

**MAXIMUS FEDERAL SERVICES, INC.**

Independent Bill Review  
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**INDEPENDENT BILLING REVIEW FINAL DETERMINATION**

March 16, 2016

[Redacted]  
[Redacted]  
[Redacted]

IBR Case Number:	CB16-0000252	Date of Injury:	06/08/2015
Claim Number:	[Redacted]	Application Received:	02/18/2016
Claims Administrator:	[Redacted]		
Date(s) of service:	06/11/2015 – 06/11/2015		
Provider Name:	[Redacted]		
Employee Name:	[Redacted]		
Disputed Codes:	71275, 96374, 96375, 96361, and 99283		

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 \$563.51 in additional reimbursement for a total of \$758.51. A detailed explanation of the decision is provided later in this letter.**

The Claim Administrator is required to reimburse the Provider a total of **\$758.51** 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

[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 Fee Schedule
- National Correct Coding Initiatives
- Medicare and Medicaid Services (CMS) Outpatient Prospective Payment System (OPPS)
- Other: OMFS Outpatient Hospital 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: Provider seeking remuneration for 71275, 96374, 96375, 96361, and 99283 for date of service 06/11/2015.**
- Provider billed the disputed HCPCS code on a UB04, bill type 131 for date of service 06/11/2015.
- EOR's reflect services denied as "included" with services billed on same day.
- Opportunity to Dispute Eligibility communicated to provider on 02/22/2016; response not yet received.
- Contractual Agreement states the following: "Notwithstanding the Contract rates contained herein, the amount payable for services rendered to occupationally ill/injured employees shall be the amount payable under guidelines established under any State law or regulation pertaining to health care services rendered to occupationally ill/injured employees. Any Workers' Compensation Service not having a fee schedule allowable shall be reimbursed at the Contract rate."
- 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."
- CPT's in Dispute:
  - **71275** Computed tomographic angiography, chest (noncoronary), with contrast material(s), including noncontrast images, if performed, and image postprocessing.
    - **PC/TC Component**
  - **96734** Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); intravenous push, single or initial substance/drug. Status Indicator "S," **PC/TC Indicator "5"**
  - **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) Status Indicator "S," **PC/TC Indicator "5"**
  - **96361** Intravenous infusion, hydration; each additional hour (list separately in addition to code for primary procedure) Status Indicator "S," **PC/TC Indicator "5"**
  - **99283 Emergency** department visit for the evaluation and management of a patient, which requires these 3 key components: an expanded problem focused history; an expanded problem focused examination; and medical decision making of moderate complexity. counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature. Status Indicator "V."
- **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.
- **Provider Seeking \$281.83 for CPT 71275.** The **Technical Component** is separately reimbursable.
- Although the Status Indicators for CPT **96374, 96375, and 96361** = “S,” these codes are listed on the CMS Physician Fee Schedule Relative Value File, with a PC/TC Indicator of “5” and are not separately reimbursable.
- **CCR 9789.12.9 The Medicare PC/TC** Indicators have been adapted for Workers’ Compensation and have the following meanings: **5 Incident To Codes**-This indicator identifies codes that describe services covered incident to a physician's service when they are provided by auxiliary personnel employed by the physician and working under his or her direct personal supervision. **These services are not payable when they are provided to hospital inpatients or patients in a hospital outpatient department.** Modifiers 26 and TC cannot be used with these codes.
- **CPT code 99283** has a status code indicator of ‘V,’ which means this code is considered a clinic or Emergency Department visit; may include ER physician or personal physicians. A separate APC payment can be paid for this code.
- Effective December 1, 2014, For services rendered on or after December 1, 2014, section 9789.31, subsections (a) and (b) are amended to incorporate by reference selected sections of the updated calendar year 2014 version of CMS’ hospital outpatient prospective payment system (HOPPS) published in the Federal Register on December 10, 2013, the updated fiscal year **2014 versions of CMS’ IPPS** Tables 2, 4A, 4B, 4C, and 4J in the final rule of August 19, 2013 and associated rules and notices to the IPPS final rule, respectively
- **Based on the aforementioned documentation and guidelines, reimbursement is indicated for 71275, 99283 and is upheld for 96374, 96375 & 96361.**

The table below describes the pertinent claim line information.

