

INDEPENDENT BILLING REVIEW FINAL DETERMINATION

June 16, 2015

[Redacted]
[Redacted]
[Redacted]

IBR Case Number:	CB15-0000396	Date of Injury:	11/14/2014
Claim Number:	[Redacted]	Application Received:	03/18/2015
Assignment Date:	04/21/2014		
Claims Administrator:	[Redacted]		
Date(s) of service:	01/08/2015 – 01/08/2015		
Provider Name:	[Redacted]		
Employee Name:	[Redacted]		
Disputed Codes:	90791 & 96118		

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 \$235.54 in additional reimbursement for a total of \$430.54. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of **\$430.54** 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 full OMFS remuneration for 96118 Neuropsych Testing and 90791 Psych Diagnostic Evaluation services performed 01/08/2015.**
- The Claims Administrator's reimbursement for services was based on an indicated "contract."
- Authorization December 2, 2014 with stamped signature by Claims Administrator agreed to the following for 96118 and 90791 services: "Agree to pay based on CA fee Schedule," hand written on authorization.
- EOR's reflect charges based on "PPO" reduction.
- Initial Neuropsychological Evaluation reviewed, time is documented for codes in dispute.
- CA response 4/6/2014 indicates the Provider was reimbursed in accordance with existing contract. Aforementioned authorization signed by Claims Administrator includes "... services are to be paid at the Official Medical Fee Schedule rate without any reductions or adjustment."
- **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.**

- Based on the aforementioned documentation and guidelines, additional remuneration is warranted for 96118 and 90791.

The table below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: 90791 & 96118

Date of Service: 01/08/2015							
Pharmacy							
Service Code	Provider Billed	Plan Allowed	Dispute Amount	Assist Surgeon	Units	Workers' Comp Allowed Amt.	Notes
90791	\$150.50	\$102.00	\$48.50	N/A	1	\$150.50	\$48.50 Due Provider – Refer to Analysis
96118	\$1,587.04	\$1,400.00	\$187.04	N/A	1	\$1,587.04	\$187.04 Due Provider – Refer to Analysis

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