MAXIMUS FEDERAL SERVICES, INC.
Independent Bill Review
P.O. Box 138006
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Fax: (916) 605-4280

INDEPENDENT BILLING REVIEW FINAL DETERMINATION

April 29, 2016

[redacted]

IBR Case Number:	CB16-0000433	Date of Injury:	09/24/2010
Claim Number:	[redacted]	Application Received:	03/16/2016
Claims Administrator:	[redacted]		
Date(s) of service:	04/06/2015		
Provider Name:	[redacted]		
Employee Name:	[redacted]		
Disputed Codes:	0232T and 27096		

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 $2,750.00 in additional reimbursement for a total of $2,945.00. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of **$2,945.00** 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,

[redacted], 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
- National Correct Coding Initiatives
- Other: OMFS Physician Fee Schedule, 2015 AMA CPT

BHOW 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 27096 and 0232T - Platelet Plasma Injection service performed on Injured Worker for date of service 04/06/2015.**
- Claims Administrator denied codes with rationale "Based upon clinical review, the services were not identified in the Operative Report"
- IMR Final Determination Letter dated 1/13/2015 shows "1. Right Shoulder Platelet Rich Plasma (PRP) Injection is medically necessary and appropriate."
- **27096**: Injection procedure for sacroiliac joint, anesthetic/steroid, with image guidance (**fluoroscopy or CT**) including arthrography when performed
- Provider's PR-2 submitted documents **"ultrasound"** was utilized not fluoroscopy or CT.
- Reimbursement of 27096 is not warranted.
- Assigned Status Code for 0232T is 'C."
- § 9789.12.3 Status Codes C, I, N and R
    - (a) Except as otherwise provided in this fee schedule, for physician and non-physician practitioner services billed using Current Procedural Terminology (CPT) codes, the RVUs listed in the Centers for Medicare and Medicaid Services (CMS') National Physician Fee Schedule Relative Value File will be utilized regardless of status code.
    - (b) When procedures with status indicator codes C, N, or R, do not have RVUs assigned under the CMS' National Physician Fee Schedule Relative Value File, these services shall be reimbursed By Report.

- 0232T Reflects Zero Value under OMFS. As such, 0232T is a By Report Code and reimbursement is based on one of the following: contractual agreement, documented paid cost, or the Providers usual and customary fee.
- Review of the Primary Treating Physician's Progress Report, PRP service was performed and documented on date of service 4/6/2015.
- Based on the aforementioned documentation and guidelines, additional reimbursement is warranted for the billed code 0232T.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: 0232T

Date of Service: 04/06/2015							
Physician Services							
Service Code	**Provider Billed**	**Plan Allowed**	**Dispute Amount**	**Units**	**Multiple Surgery**	**Workers' Comp Allowed Amt.**	**Notes**
0232T	$2,750.00	$0.00	$2,750.00	1	N/A	$2,750.00	**$2,750.00 Due Provider**

[redacted]

[redacted]