

INDEPENDENT BILLING REVIEW FINAL DETERMINATION

December 16, 2014

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

IBR Case Number:	CB14-0001193	Date of Injury:	04/27/2014
Claim Number:	[REDACTED]	Application Received:	08/21/2014
Claims Administrator:	[REDACTED]	Assignment Date:	09/23/2014
Provider Name:	[REDACTED]		
Employee Name:	[REDACTED]		
Disputed Codes:	64702, 99060		

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 \$250.00 for the review cost and \$883.49 in additional reimbursement for a total of \$1133.49. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of \$1133.49 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]
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
- Official Medical Fee Schedule
- Negotiated contracted rates:
- National Correct Coding Initiatives
- Medicare and Medicaid Services (CMS) Outpatient Prospective Payment System (OPPS)
- Other:

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 disputing the PPO Discount taken in reimbursement by Claims Administrator. Provider disputes there is a contract agreement with Claims Administrator and contract had been terminated over a year ago.
- Claims Administrator reimbursed \$567.76 indicating on the Explanation of Review “This charge was adjusted to comply with the rate and rules of the contract indicated.”
- For services rendered before January 1, 2013, "Workers' Compensation Multiplier" means the 120% Medicare multiplier required by Labor Code Section 5307.1, or the 122% multiplier that includes an extra 2% reimbursement for high cost outlier cases. For services rendered in hospital outpatient departments on or after January 1, 2013, Workers' Compensation Multiplier means the 120% Medicare multiplier or the 122% multiplier that includes an extra 2% reimbursement for high cost outlier cases. For services rendered in ambulatory surgical centers on or after January 1, 2013, the Workers' Compensation Multiplier will be 80% Medicare multiplier, or the 82% multiplier that includes an extra 2% reimbursement for high cost outlier cases.
- Documentation submitted by Provider shows a Termination of Contract letter with Claims Administrator dated January 15, 2013.

- Claims Administrator did not dispute the termination of contract with any proof that a contract with Provider is withstanding. Therefore, Provider is warranted reimbursement of services performed on date of service 5/2/2014.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: Based on information reviewed, additional reimbursement of services is warranted.

Date of Service: 5/2/2014						
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Multiple Surgery	Workers' Comp Allowed Amt.	Notes
64702 & 99060	\$1451.25	\$567.79	\$883.49	N/A	\$1451.25	DISPUTED SERVICE: Allow reimbursement \$883.49

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