

**INDEPENDENT BILLING REVIEW FINAL DETERMINATION**

May 25, 2016

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

IBR Case Number:	CB16-0000717	Date of Injury:	03/30/2002
Claim Number:	[REDACTED]	Application Received:	04/29/2016
Assignment Date:	05/18/2016		
Claims Administrator:	[REDACTED]		
Date(s) of service:	08/24/2015 – 08/24/2015		
Provider Name:	[REDACTED]		
Employee Name:	[REDACTED]		
Disputed Codes:	G0463 (originally billed as 99212)		

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 \$128.56 in additional reimbursement for a total of \$323.56. A detailed explanation of the decision is provided later in this letter.**

The Claim Administrator is required to reimburse the Provider a total of **\$323.56** 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,  
MAXIMUS

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
- OMFS

## **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 G0463 Evaluation and Management services performed at Hospital Outpatient facility on 08/24/2015.**
- The Claims Administrator denied charge indicating services previously reviewed.
  - Original EOR indicated 99212 submitted and subsequently denied as not reimbursable under OPSS resulting in a corrected claim to G0463.
    - Note: 99212 is reimbursable under HOPPS OMFS under “Other Services,” section “iii.”
  - G0463 denied as previously billed.
- UB-04, Hospital Outpatient Bill Type.
- EOR’s reflect \$0.00 payment for charges.
- HOPPS, OMFS has yet to adopt 2015 fee schedule; 2014 Medicare Utilized G0463, Hospital Outpatient Clinic visit for assessment and management of a patient.
- G0463, Status Indicator “Q3,” **weight 1.2732.**
- For services rendered on or after September 1, 2014 “S”, “T”, “X”, or “V”, “Q1”, Q2”, or “Q3” status code indicators must qualify for separate payment as follows: APC relative weight x adjusted conversion factor x 1.212 workers’ compensation multiplier, pursuant to Section 9789.30(aa). See Section 9789.39(b) for the APC relative **weight** by date of service
- **MLN Matters® Number: MM8572 Effective January 1, 2014**, CMS will recognize HCPCS code **G0463** (Hospital outpatient clinic visit for assessment and management of a patient) for payment under the OPSS for outpatient hospital clinic visits. Effective January 1, 2014, CPT codes 99201-99205 and 99211-99215 will no longer be recognized for payment under the OPSS.
- Provider indicates “no PPO” contract; OMFS will be utilized.
- **Based on the aforementioned documentation and guidelines, reimbursement is warranted for G0463.**

The table on page 4 describes the pertinent claim line information.

**DETERMINATION OF ISSUE IN DISPUTE: G0463**

<b>Date of Service:</b> 08/24/2015 HOPPS						
<b>Service Code</b>	<b>Provider Billed</b>	<b>Plan Allowed</b>	<b>Dispute Amount</b>	<b>Units</b>	<b>Workers' Comp Allowed Amt.</b>	<b>Notes</b>
G0463	\$209.72	\$0.00	\$128.56	1	\$128.56	<b>Refer to Analysis</b>

Copy to:

[REDACTED]

[REDACTED]