MAXIMUS FEDERAL SERVICES, INC.
Independent Bill Review
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MAXIMUS Federal Services

INDEPENDENT BILLING REVIEW FINAL DETERMINATION

March 9, 2016

[redacted]

IBR Case Number:	CB16-0000217	Date of Injury:	05/13/2003
Claim Number:	[redacted]	Application Received:	02/12/2016
Assignment Date:	03/03/2016		
Claims Administrator:	[redacted]		
Date(s) of service:	08/05/2015 – 08/05/2015		
Provider Name:	[redacted]		
Employee Name:	[redacted]		
Disputed Codes:	HCPCS/CPT codes 80053, 85025, 96361, 96413, 99213-25, J7040, J7050 x 2, and J9035		

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 $1,682.19 in additional reimbursement for a total of $1,877.19. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of **$1,877.l9** 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
- Negotiated contracted rates: Contract Agreement
- Other: CCR § 5307.11, § 9789.50, § 9789.40

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 additional remuneration for 99213-25, 96361, 96413 80053, 85025, 96413, J7040. J7050 x 2 and J9035 for date of service 08/05/2015.**
- Final EOR indicates reimbursement as per contractual obligation and "section 2" of contractual agreement and the statement, "Per this facility's 2007 PPO amended contract, section #2 refers the provider back to the 2002 contract where #13 states "Nothing in this Agreement shall be construed as to require Payer to reimburse a greater amount or to cover more services than if this Agreement were not in effect".
- The Contract Agreement (copy) received for this review states the following under heading, "**Amendment to Participating Hospital Agreement"**:

> This Amendment to Participating Hospital Agreement ("Amendment") is entered into by and between Claims Administrator and Facility effective this August 1, 2007 to amend the agreement between the parties dated October 1, 1991 ("Agreement")
>
> 1. Amendment of Fee Addendum. The Fee Addendum is hereby deleted in its entirety and replaced as follows: Applicable for Group Health, **Workers' Compensation** and Other Payment Programs: A. Hospital Services All services **shall be reimbursed at 90% of Provider's billed charges.**

As an Exempt Facility under the California Workers' Compensation Official Medical Fee Schedule, **all Workers' Compensation services shall be reimbursed under the rates/items listed above**."

- Contractual Agreement **does not indicate** "eligible billed charges" or "eligible billed charges in accordance with a state mandated fee schedule." Contractual Agreement specifically indicates '90% of Provider's billed charges,' and acknowledges the Provider's "Exempt" status relating to the OMFS. **However, page 2, item 13** reflects the following contractual provision: '**Nothing in this Agreement shall be construed as to require Payer to reimburse a greater amount** or to cover more services than if this Agreement were not in effect, " indicating reimbursement subject to applicable sections of the OMFS for non-facility charges and the PPO Contract for facility related charges.
- **Exempt Facilities** under the OMFS are exempt from **Facility Only** reimbursement **but are not exempt** from reimbursement under various OMFS fee schedules such as DMEPOS, Laboratory, OMFS RBRVS, etc.
- **CCR § 5307.11:** A health care provider or health facility licensed pursuant to Section 1250 of the Health and Safety Code, and a contracting agent, employer, or carrier may contract for reimbursement rates different from those in the fee schedule adopted and revised pursuant to Section 5307.1. When a health care provider or health facility licensed pursuant to Section 1250 of the Health and Safety Code, and a contracting agent, employer, or carrier contract for reimbursement rates **different from those in the fee schedule**, the medical fee schedule for that health care provider or health facility licensed pursuant to Section 1250 of the Health and Safety Code **shall not apply to the contracted reimbursement rates.**
- **CCR § 9789.50 (a)** Pathology and Laboratory: Effective for services after January 1, 2004, the maximum reasonable fees for pathology and laboratory services shall not exceed one hundred twenty (120) percent of the rate for the same procedure code in the CMS' Clinical Diagnostic Laboratory Fee Schedule, as established by Sections 1833 and 1834 of the Social Security Act (42 U.S.C. §§ 1395l and 1395m) and applicable to California.
- **EOR's reflect 80053 & 85025,** reimbursed accordingly pursuant to **CCR § 9789.50 (a)** Pathology and Laboratory Fee Schedule.
- **NCCI indicates CPT 96413**, Chemotherapy administration, intravenous infusion technique; up to 1 hour, single or initial substance/drug and **99213-25** Evaluation and Management Established Patient are paired codes.

