

INDEPENDENT BILLING REVIEW FINAL DETERMINATION

April 23, 2015

[REDACTED]

IBR Case Number:	CB15-0000164	Date of Injury:	05/24/2013
Claim Number:	[REDACTED]	Application Received:	02/04/2015
Claims Administrator:	[REDACTED]		
Assigned Date:	02/24/2015		
Provider Name:	[REDACTED]		
Employee Name:	[REDACTED]		
Disputed Codes:	99284, 94761, 96372, 71020 and 93010		

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 \$15.07 in additional reimbursement for a total of \$210.07. A detailed explanation of the decision is provided later in this letter.

Note: The application you submitted included a check for \$250.00. The application fee was \$195.00. Maximus will reimburse the \$55.00 overpayment of the application fee.

The Claim Administrator is required to reimburse the Provider a total of \$210.07 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, MD MPH
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
- 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: Reimbursement of CPT 94761, 96372, 71020, 93010 and 99284.**
- Provider billed the disputed CPT codes on a UB04, bill type 131 for date of service 10/14/2014.
- Based on the NCCI edits The following code pairs generally cannot be reported together: 94761 and 99285;
- Modifier Indicator column shows '1' which states if a proper modifier is appended to the correct code and documentation supports the use of the procedure code then the edit may be overridden.
- Modifiers that may be used under appropriate clinical circumstances to bypass an NCCI edit include:
 - Anatomic modifiers: E1-E4, FA, F1-F9, TA, T1-T9, LT, RT, LC, LD, RC, LM, RI
 - Global surgery modifiers: 24, 25, 57, 58, 78, 79
 - Other modifiers: 27, 59, 91
- A qualifying modifier was not appended to the column 2 code: CPT 99285.
- Reimbursement is not recommended for CPT 99285.
- CPT 94761 has an assigned Status Indicator of "N."

- Definition of Payment Status Indicator “N”: Items and Services Packaged into APC Rates. Paid under OPPS; payment is packaged into payment for other services. Therefore, there is no separate APC payment. Reimbursement is not recommended for CPT 94761.
- 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. For purposes of this section, emergency room visits and surgical procedures shall be defined by HCPCS codes set forth in section 9789.39(b) by date of service. A facility fee is pay-able only for the specified emergency room, surgical codes, Facility Only Services, and for supplies, drugs, devices, blood products and biologicals that are an integral part of the emergency room visit, surgical procedure, or Facility Only Service.
 - (b) Sections 9789.30 through 9789.39 apply to any hospital outpatient department as defined in Section 9789.30(o) and any ASC as defined in Section 9789.30(c).
 - (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.
 - (i) 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.
 - Based on the above mentioned guidelines the reimbursement for CPT 71020-27, 96372 and 93010 was not correct. Additional Reimbursement is recommended for CPT 71020-27, 96372 and 93010.
 - Reimbursement is not recommended for the disputed codes: 99285 and 94761.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Recommended reimbursement of code 71020-27, 96372, 93010, 99285 and 94761.

Date of Service: 10/14/2014						
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Multiple Surgery	Workers' Comp Allowed Amt.	Notes
71020-27	\$ 1023.00	\$ 33.90	\$.35	N/A	\$ 34.25	DISPUTED SERVICE: See Analysis. Additional Reimbursement of \$.35 recommended
96372	\$463.00	\$23.13	\$7.68	N/A	\$30.81	DISPUTED SERVICE: See Analysis. Additional Reimbursement of \$7.68 recommended
93010	\$537.00	\$2.67	\$7.04	N/A	\$9.71	DISPUTED SERVICE: See Analysis. Additional Reimbursement of \$7.04 recommended
99285	\$2255.00	\$0.00	\$327.42	N/A	\$0.00	DISPUTED SERVICE: See Analysis.
94761	\$370.00	\$0.00	6.04	N/A	\$0.00	DISPUTED SERVICE: See Analysis.

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