

**INDEPENDENT BILLING REVIEW FINAL DETERMINATION**

August 26, 2015

[Redacted]

IBR Case Number:	CB15-0001230	Date of Injury:	01/09/2015
Claim Number:	[Redacted]	Application Received:	07/28/2015
Claims Administrator:	[Redacted]		
Date(s) of service:	01/09/2015		
Provider Name:	[Redacted]		
Employee Name:	[Redacted]		
Disputed Codes:	99204		

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 \$112.88 in additional reimbursement for a total of \$307.88. A detailed explanation of the decision is provided later in this letter.**

The Claim Administrator is required to reimburse the Provider a total of \$307.88 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, MD, MPH  
Medical Director

cc: [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
- Negotiated contracted rates:
- National Correct Coding Initiatives
- Other: Outpatient Hospital Department and Ambulatory Surgical Center Fee Schedule - Applicability.

## 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 is dissatisfied with denial of CPT 99204.
- Claims Administrator denied code indicating on the Explanation of Review “Service not paid under Outpatient Facility Fee Schedule”
- Provider originally billed code 99204 on a UB-04 claim form for outpatient services. Second claim form shows HCPCS G0463 – Hospital Outpatient Clinic, which is the appropriate code to bill for services on date of service 1/9/2015.
- Provider submitted documentation which included the Doctor’s First Report of Occupational Injury or Illness which details services for date of service 1/9/2015 along with the “Urgent Care Record Head Injury”
- G0463 has a status indicator ‘Q3”
- 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 1.010 workers’ compensation multiplier, pursuant to Section 9789.30(aa). See Section 9789.39(b) for the APC relative weight by date of service.
- For services rendered on or after December 1, 2014, section 9789.30, subsections (a) adjusted conversion factor, (e) APC payment rate, (f) APC relative weight, (j) Facility Only Services, (q) labor-related share, (r) market basket inflation factor, and (z) wage

index, are adjusted to conform to the Medicare hospital outpatient prospective payment system (HOPPS) final rule of December 10, 2013, the relative values in the 2014 Medicare Physician fee schedule, and the wage index values in the Medicare IPPS final rule of August 19, 2013, and associated rules and notices to the IPPS final rule published in the Federal Register.

- Based on information reviewed, reimbursement of G0463 is warranted.

The table below describes the pertinent claim line information.

**DETERMINATION OF ISSUE IN DISPUTE: Reimbursement of code G0463**

<b>Date of Service:</b> 1/9/2015						
<b>Physician Services</b>						
<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	\$361.20	\$0.00	\$112.88	1	\$112.88	<b>DISPUTED SERVICE:</b> Allow reimbursement \$112.88

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