Column 1	Column 2	CCI Edit Description	Modifier Indicator	Effective Date
96413	99213	Misuse of column two code with column one code	1	1/1/2009

- **EOR's reflect CPT 99213 denied as "not paid under OPPS." 99213 is not reimbursable pursuant to** Medicare Billing Manual, Page I6, and paragraph 1: Each edit table contains edits which are pairs of HCPCS/CPT codes that in general should not be reported together. Each edit has a column one and column two HCPCS/CPT code. If a provider reports the two codes of an edit pair, the column two code is denied, and the column one code is eligible for payment.
  - Clinical Note indicates Injured Worker presented for follow up on metastatic renal cell carcinoma. Modifier -25 applied to 99213 does not substantiate a significantly separately identifiable E&M service.

- EOR's reflect **CPT 96413 and 96361** reimbursed pursuant to § 9789.32. Applicability (iii) The fees for any physician and non-physician practitioner professional services billed by the hospital shall be calculated in accordance with the OMFS RBRVS, using the OMFS RBRVS total facility relative value units.
  - EOR reflects $181.43 total reimbursement.
  - As an exempt facility under the OMFS, "**facility**" fees do not apply and services are reimbursable under contractual provision of 90% of billed charges.
  - Additional Reimbursement is Due Provider pursuant to CCR § 5307.11
- **§ 9789.40. Pharmacy** (a) The maximum reasonable fee for pharmaceuticals and pharmacy services rendered after January 1, 2004 is 100% of the reimbursement prescribed in the relevant **Medi-Cal** payment system, including the Medi-Cal professional fee for dispensing.
- **§ 9789.40. Pharmacy** (2) If the National Drug Code for the drug product as dispensed is not in the Medi-Cal database and the National Drug Code for the underlying drug product from the original labeler is not in the Medi-Cal database, then the maximum fee shall be 83 percent of the average wholesale price of the lowest priced therapeutically equivalent drug, calculated on a per unit basis, plus the professional fee allowed by subdivision (b) of this section.
- **HCPCS J7040, J7050, & J7050**
  - Saline Solution
  - Nursing documentation for hydration not submitted for review.
  - Unable to verify dose/units; reimbursement Upheld.
- **J9035 HCPCS –** Medi-Cal Pricing
  - Medi-Cal Pricing sheet indicates $71.11 per 10mg unit.
  - Documentation reflects **998 mg** IV x1.
  - UB-04 reflects 100 units.
  - **HCPCS J9035 does not adequately represent 100% of the medication utilized**.
- **NDC Pricing for J9035 HCPCS**
  - Red Book reflects NDC 50242-0061-01 bevacizumab **25 mg/1 ml.**
  - Documentation reflects **998 mg** IV x1.
  - **39.92 mls** bevacizumab **total** product utilized
  - Injection Pricing Included in the Value of CPT 99213
  - DWC Calculator indicates $6,897.92 total ingredients utilized.
  - EOR reflect $6,665.00 reimbursement
  - **Additional Reimbursement Due Provider**
- **Based on the aforementioned documentation and guidelines, additional reimbursement is due for 96413, 96361, J9035 and is Upheld for CPT/HCPCs 99213-25 80053, 85025, J7040, J7050 and J7050.**

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: 99213-25, 96361, 96413 80053, 85025, J7040. J7050, J7050 and J9035

Date of Service: 08/05/2015					
HOPPS					
Service Codes	**Provider Billed**	**Plan Allowed**	**Dispute Amount**	**Workers' Comp Allowed Amt.**	**Notes**
96413 Add-On Code 96361	$1,182.12	$181.43	$1,449.37	$1,630.80	PPO (-) Reimbursed Amount = $1,449.37 Due Provider Refer to Analysis
99213 - 25	$280.00	$0.00	$252.00	$0.00	Refer to Analysis
80053, 85025	$553.00	$30.02	$475.89	$44.49	Refer to Analysis
J7040 J7050 J7050	$435.19	$21.81	$413.38	$21.81	Refer to Analysis
J9035	$37,789.45	$6,665.00	$27,345.51	$6,897.92	OMFS (-) Reimbursed Amount = $232.82 Due Provider Refer to Analysis

[redacted]

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