

INDEPENDENT BILLING REVIEW FINAL DETERMINATION

January 6, 2016

[Redacted]

IBR Case Number:	CB15-0002232	Date of Injury:	02/19/2105
Claim Number:	[Redacted]	Application Received:	12/07/2015
Claims Administrator:	[Redacted]		
Date(s) of service:	02/22/2015 – 02/22/2015		
Provider Name:	[Redacted]		
Employee Name:	[Redacted]		
Disputed Codes:	99283-25, 72100, 70450, 96361, 96374, and 96375		

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 \$414.76 in additional reimbursement for a total of \$609.76. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of **\$609.76** 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]

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 99283-25, 72100, 70450, 96361, 96374, and 96375 services performed on 02/22/2015.**
- The Claims Administrator denied services as not payable “under outpatient fee schedule.”
- Provider billed the disputed HCPCS code on a UB04, bill type 131 for date of service 02/22/2015.
- Based on the provider type, the reimbursement for services is calculated on the Centers for Medicare and Medicaid Services (CMS) Outpatient Prospective Payment System (OPPS). Procedures are assigned APC weights and "Proposed Payment Status Indicators."
- Section 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. (c) The maximum allowable fees for services, drugs and supplies furnished by hospitals and ambulatory surgical centers that do not meet the requirements in (a) for a facility fee payment and are not bundled in the APC payment rate for services in (a) will be determined as follows:
(1)(A) For services rendered before September 1, 2014, the maximum allowable hospital outpatient facility fees for professional medical services which are performed by physicians and other licensed health care providers to hospital outpatients shall be paid according to Section 9789.10 and Section 9789.11.
(B) For Other Services rendered on or after September 1, 2014 to hospital outpatients, the maximum allowable hospital outpatient 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.
- Medical record submitted included the H&P notes for the ER visit on 11/20/14. CPT guidelines requires all three components to be met for CPT **99283**: Expanded Problem Focused History; Expanded Problem Focused Examination; Medical decision making of Moderate Complexity.
- Medical record demonstrated an Expanded Problem Focused History; Expanded Problem Focused Examination; Medical decision making of Moderate Complexity. CPT 99283 is recommended.
- CPT 72100 X-ray exam l-s spine 2/3 views and 70450 Ct head/brain w/o dye the **Technical Component** is reimbursable for each service.
- ER and Nursing Documentation does not reflect intravenous services 96361, 96374, and 96375, as such, these services cannot be verified and reimbursement cannot be determined.
- **Based on the aforementioned documentation and guidelines, reimbursement is indicated for 99283-25, 72100 & 70450 and is not indicated for 96361, 96374, and 96375.**

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: 99283-25, 72100, 70450, 96361, 96374, and 96375

Date of Service: 02/22/2015						
Physician Services						
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Units	Workers' Comp Allowed Amt.	Notes
99283.25	\$1,268.00	\$0.00	\$231.63	1	\$231.63	Refer to Analysis
72100	\$529.00	\$0.00	\$42.26	1	\$42.26	Refer to Analysis
70450	\$3,044.00	\$0.00	\$140.87	1	\$140.87	Refer to Analysis
96361	\$229.30	\$0.00	\$14.24	1	\$0.00	Refer to Analysis
96374	\$354.00	\$0.00	\$60.54	1	\$0.00	Refer to Analysis
96375	\$223.00	\$0.00	\$22.70	1	\$0.00	Refer to Analysis

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