician’s progress report including documentation supporting the injection of platelet rich plasma was performed on February 18, 2015 for this service.
- Assigned Status Code for 0232T is “C”.
- § 9789.12.3 Status Codes C, I, N and R
  - (a) Except as otherwise provided in this fee schedule, for physician and non-physician practitioner services billed using Current Procedural Terminology (CPT) codes, the RVUs listed in the Centers for Medicare and Medicaid Services (CMS) National Physician Fee Schedule Relative Value File will be utilized regardless of status code.
  - (b) When procedures with status indicator codes C, N, or R, do not have RVUs assigned under the CMS National Physician Fee Schedule Relative Value File, these services shall be reimbursed by Report.
- Based on a review of the physician progress report, services were performed and documented.
- The Physicians Fee Schedule does not have code 0232T listed with an RVU.

- Contractual Agreement, Appendix B, II Worker’s Compensation, B state: “Reimbursement for services that are billed with a procedure code for which there is not assigned value for that Procedure as outlined above shall be reimbursed at 90% of the Provider’s billed charges.”
- Reimbursement is warranted for the billed code 0232T at 90% of billed charge.

The table below describes the pertinent claim line information.

**DETERMINATION OF ISSUE IN DISPUTE: 95913**

Date of Service: 02/18/2015							
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Assist Surgeon	Units	Workers’ Comp Allowed Amt.	Notes
95913	\$2000.00	\$830.38	\$969.62	N/A	1	\$1800.00	Refer to Analysis

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