

**INDEPENDENT BILLING REVIEW FINAL DETERMINATION**

January 19, 2016

[REDACTED]  
[REDACTED]  
[REDACTED]

IBR Case Number:	CB15-0002313	Date of Injury:	07/23/2015
Claim Number:	[REDACTED]	Application Received:	12/22/2015
Claims Administrator:	[REDACTED]		
Date(s) of service:	07/23/2015		
Provider Name:	[REDACTED]		
Employee Name:	[REDACTED]		
Disputed Codes:	29130, 71020, 93005, 94761, 96361, 96372, 96375, and 99285-25		

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 \$709.78 in additional reimbursement for a total of \$904.78. A detailed explanation of the decision is provided later in this letter.**

The Claim Administrator is required to reimburse the Provider a total of **\$904.78** 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 codes 29130, 71020, 93005, 94761, 96361, 96372, 96375, and 99285-25 performed on 07/23/2015.**
- The Claims Administrator denied codes as “included” in the value of another service.
- Codes also billed
- For services rendered on or after December 1, 2014, section 9789.30, subsections (a) adjusted conversion factor, (e) APC payment rate, (f) APC relative weight, (j) Facility Only Services, (q) labor-related share, (r) market basket inflation factor, and (z) wage index, are adjusted to conform to the **Medicare hospital outpatient prospective payment system (HOPPS) final rule of December 10, 2013**, the relative values in the 2014 Medicare Physician fee schedule, and the wage index values in the Medicare IPPS final rule of August 19, 2013, and associated rules and notices to the IPPS final rule published in the Federal Register. The adjustments to these subsections are specified in section 9789.39 by date of service.
- **CPT 29130**, Application of finger splint, Status Indicator = S
- A pair code does exist between billed codes 29130 and 26951 which was reimbursed. Modifier Indicator column shows a ‘1’ which states if a proper modifier is appended to the column ‘2’ code and documentation supports billed code, then the edit may be overridden.
- UB04 does not show column ‘2’ code 29130 with any modifier and therefore, reimbursement is not warranted.
- **CPT 71020** Radiologic examination, chest, 2 views, frontal and lateral, Status Indicator = Q3
- **CPT 93005** Electrocardiogram, routine ECG with at least 12 leads; tracing only, without interpretation and report, Status Indicator = S

- **CPT 94761** Noninvasive ear or pulse oximetry for oxygen saturation; multiple determinations (eg, during exercise), Status Indicator = N
- **CPT 96361 Intravenous infusion**, hydration; each additional hour; add on (List separately in addition to code for primary procedure); **Parenthetical Guidelines specific to 96361 – use 96361 in conjunction with 96360; Report 96361 to identify hydration if provided as a secondary or subsequent service after a different initial service [96360, 96365, 96374, 96409, 96413] is administered through the same IV access.**
- A Parent code for 96361 was not identified on UB04. Reimbursement of 96361 is not warranted.
- **CPT 96372** Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular; Status Indicator = S
- **CPT 96375** Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); each additional sequential intravenous push of a new substance/drug (List separately in addition to code for primary procedure); **Parenthetical Guidelines specific to 96375: Use 96375 in conjunction with 96365, 96374, 96409, 96413;**
- A Parent code for 96375 was not identified on UB04. Reimbursement of 96375 not warranted.
- § 9789.33, 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.
- **Q1 - STV-Packaged Codes; Paid under OPPS; Addendum B displays APC assignments when services are separately payable. (1) Packaged APC payment if billed on the same date of service as a HCPCS code assigned status indicator "S," "T," or "V". (2) In other circumstances, payment is made through a separate APC payment.**
- **Q3 - Codes that may be paid through a composite APC; Paid under OPPS; Addendum B displays APC assignments when services are separately payable. Addendum M displays composite APC assignments when codes are paid through a composite APC. (1) Composite APC payment based on OPPS composite-specific payment criteria. Payment is packaged into a single payment for specific combinations of service. (2) In all other circumstances, payment is made through a separate APC payment or packaged into payment for other services.**
- Pursuant 9789.32: For services rendered on or after September 1, 2014: the item has a **status code N, Q1, Q2, or Q3 and is packaged into the APC payment for the emergency room visit, surgical procedure, or Facility Only Service (in which case no additional fee is allowable).**
- Reimbursement of codes 71020 and 94761 is not warranted.
- Provider also billed code 99285-25.
- Modifier -25: Significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service.
- Documentation supports a separate evaluation and management service on date of service 7/23/2015. Reimbursement of 99285-25 is warranted.
- Contractual Agreement not submitted for IBR.
- Pursuant to § 9789.33, reimbursement is indicated for billed codes 99285-25, 96372 and 93005.

The table below describes the pertinent claim line information.

**DETERMINATION OF ISSUE IN DISPUTE: 99285-25, 96372 and 93005**

<b>Date of Service: 07/23/2015</b> HOSP ASC						
<b>Service Code</b>	<b>Provider Billed</b>	<b>Plan Allowed</b>	<b>Dispute Amount</b>	<b>Units</b>	<b>Workers' Comp Allowed Amt.</b>	<b>Notes</b>
99285	\$3,166.00	\$0.00	\$667.47	1	\$667.47	<b>\$667.47 Due Provider Refer to Analysis</b>
96372	\$465.00	\$0.00	\$32.26	1	\$32.26	<b>\$32.26 Due Provider Refer to Analysis</b>
93005	\$557.00	\$0.00	\$11.07	1	\$10.05	<b>\$10.05 Due to Provider</b>

Copy to:

[REDACTED]  
[REDACTED]  
[REDACTED]

Copy to:

[REDACTED]  
[REDACTED]  
[REDACTED]