

INDEPENDENT BILLING REVIEW FINAL DETERMINATION

June 15, 2015

[Redacted]
[Redacted]
[Redacted]

IBR Case Number:	CB15-0000372	Date of Injury:	02/13/2013
Claim Number:	[Redacted]	Application Received:	03/16/2015
Assignment Date:	04/14/2015		
Claims Administrator:	[Redacted]		
Date(s) of service:	09/11/2014 – 09/11/2014		
Provider Name:	[Redacted]		
Employee Name:	[Redacted]		
Disputed Codes:	WC004-17 (x11Units) & 99499-17 (x6 Units)		

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 \$93.12 in additional reimbursement for a total of \$288.12. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of **\$288.12** 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).

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 additional remuneration for WC004 Primary Treating Physician's Permanent and Stationary Report and 99499 Unlisted Evaluation and Management Services performed on 09/11/2014.**
- Claims Administrator denied reimbursement based on the following rationale:
 - WC004 – Report by secondary treating physician is not separately reimbursable per OMFS.
 - 99499 – Documentation provided does not justify the payment for a Prolonged Evaluating and Management Service.
- **Prior-Authorization** signed by Claims Administrator **8/19/2014** approved WC004 and 99499 with the Provider's Usual and Customary Charge. The services were pre-approved for 9/11/2014 date of service.
- **09/11/2014 Permanent and Stationary** report reviewed, for WC004 and 99499, Provider documents services on page 1 of report.
- **Pursuant to LC § 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.**

- The aforementioned 8/14/2014 Prior-Authorization is contractual in nature. As such, the contractual rates apply pursuant to LC § 5307.11.
- EOR 02/23/2015, indicates Provider paid in full for WC004. 99499 changed to 99358 for “record review” reimbursed \$124.94 of \$218.03.
- Page 1, provider states ‘1.5” hours of record review. Contractual Agreement usual and customary fee states \$37.00 per 15 min.
 - 6 units x \$37.00 = \$222.00
- Based on the aforementioned documentation and guidelines, additional reimbursement is warranted for 99499.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: WC004 & 99499

Date of Service: 09/11/2014							
Pharmacy							
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Assist Surgeon	Units	Workers’ Comp Allowed Amt.	Notes
WC004	\$276.00	\$276.00	\$276.00	N/A	1	\$276.00	Refer to Analysis
99499 as 99358	\$218.03	\$124.91	\$93.12	N/A	6	\$218.03	\$93.12 Due Provider Refer to Analysis

Copy to:

████████████████████
 ████████████████
 ██████████████████

Copy to:

██
 ████████████████████████████████████
 ████████████████████████████████