

MAXIMUS FEDERAL SERVICES, INC.

Independent Bill Review
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INDEPENDENT BILLING REVIEW FINAL DETERMINATION

October 10, 2015

[Redacted]
[Redacted]
[Redacted]

IBR Case Number:	CB15-0001653	Date of Injury:	05/15/2015
Claim Number:	[Redacted]	Application Received:	09/21/2015
Assignment Date:	10/09/2015		
Claims Administrator:	[Redacted]		
Date(s) of service:	05/15/2015 – 05/15/2015		
Provider Name:	[Redacted]		
Employee Name:	[Redacted]		
Disputed Codes:	G0463, 73090, and 73110		

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 \$70.15 in additional reimbursement for a total of \$265.15. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of **\$265.15** 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
- 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, 73090 and 73110 performed on 05/15/2015.**
- The Claims Administrator denied the following cods as “not paid” under HOPPS:
 - G0463 Hospital Outpatient Facility Evaluation and Management, Status Indicator “**Q3**.”
 - 73090 X-ray forearm, Status Indicator “**X**.”
 - 73110 X-ray, wrist, Status Indicator “**X**.”
- **CCR § 9789.33**, For services rendered on or after September 1, 2014, Status Indicators; “S”, “T”, “X”, or “V”, “Q1,” Q2,” or “**Q3**” must qualify for separate payment.” must qualify for separate payment. 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.
- G0463 does not have a value for 2014 OMFS, however, an Evaluation and Management Cross-Walk Code can be abstracted from the visit documentation providing the documentation and submitted billing supports reimbursement.
- UB-04, bill type “131,” reflecting Pharmacy Services and **Injection Procedure**.
- **CPT G0463** and billed **Injection Procedure** are mutually exclusive. G0463 may be reimbursed under certain circumstances if the appropriate modifier, Modifier -25, is appended to the Evaluation and Management Service.
- UB-04 and the EOR’s do not reflect a modifier for G0463. Reimbursement for the Injection Procedure is reflected in the EOR’s; Reimbursement upheld for G0463
- **CCR § 9.13.2**. Physician-Administered Drugs, Biologicals, Vaccines, Blood Products.(b)(1) **Injection services** (codes 96365 through 96379) **are not paid for separately**, if the physician is paid for any other physician fee schedule service furnished at the same time. Pay separately for those injection services only if no other physician fee schedule service is being paid.
- **CCR 9789.32 (c) (B) (i)** If the Other Service has a Professional Component/Technical Component under the OMFS RBRVS, the hospital outpatient facility fee shall be the **Technical Component** amount determined according to the OMFS RBRVS.
- 73090 & 73110 reimbursable at Technical Component.
- **Based on the aforementioned documentation and guidelines, reimbursement is indicated for 73090 and 73110 and is not indicated G0463.**

The table below describes the pertinent claim line information.

