

INDEPENDENT BILLING REVIEW FINAL DETERMINATION

October 12, 2015

[REDACTED]
[REDACTED]
[REDACTED]

IBR Case Number:	CB15-0001655	Date of Injury:	04/04/2015
Claim Number:	[REDACTED]	Application Received:	09/21/2015
Assignment Date:	10/09/2015		
Claims Administrator:	[REDACTED]		
Date(s) of service:	04/04/2015 – 04/04/2015		
Provider Name:	[REDACTED]		
Employee Name:	[REDACTED]		
Disputed Codes:	99204 and 80074		

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 \$123.04 in additional reimbursement for a total of \$318.04. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of **\$318.04** 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 \$45.05 in remuneration for 99204 New Patient Evaluation and Management services and 80074 Acute Hepatitis Panel performed at a Hospital Outpatient facility on 04/04/2015.**
- The Claims Administrator denied charge as “not payable under OPPTS.”
- UB-04, Hospital Outpatient Bill Type.
- EOR’s reflect \$0.00 payment for charges.
- 99204 is a status indicator “B” and is not reimbursable for this bill type. Cross-walk code for this services is G0463, Hospital Outpatient clinic visit.
- Documentation indicates Evaluation and Management services was not billed in conjunction with conflicting procedural services.
- G0463, Status Indicator “**Q3**.”
- **CCR § 9789.33** 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.
- **CPT 80074** is reimbursable pursuant to **CCR § 9789.50 (a)** Pathology and Laboratory: Effective for services after January 1, 2004, the maximum reasonable fees for pathology and laboratory services shall not exceed one hundred twenty (120) percent of the rate for the same procedure code in the CMS' Clinical Diagnostic Laboratory Fee Schedule, as established by Sections 1833 and 1834 of the Social Security Act (42 U.S.C. §§ 1395l and 1395m) and applicable to California
- **Based on the aforementioned documentation and guidelines, reimbursement is warranted for 99204 as G0463.**

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: 99204 and 80074

Date of Service: 04/04/2015 HOPPS						
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Units	Workers' Comp Allowed Amt.	Notes
99204 as G0463	\$311.00	\$0.00	\$45.05	1	\$27.15	Refer to Analysis
80074	\$324.95	\$0.00	\$77.99	1	\$77.99	Refer to Analysis

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