

MAXIMUS FEDERAL SERVICES, INC.

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



INDEPENDENT BILLING REVIEW FINAL DETERMINATION

February 2, 2015

[Redacted]

IBR Case Number:	CB14-0001571	Date of Injury:	12/19/2013
Claim Number:	[Redacted]	Application Received:	10/20/2014
Claims Administrator:	[Redacted]	Assignment Date:	11/12/2014
Provider Name:	[Redacted]		
Employee Name:	[Redacted]		
Disputed Codes:	86900, 86850, 86901, 36415, 82055 (85055), 82150, 80048, 85027, 85384, 85610, 85730, 85007, 71010, 74177 (74160), 99291 (99281), 96374 (90784), 94761, J2405, Q9967 and G0390		

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 \$250.00 for the review cost and \$1,312.42 in additional reimbursement for a total of \$1,562.42. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of \$1,562.42 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
- Official Medical 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 full remuneration for 86900, 86850, 86901, 36415, 82055 (85055), 82150, 80048, 85027, 85384, 85610, 85730, 85007, 71010, 74177 (74160), 99291 (99281), 96374 (90784), 94761, J2405, Q9967, & G0390. Critical Care and related services performed on 12/19/2013.**
- 2nd EOR dated 09/22/2014 indicates \$527.21 reimbursement of \$16,994.95 charge.
- Provider indicates additional expected payment of \$1,809.66 is warranted for billed procedure codes.
- UB-04, Bill Type 137 Hospital Outpatient when compared to EOR 09/22/2014 reflects a discrepancy between three (3) procedure codes: 1) UB-04 indicates Procedure Code 99291-25 whereas the EOR reflects 99281-25. 2) UB-04 indicates Procedure Code 82055 whereas the EOR reflects 85055. 3) UB-04 Indicates Procedure Code 96374 whereas the EOR reflects 90872.
- 99281-25 assigned by the Claims Administrator with the rationale: "Service not paid under outpatient facility schedule."
- Partial Contractual Agreement indicates 99281-25 Emergency Department Service is separately reimbursable at \$120,712.00 when billed with Revenue Code 0682 (G0390) Trauma Response with Hospital Critical Care Service.
- Since there is no explanation listed, per Labor Code §4603.2 (d) (2), as to the reason for the 99291-25 code change to 99281-25, IBR will utilize the actual billed code for analysis of the claim.
- OMFS 2013 fee schedule reflects 99291-25 and has a status indicator of "Q3." Addendum "B" of the 2013 OPPS payment system does not indicate an alternative status can be applied. Status 'Q3' §9789.23 the OMFS indicates "no additional fee is allowable."
- G0390; denied by the Claims Administrator indicating, "The OMFS does not list this code. No payment is being made at this time. Please resubmit your claim with the OMFS code(s) that best describe the service(s) provided and your supporting documentation."

