

**INDEPENDENT BILLING REVIEW FINAL DETERMINATION**

April 7, 2016

[REDACTED]  
[REDACTED]  
[REDACTED]

IBR Case Number:	CB16-0000404	Date of Injury:	02/27/2011
Claim Number:	[REDACTED]	Application Received:	03/09/2016
Assignment Date:	03/28/2016		
Claims Administrator:	[REDACTED]		
Date(s) of service:	11/05/2015 – 11/05/2015		
Provider Name:	[REDACTED]		
Employee Name:	[REDACTED]		
Disputed Codes:	G0453		

Dear Menaka Neelantha Desilva, MD:

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 \$39.79 additional reimbursement for a total of \$234.79. A detailed explanation of the decision is provided later in this letter.**

The Claim Administrator is required to reimburse the Provider a total of **\$234.79** 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 additional remuneration for G0453 submitted for date of service 11/05/2015.**
- Opportunity to Dispute Eligibility communicated with Claims Administrator on 03/10/2016; response received 03/18/2016. The Claims Administrator ascertains the Provider's "attention directed exclusive to one patient," begins and ends during the transmission phase between Technician and Provider.
- **G0453 - Continuous** intraoperative neurophysiology monitoring, from outside the operating room (remote or nearby), per patient, (attention directed exclusively to one patient) each 15 minutes (list in addition to primary procedure). (Emphasis added)
- General CPT Instructions for timed codes indicate that a unit of time is attained when the mid-point is passed. Medicare recognizes this CPT guidance for many timed codes, including G0453. Therefore, physicians may bill for one unit of G0453 if at least 8 minutes of service is provided as long as no more than 4 units of G0453 are billed for each 60 minutes.
- Documentation submitted for review included the Intraoperative Monitoring Report dictated by Monitoring Physician. Page 1, paragraph 1, line 5, states the following:  
    "Physician Supervision of monitoring **in visual real time started with baseline values** were obtained **and continued until closing ...**" (Emphasis added)
- Event Log indicates communication established with monitoring Provider at 10:58.33 until last Provider Transmission at 11:50:29.
- **Based on the aforementioned documentation and guidelines, additional reimbursement is indicated for G0453.**

The table below describes the pertinent claim line information.

**DETERMINATION OF ISSUE IN DISPUTE: G0453**

<b>Date of Service</b> 11/05/2015							
<b>Practitioner</b>							
<b>Service Code</b>	<b>Provider Billed</b>	<b>Plan Allowed</b>	<b>Dispute Amount</b>	<b>Assist Surgeon</b>	<b>Units</b>	<b>Workers' Comp Allowed Amt.</b>	<b>Notes</b>
G0453	\$198.95	\$39.79	\$39.79	N/A	2	\$79.58	<b>\$39.79</b> <b>Due Provider</b> <b>Refer to Analysis</b>

Copy to:

[REDACTED]