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

INDEPENDENT BILLING REVIEW FINAL DETERMINATION

October 6, 2015

[redacted]

IBR Case Number:	CB15-0001581	Date of Injury:	01/14/2015
Claim Number:	[redacted]	Application Received:	09/10/2015
Claims Administrator:	[redacted]		
Date(s) of service:	03/10/2015 & 03/27/2015		
Provider Name:	[redacted]		
Employee Name:	[redacted]		
Disputed Codes:	99214		

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 $249.41 in additional reimbursement for a total of $444.41. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of $444.41 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
- National Correct Coding Initiatives
- Medicare and Medicaid Services (CMS) Outpatient Prospective Payment System (OPPS)
- Other: OMFS Outpatient Hospital 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 reimbursement for CPT 99214 for two separate dates of service.**
- Claims administrator denial rationale for both dates of service: "A charge was made or a separate procedure that does not meet the criteria for separate payment. See Physician's Fee Schedule"
- Evaluation and Management code 99214 has a status indicator 'B' - Not paid under OPPS.
- Codes that are not recognized by OPPS when submitted on an outpatient hospital Part B bill type (12x, and 13x). May be paid by MAC when submitted on a different bill type, for example, 75x (CORF), but not paid under OPPS; An alternate code that is recognized by OPPS when submitted on an outpatient hospital Part B bill type (12x and 13x) may be available
- Evaluation and Management code 99214 for both dates of service should have been cross walked to HCPCS G0463 - Hospital outpatient clinic visit for assessment and management of a patient.
- Title 8, CCR 9789.32. Applicability (a) Sections 9789.30 through 9789.39 shall be applicable to the maximum allowable fees for emergency room visits and surgical procedures rendered on or after July 1, 2004 and before September 1, 2014. Sections 9789.30 through 9789.39 shall be applicable to the maximum allowable fees for emergency room visits, surgical procedures, and Facility Only Services rendered on or after September 1, 2014.

- Provider billed the procedure code UB04 with bill type 137, no other services were billed for each date of service.
- G0463: Hospital outpatient clinic visit for assessment and management of a patient, has a status indicator Q3 - Composite Paid under OPPS; Addendum B displays APC assignments when services are separately payable. Addendum M displays composite APC assignments when codes are paid through a composite APC. (1) Composite APC payment based on OPPS composite-specific payment criteria. Payment is packaged into a single payment for specific combinations of services. (2) In other circumstances, payment is made through a separate APC payment or packaged into payment for other services.
- Documentation submitted reflects services of G0463 for both dates of service in dispute
- PPO contract received shows a 3% PPO discount to be applied to reimbursement.

DETERMINATION OF ISSUE IN DISPUTE: Recommended reimbursement of code: HCPCS G0463.

Date of Service 03/10/2015 & 03/27/2015						
Service Code	**Provider Billed**	**Plan Allowed**	**Dispute Amount**	**Multiple Surgery**	**Workers' Comp Allowed Amt.**	**Notes**
G0463	$ 642.00	$ 0.00	$ 249.41	N/A	$249.41	**DISPUTED SERVICE**: See Analysis. Additional Reimbursement of $249.41 recommended

Copy to:

[redacted]

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