

MAXIMUS FEDERAL SERVICES, INC.

Independent Bill Review
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Fax: (916) 605-4280



INDEPENDENT BILLING REVIEW FINAL DETERMINATION

March 4, 2016

[Redacted]
[Redacted]
[Redacted]
[Redacted]

IBR Case Number:	CB16-0000203	Date of Injury:	08/11/2014
Claim Number:	[Redacted]	Application Received:	02/11/2016
Claims Administrator:	[Redacted]		
Date(s) of service:	08/11/2014 – 08/11/2014		
Provider Name:	[Redacted]		
Employee Name:	[Redacted]		
Disputed Codes:	G0390, 90788, and 90784		

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 \$946.78 in additional reimbursement for a total of \$1,141.78. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of **\$1,141.78** 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 G0390 Trauma Response 90788 Intramuscular injection of antibiotic and 90784 Therapeutic, prophylactic or diagnostic injection; intravenous, services performed 08/11/2014.**
- EOR 01/14/2016 Document Number 030617165, Check Number CU-26546 reflects the following reimbursement for G0390, 90788 & 90784:
 - G0390 \$0.00
 - 90788 \$30.76
 - 90784 \$31.37
- Based on EOR 01/17/2016, Additional reimbursement is not indicated for 90788 and 90784.
- Based on Date of Service, 08/11/2014 applicable to HOPPS OMFS Regulation effective Apr. 1, 2013 sections 9789.30 - 9789.3
- **Acting Administrative Director Order effective April 1, 2013 § 9789.32** (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. For purposes of this section, **emergency room visits** shall be **defined by** CPT codes **99281-99285** and surgical procedures shall be defined by CPT codes 10021-69990. **A facility fee is payable only for the specified emergency room** and surgical codes and for supplies, drugs, devices, blood products and biologicals **that are an integral part of the emergency room visit** or surgical procedure.
- Based on Provider Type, Bill Type, and Date of Service **08/11/2014**, **HCPCS G0390** is reimbursable under HOPPS OMFS beginning **09/01/2014**.
- **APC payment rates are not applicable to HCPCS G0390** as these services were not classified as “emergency room” or related services under the OMFS for date of service 08/11/2014. **§ 9789.32 (1)** The maximum allowable fees for professional medical services which are performed by physicians and other licensed health care providers shall be paid according to **§ 9789.10 and § 9789.11**.
- **OMFS RBRVS - Physician Services § 9789.10 and § 9789.11** reflect a relative value of “0.”
- **Contractual Agreement not submitted for IBR.**
- **Communication from Claims Administrator**, dated 02/22/2016 indicates acknowledgement of HCPCS G0390 and reimbursement status under § 9789.10 and § 9789.11. However, reimbursement was not issued due to “0” value and § 9792.2.7 (b)(1).
- **§ 9792.2.7 (b)** Unless as permitted by section 9792.5.12, independent bill review shall only be conducted if the only dispute between the provider and the claims administrator is the amount of payment owed to the provider. Any other issue, including issues of contested liability or the applicability of a contract for reimbursement rates under Labor Code section 5307.11 shall be resolved before seeking independent bill review. Issues that are not eligible for independent bill review shall include:
 - **(1)** The determination of a reasonable fee for services **where that category of services is not covered by a fee schedule** adopted by the Administrative Director or a contract for reimbursement rates under Labor Code section 5307.11.
- **§ 9792.2.7 (b) is not applicable to HCPCS G0390** as the category of services is covered under the OMFS RBRVS; the value itself is undetermined, not the service. **LC 5307.11** is not applicable as the Contractual Agreement was not submitted for IBR.

- **§ 9789.33** For services rendered on or after January 1, 2013 “S”, “T”, “X”, or “V”, “Q1”, “Q2”, or “Q3”. Status code indicators “Q1”, “Q2”, and “Q3” must qualify for separate payment. **G0390 HOPPS = S, Physician = X**
- **Since the APC formula cannot be applied to G0390 and, based on date of service, the 01/01/2014 OMFS RBRVS does not list a value for G0390** and the Claims Administrator acknowledged, by reference to § 9789.10 and § 9789.11 that the Provider is due reimbursement for services rendered, **the maximum reasonable fee can be calculated as follows:**
 - A) Provider’s Charge: \$17,342.35
 - B) Provider’s 2014 Cost-To-Charge Ratio: 0.191
 - C) 2014 Facility Only Workman’s Compensation Multiplier: 1.01
 - $A \times B \times C = \text{Reasonable Fee}$
- **Based on the aforementioned documentation and guidelines, reimbursement is indicated for G0390 and additional reimbursement is not indicated for 90788 & 90784.**

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: G0390, 90788 & 90784

Date of Service: 08/11/2014 Physician Services						
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Units	Workers’ Comp Allowed Amt.	Notes
G0390	\$17,342.35	\$0.00	\$1,268.00	1	\$946.78	Refer to Analysis
90788	\$1,589.64	\$30.76	\$15.38	1	\$30.76	Refer to Analysis
90784	\$187.43	\$31.37	\$31.37	1	\$31.37	Refer to Analysis

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