- G0390 is a valid code for 2013 with a relative value with a status indicator of “S.” Status indicator ‘S’ indicates a separate APC payment is allowable.
- 96374 Therapeutic Prophylactic injection; denied by the Claims Administrator as a “bundled service,” has a status indicator of “S.” Status indicator ‘S’ indicates a separate APC payment is allowable.
- CPT Codes 86900, 86850, 86901, 36415, 82150, 80048, 85027, 85384, 85610, 85730, 85007, 71010, 74177, 99291, & 94761 Reflected as reimbursed on EOR 09/22/2014 with the following rational: “This charge was adjusted to comply with the rate and rules of the contract indicated.”
- Partial contractual agreement received does not list the contractual amounts or percentage rates of reimbursement for CPT Codes: 86900, 86850, 86901, 36415, 82150, 80048, 85027, 85384, 85610, 85730, 85007, 71010, 99291, & 94761. As such, IBR unable to determine if reimbursed amount for each code is in accordance with the contractual agreement.
- EOR reflects CPT Code 82055 Alcohol (ethanol); any specimen except breath reimbursed by the Claims Administrator as CPT 85055 reticulated platelet assay, with the following rational: “Service not reimbursable under Outpatient Facility Fee Schedule. Charge has been adjusted to the scheduled allowance.”
- CPT 82055 is a valid code for the date of service indicated and has a service indicator of “A,” and is separately reimbursable in accordance with Title 8, California Code of Regulations, §9789.50 Laboratory Fee Schedule.
- CPT 96374 Ther. proph. Diag. inj. IV push; Reimbursed by the Claims Administrator as CPT 99281 Therapeutic Injections Sub Q, IM. Rational for code change not stated on 2nd EOR 09/22/2013.
- CPT 96734 is a valid code for the date of service and has a status indicator code of “S,” and is a separately reimbursable APC payment.
- CPT 94761 Noninvasive ear or pulse oximetry and J2405 Odansetron hcl injection, denied by the Claims Administrator has a status indicator of “N” and is not separately reimbursable.
- COT Q9967 Low osmolar contrast material, 300-399 mg/ml iodine concentration, per m, x 100 Units has a status indicator of “N” and is not separately reimbursable.
- Revenue Code 0272, Med/Surg. Supplies denied by the Claims Administrator is not separately reimbursable as these supplies are bundled in with services performed on 12/19/2013.
- 2013 fee schedule reflects 74177 CT and CTA with Contrast and has a status indicator of “Q3.” Addendum “B” of the 2013 OPFS payment system does not indicate an alternative status can be applied. Status ‘Q3’ §9789.23 the OMFS indicates “no additional fee is allowable.”

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Additional reimbursement for codesw 86900, 86850, 86901, 36415, 82055 (85055), 82150, 80048, 85027, 85384, 85610, 85730, 85007, 71010, 74177 (74160), 99291 (99281), 96374 (90784), 94761, J2405, Q9967, & G0390 is warranted.

Date of Service: 12/19/2013						
Hospital Outpatient						
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Units	Workers’ Comp Allowed Amt.	Notes
G0390	\$5,657.00	\$0.00	\$1,258.59	1	\$1,258.56	OMFS – Reimbursed Amount = \$1,258.59 Due Provider, Refer to Analysis
82055	\$243.00	\$44.16	\$17.82	1	\$17.82	Reimbursed as 85055
86900	\$98.00	\$4.92	\$4.92	1	\$4.92	Refer to Analysis

86850	\$146.00	\$19.50	\$24.72	1	\$19.50	Refer to Analysis
86901	\$98.00	\$4.92	\$4.92	1	\$4.92	Refer to Analysis
36145	\$39.00	\$14.54	\$3.60	1	\$14.54	Refer to Analysis
82150	\$153.00	\$10.69	\$4.92	1	\$10.69	Refer to Analysis
80048	\$265.00	\$13.96	\$13.96	1	\$13.96	Refer to Analysis
85027	\$109.00	\$10.67	\$10.67	1	\$10.67	Refer to Analysis
85384	\$177.00	\$14.02	\$14.02	1	\$14.02	Refer to Analysis
85610	\$111.00	\$6.48	\$6.48	1	\$6.48	Refer to Analysis
85730	\$175.00	\$9.90	\$9.90	1	\$9.90	Refer to Analysis
85007	\$89.00	\$5.68	\$5.68	1	\$5.68	Refer to Analysis
71010	\$399.00	\$22.80	\$22.80	1	\$22.80	Refer to Analysis
74177	\$4,875.00	\$277.64	\$277.64	1	277.64	74160 Refer to Analysis
99291	\$3,045.00	\$71.32	\$202.80	1	\$71.31	99281 Refer to Analysis
96374	\$202.00	\$15.32	\$185.95	1	\$53.85	Reimbursed As 90784 OMFS – Reimbursed Amount = \$28.53 Due Provider, Refer to Analysis
94761	\$310.00	\$28.63	\$28.63	1	\$28.63	Refer to Analysis
J2405	\$2.45	\$0.00	\$2.45	1	\$0.00	Refer to Analysis
Q9967	\$202.00	\$0.00	\$4.92	1	\$0.00	Refer to Analysis

Copy to:

████████████████████
████████████████
████████████████████████████

Copy to:

██
████████████████████████████████
████████████████████████