MAXIMUS FEDERAL SERVICES, INC.
Independent Bill Review
P.O. Box 138006
Sacramento, CA 95813-8006
Fax: (916) 605-4280

INDEPENDENT BILLING REVIEW FINAL DETERMINATION

June 10, 2015

[redacted]

IBR Case Number:	CB15-0000379	Date of Injury:	04/22/2014
Claim Number:	[redacted]	Application Received:	03/16/2015
Assignment Date:	04/14/2015		
Claims Administrator:	[redacted]		
Date(s) of service:	10/16/2014 – 10/16/2014		
Provider Name:	[redacted]		
Employee Name:	[redacted]		
Disputed Codes:	99214-17 & WC002		

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: 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,

Paul Manchester, 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
- 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 99214 Established Patient and WC002 Primary Treating Physician Progress Report for date of service 09/08/2014.**
- EOR reflects Claims Administrator's reimbursement rational as follows:
  - 99214 – PPO Reduction
  - WC002 – PPO Reduction
- EOR indicates Provider was reimbursed for 99214 & WC002.
- IBR Application reflects Claims Administrator Listed on 1st and 2nd EOR.
- Correspondence from the Provider to the Contracting network agent presented for IBR, indicates the Provider is not aware of a contractual agreement.
- Provided documentation does not include a response from Claims Administrator regarding Contractual Agreement.
- **Labor Code § 4611 states:** (a) When a contracting agent sells, leases, or transfers a health provider's contract to a payor, the rights and obligations of the Provider shall be governed by the underlying contract between the health care provider and contracting agent.
- **Research** on the Claims Administrator's web-site listed on the IBR application indicates the contracting agent and lists the Provider as part of the network.
- **Pursuant to LC § 5307.11** – "the medical fee schedule shall not apply to the contracted reimbursement rates." California State Assembly Bill 1177 amended the Labor Code effective January 1, 2002 to add §5307.11:

- **LC § 5307.11 states:** 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**.
- **§ 9792.5.7 (b)** Unless as permitted by section 9792.5.12, independent bill review shall only be conducted if the only dispute between the provider and the claims administrator is the amount of payment owed to the provider. Any other issue, including issues of contested liability or the applicability of a contract for reimbursement rates under Labor Code 5307.11shall be resolved before seeking independent bill review.
- Without a contractual agreement, a network discount cannot be verified for mathematical accuracy.
- Based on the aforementioned guidelines, IBR is prohibited from resolving conflicts contractual in nature.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: 99214-17 & WC002

Date of Service: 10/16/2014							
Med-Legal Services							
Service Code	**Provider Billed**	**Plan Allowed**	**Dispute Amount**	**Assist Surgeon**	**Units**	**Workers' Comp Allowed Amt.**	**Notes**
99214-17	$230.00	$69.65	$55.49	N/A	1	$69.65	**Refer to Analysis**
WC002	$11.91	$7.15	$4.76	N/A	1	$7.15	**Refer to Analysis**

Copy to:

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