

INDEPENDENT BILLING REVIEW FINAL DETERMINATION

August 6, 2015

[REDACTED]
[REDACTED]
[REDACTED]

IBR Case Number:	CB15-0001104	Date of Injury:	02/16/2015
Claim Number:	[REDACTED]	Application Received:	07/09/2015
Claims Administrator:	[REDACTED]		
Assigned Date:	07/31/2015		
Provider Name:	[REDACTED]		
Employee Name:	[REDACTED]		
Disputed Codes:	72155 and 72131		

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 \$413.45 in additional reimbursement for a total of \$608.45. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of **\$608.45** 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
- Official Medical Hospital Fee Schedule
- National Correct Coding Initiatives
- Medicare and Medicaid Services (CMS) Outpatient Prospective Payment System (OPPS)

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 72125 CT Cervical Spine without Contrast and 72131 CT Lumbar Spine without Contrast provided on 02/16/2015.**
- Provider billed disputed services as part of an outpatient hospital service on a UB04 with by type 131.
- Claims Administrator denied payment with the reason “the payment reflects the recommended allowance.”
- Per OMFS Outpatient Hospital and Ambulatory Surgery Center Fee Schedule effective January 1, 2015, status code indicators and APC Relative Weights are based on CMS Addendum B effective for date of service February 16, 2015.
- CPT codes 78125 and 72131 have the assigned status indicator for this disputed code for 2015 is “Q3”. Q3 = Codes that may be paid through a composite APC.
 - Paid under OPSS; Addendum B displays APC assignments when services are separately payable. Addendum M displays composite APC assignment when codes are paid through a composite APC.
 - 1) Composite APC payment based on OPSS composite-specific payment criteria. Payment is packaged into a single payment for specific combinations of service.
 - 2) In all other circumstances, payment is through a separate APC payment or packaged into payment for other services.
- CPT codes 78125 and 72131 are listed on Addendum M and therefore payment is packaged into a single composite APC payment, APC 8005.

- Section 9789.32. Applicability: For Other Services rendered on or after September 1, 2014 to hospital outpatients, the maximum allowable hospital outpatient t facility fees shall be paid according to the OMFS RBRVS. 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.
- These services are packaged into composite APC 8005 and warrant additional reimbursement.
- There were no NCCI edits identified for the code combinations submitted for date of service February 16, 2015.
- **OMFS § 9789.33** For services rendered on or after September 1, 2014 “S”, “T”, “X”, or “V”, “Q1”, “Q2”, or “Q3”. Status code indicators “Q1”, “Q2”, and “Q3” must qualify for separate payment. APC relative weight x adjusted conversion factor x 1.212 workers’ compensation multiplier, pursuant to Section 9789.30(aa).
- Provider indicates PPO Contract “97%” OMFS.
- Opportunity to Dispute Eligibility sent to Claims Administrator on 07/13/2015; response not yet received.
- **Based on the aforementioned documentation and guidelines, additional reimbursement is warranted for 78125 and 72131.**

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: 72125 and 72131

Date of Service: 2/16/2015							
Hospital Outpatient							
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Assist Surgeon	Units	Workers' Comp Allowed Amt.	Notes
72125 72131	\$5,511.00	\$0.00	\$413.45	N/A	1	\$413.45	PPO Contract, Composite Payment, Refer to Analysis

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