

INDEPENDENT BILLING REVIEW FINAL DETERMINATION

November 3, 2014

[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]

| | | | |
|------------------------------|--|------------------------------|------------|
| IBR Case Number: | CB13-0000526 | Date of Injury: | 01/16/2003 |
| Claim Number: | [REDACTED] | Application Received: | 09/26/2013 |
| Claims Administrator: | [REDACTED] | | |
| Provider Name: | [REDACTED] | | |
| Employee Name: | [REDACTED] | | |
| Disputed Codes: | 99081, L3762, 99214, 99070 NDC # (52048000300) | | |

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.

IBR Case Assigned: 04/30/2014

Final Determination: UPHOLD. MAXIMUS Federal Services has determined that no additional reimbursement is warranted. The Claims Administrator’s determination is upheld and the Claim Administrator does not owe the Provider additional reimbursement. A detailed explanation of the decision is provided later in this letter.

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]
Chief Coding Reviewer

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
- Official Medical Fee Schedule
- Negotiated contracted rates: None received
- National Correct Coding Initiatives
- Other: 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 is dissatisfied with the zero reimbursement of billed codes 99081, L3762, 99214, 99070 NDC # (52048000300).
- Claims Administrator denied claim and indicates in the Explanation of Review “You are not in the MPN that applies to the claim. Accordingly, your services are unauthorized and not subject to reimbursement.”
- According to the National Plan & Provider Enumeration System, Provider is indeed authorized to perform the services billed. NPPES information on this Provider can be viewed at the link provided:

- Provider submitted two documents of Reconsiderations. Both documents discuss the Provider’s participation of the MPN, the injured worker can be seen by the nurse practitioner and other bills submitted by this provider have been reimbursed before and after this date of service. Reconsideration dated September 3, 2013 also mentions “CRR 9792, states ‘The fee is determined by the use of the Official Medical Fee Schedule’, it also states in CRR 9791 ‘...the Official Medical Fee Schedule applies to all covered medical services provided...’”
- PPO Contract was requested but not received so unable to determine any financial arrangement between Claims Administrator and Provider.
- Other than the two Reconsideration documents submitted, is the CMS 1500 form with billed with codes 99081, L3762, 99214 and 99070 NDC # (52048000300).

