

**MAXIMUS FEDERAL SERVICES, INC.**

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



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**INDEPENDENT BILLING REVIEW FINAL DETERMINATION**

July 13, 2015

[REDACTED]  
[REDACTED]  
[REDACTED]

IBR Case Number:	CB15-0000862	Date of Injury:	01/29/2105
Claim Number:	[REDACTED]	Application Received:	05/27/2015
Claims Administrator:	[REDACTED]		
Assigned Date:	06/26/2015		
Provider Name:	[REDACTED]		
Employee Name:	[REDACTED]		
Disputed Codes:	HCPCS G0378 and Additional Trauma Activation Reimbursement for outpatient emergency room services.		

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: UPHOLD. MAXIMUS Federal Services has determined that no additional reimbursement is warranted. The Claims Administrator’s determination is upheld and the Claim Administrator does not owe the Provider additional reimbursement. A detailed explanation of the decision is provided later in this letter.**

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).

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Sincerely,

Paul Manchester, MD MPH

Medical Director

cc:



## **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
- OMFS Outpatient Hospital and ASC 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:** The Provider is seeking additional reimbursement for Trauma Activation Services and HCPCS G0378.
- The Request for IBR review letter from the Provider requested a review of the following: Composite APC 8009 rate for G0378; and Trauma Activation costs.
- Additional reimbursement is not recommended based on the findings.
- Based on review of the CY 2014 OPDS Addendum B, code G0378 has a status indicator of 'N'.
- Per Title 8, CCR 9789.32 (a)(1), codes with a status indicator of N, Q, Q1, Q2, and Q3 are “packaged into the APC payment for the emergency room visit or surgical procedure (in which case no additional fee is allowable)”
- Medicare Claims Processing Manual, Chapter 4, Section 10.2.1 has directed to use a composite APC for this service, however the specific instruction in the CCR directs otherwise.
- No additional reimbursement is warranted for G0378.
- Trauma Activation: Provider did not bill this service with a CPT/HCPCS code. CCR sections 9789.30 through 9789.39 does not have specific language addressing additional reimbursement for outpatient hospital Trauma Activation Services. There are no listed guidelines indicating an additional allowance for all billed services when billed as a Trauma Activation. Reimbursement for Outpatient Hospital services is based on the use

of CPT/HCPCS, associated status code indicators, APC weights and payment rates based on dates of service. The provider did not bill an appropriate CPT or HCPCS code. No additional reimbursement is recommended.

The table below describes the pertinent claim line information.

**DETERMINATION OF ISSUE IN DISPUTE:** Reimbursement is not recommended for CPT G0378 and Trauma Activation Services.

<b>Date of Service: 1/29/2015 – 1/30/2015</b>						
<b>Service Code</b>	<b>Provider Billed</b>	<b>Plan Allowed</b>	<b>Dispute Amount</b>	<b>Multiple Surgery</b>	<b>Workers' Comp Allowed Amt.</b>	<b>Notes</b>
G0378	\$ 4245.00	\$0.00	\$ 1665.79	100%	\$ 0.00	<b>DISPUTED SERVICE: See Analysis.</b>
Trauma Activation Services	\$17,342.35	\$0.00	4366.96	50%	\$0.00	<b>DISPUTED SERVICE: See Analysis.</b>

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